Hoosier Healthwise
Health Care Program

HEALTHY INDIANA PLAN℠
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External Quality Review of Indiana's Hoosier Healthwise Program and Healthy Indiana Plan for the Review Year Calendar 2013

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ABBREVIATIONS LIST

Abbreviation	Meaning
ABD	Aged, Blind, or Disabled
B&A	Burns & Associates, Inc.
BH	Behavioral Health
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CHIP	Children's Health Insurance Program
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
CY	Calendar Year
DM/CM	Disease Management/Care Management/Case Management
EOB	Explanation of Benefits
EQR	External Quality Review
EQRO	External Quality Review Organization
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FSSA	Family and Social Services Administration
HEDIS	Healthcare Effectiveness Data and Information Set
HHW	Hoosier Healthwise
HIP	Healthy Indiana Plan
HRA	Health Risk Assessment
HRS	Health Risk Screening
IEP	Individualized Education Plans
IHCP	Indiana Health Coverage Programs (Indiana's Medicaid Programs)
IRU	Internal Resolution Unit
ISMA	Indiana State Medical Association
MCE	Managed Care Entity
MCO	Managed Care Organization
MHS	Managed Health Solutions
NEMT	Non-emergency Medical Transportation
NOP	Notification of Pregnancy
OMPP	Office of Medicaid Policy and Planning
PA	Prior Authorization
PCCM	Primary Care Case Management
PIHPs	Prepaid Inpatient Health Plans
PIPs	Performance Improvement Projects
PMP	Primary Medical Provider
PMPM	Per Member Per Month
POWER Account	Personal Wellness and Responsibility Account
PR	Provider Relations
QIP	Quality Improvement Project
RA	Remittance Advice
RHC	Rural Health Clinic
RY	Reviewed Year
SAS	Statistical Analysis System
SWOT	Strengths, Weaknesses, Opportunities, and Threats Analysis
TANF	Temporary Assistance for Needy Families
TPL	Third Party Liability

EXECUTIVE SUMMARY

As the state agencies responsible for Indiana's Medicaid program, the Family and Social Services Administration (FSSA) and the Indiana Office of Medicaid Policy and Planning (OMPP) have implemented two managed care programs using Section 1115 waiver authority. The Hoosier Healthwise (HHW) program, which began in 1994, covers children, pregnant women, and low-income families. The Healthy Indiana Plan (HIP), which began in 2008, covers custodial parents, noncustodial parents and childless adults ages 19 through 64 with family income up to 200 percent of the Federal Poverty Level who are not otherwise eligible for Medicare or Medicaid.

At the end of Calendar Year (CY) 2013, enrollment in HHW was 685,674 and enrollment in HIP was 34,562. Enrollment decreased 5.6 percent for HHW children and increased 19.8 percent for HHW adults when comparing the populations from the end of CY 2012 to the end of CY 2013. The HIP enrollment decreased 8.0 percent in CY 2013 from the previous year.

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

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

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

EQRO Activities in CY 2014

In past EQRs, B&A has worked with the OMPP on the topics to cover in each annual review. A more general review of compliance with Medicaid managed care regulations occurred for HHW and for HIP in the CY 2012 review. This year, in cooperation with the OMPP, B&A developed focus studies in addition to the mandatory activities. This year's topics include the following:

- Validation of Performance Measures
- Validation of MCE Performance Improvement Projects
- Optional EQR Activity: Focus Study on Non-Emergency Medical Transportation Services
- Option EQR Activity: Focus Study on New Member Activities
- Optional EQR Activity: Focus Study on Provider Services Staff and Communication with Providers
- Optional EQR Activity: Focus Study on Third Party Liability

Validation of Performance Measures

B&A used CMS's EQR Protocol #2, *Validation of Performance Measures*, as the basis for conducting the validation of three measures that the MCEs are required to report to the OMPP on a quarterly basis.

The measures included in this year's validation were:

1. Provider Helpline Performance
2. Primary Medical Provider (PMP) Assignments
3. New Member Health Screenings

All three measures were validated in both HHW and HIP.

This validation exercise was intended to match B&A's results using the method for the quarterly submissions (administrative method only) against the results reported by the MCEs.

B&A received an extract from the State's data warehouse that contained the encounters submitted by the MCEs along with enrollment information as well as extracts of source data from the MCEs. We then computed the values for each measure on a quarterly basis to mimic what would have been completed by each MCE to submit its quarterly reports. The B&A results were then compared to the MCE's results on a measure-by-measure, quarter-by-quarter basis. Results were shared with MCE staff in onsite meetings held in July.

Ultimately, it was found that the three MCEs were calculating the Provider Helpline Performance report accurately. MHS and MDwise were accurately reporting the New Member Health Screenings report, while Anthem was not. B&A was unable to validate the PMP Assignment report for any of the MCEs due to ambiguous wording in the report specification and different interpretations of the reporting specification.

While B&A was able to replicate the results on the New Member Health Screening report for two of the three MCEs using the source data submitted by the MCEs, B&A was not able to validate the accuracy of the source data itself. This brings into question the validity of the results.

B&A has made recommendations to both the MCEs and to the OMPP on improvements that can be made on the interpretation and reporting of data for these performance measures in the future.

Validation of Performance Improvement Projects

B&A chose to validate three PIPs from each MCE. The PIPs that were selected were among those that the MCEs selected from pre-set lists defined by the OMPP that are tied to the State's overall quality strategy. The PIPs selected by B&A for review were chosen by all three MCEs (with some minor differences noted). They include:

1. Postpartum Care (HHW only)
2. Emergency Room Utilization (HHW and HIP for Anthem and MHS, HHW only for MDwise)
3. Smoking Cessation (HHW and HIP)

B&A followed the steps in Activity 1 of the CMS EQR Protocol #3, *Validating Performance Improvement Projects*, to complete this validation. MCEs were asked to submit to B&A information about their PIPs for B&A to conduct a desk review. The information reviewed included the methodology used, interventions chosen, and results from both the benchmark period and any remeasurement periods.

Two members from B&A's EQR Review Team each reviewed these materials and independently completed a draft of the EQR PIP Review Worksheet. After meeting to compare results, areas that could not be fully assessed on the PIP Review Worksheet were identified. The team members created customized interview protocols for each MCE/PIP for the onsite meeting in order to have a full assessment to complete the PIP Review Worksheets.

After the onsite meetings were completed in early August, the EQR team members re-reviewed their responses to each PIP Review Worksheet and supplied justifications to each of the components on the tool. This was done independently by each reviewer and then responses were shared to confirm concurrence between the reviewers so that each PIP Review Worksheet could be finalized.

Unlike in prior years, the PIPs selected for validation were not all HEDIS®-based. In prior years, our findings yielded high confidence in the measures examined in the PIPs because the results were compiled by certified HEDIS® auditors. In this year's review, B&A found that overall there was not always high confidence in the validity of the PIPs because the data collected on PIPs, particularly related to interventions, was not always as complete as the OMPP would like.

This year's review, therefore, was primarily used as a continuous quality improvement exercise with the MCEs to collaboratively design a revised Quality Improvement Project (QIP) Report and to test the completion of the tool on this year's PIPs before it is officially launches in January 2015.

The development of the QIP Report is based on a recommendation from last year's EQR. The OMPP and B&A collaborated with the MCEs in its design to ensure consistency in reporting once it is launched. The OMPP selected the QIP term to differentiate between it and the Performance Improvement Projects that the OMPP requires from Corrective Action Plans submitted by the MCEs on occasion. Before the implementation of this tool, the State and the MCEs used the terms "QIPs" and "PIPs" synonymously in the HHW and HIP programs. Going forward, the OMPP will use the term "QIP" when referring to the Quality related improvement projects.

Focus Study on Non-Emergency Medical Transportation

Non-Emergency Medical Transportation (NEMT) is a benefit for Hoosier Healthwise (HHW) members**.** The MCEs are responsible for providing members with transportation to and from services covered by the MCE as well as for services covered only under fee-for-service. The three MCEs have subcontracted with transportation brokers to administer this benefit. All three MCEs met expectations regarding delegation oversight on previous EQR reviews (CY 2011 and CY 2012), but during the CY 2013 EQR providers noted several concerns with transportation vendors such as long wait times, no interpretation services, access and availability issues for members, and refusal of same-day appointments. These concerns prompted OMPP to request a focused study of NEMT for this year's EQR. The study contained the following elements.

- Indiana's NEMT benefit compared to neighboring states
- MCE oversight of transportation vendors
- NEMT utilization trends, including:
    - NEMT utilization across regions within the HHW population
    - Average distance traveled for an NEMT trip
    - Purpose (service going to obtain) in conjunction with NEMT
    - Access to NEMT providers

Several findings were noted related to this focus study. First, it was found that not all of the MCEs are verifying provider IHCP enrollment prior to enrolling the provider in the MCEs network. Additionally, minimal oversight of the NEMT benefit is occurring by the MCEs. From a utilization perspective, the rate of NEMT trips per 1,000 member months varied quite a bit between the MCEs, from a low of 13.4 for MHS to a high of 21.6 for MDwise. When examined at the county level for each MCE, there was relative consistency in the rate of trips provided (i.e., the MCEs had similar findings for which counties had the most trips per 1,000).

About 65 percent of NEMT trips for Anthem and MHS members were to physician or clinic offices, while this was true of only 43 percent of MDwise's trips. Hospital and mental health providers generally represented 20 percent of all trips across MCEs. Trips to other providers were 16 percent of Anthem's total, 12 percent of MHS's total, and 35 percent of MDwise's total.

Since members are to use the NEMT benefit to travel to or from a covered benefit, it would be expected to find a service from another provider on the same day as the transport. When this was examined by B&A, as many as 35 percent of NEMT trips did not have a corresponding service from another provider on the same day as the transport. Based on this analysis, it appears that members are either utilizing NEMT to take trips to non-covered services, or not all encounters for services representing these trips are being submitted to the State by the MCEs. Each MCE did cite situations where they offer NEMT to non-service destinations (e.g., to an eligibility office), but the high rate of non-matches to a covered service is an area of concern.

Finally, while most regions of the state appear to have an adequate NEMT provider network, there are specific areas that appear to lack providers, especially for MDwise. B&A offers recommendations to both the MCEs and to Indiana Medicaid on how to improve the delivery and oversight of the NEMT benefit in this report.

Focus Study on New Member Activities

During the EQR conducted by B&A in CY 2013, 59 interviews were conducted with provider offices in the field. In these interviews, concerns were raised about the PMP assignment process 52 percent of the time. Providers also noted that there is often inconsistent PMP information for members when looking at Web interChange (the State's member eligibility system supported by HP) and the MCE's individual web portals. B&A, therefore, attempted to quantify these concerns noted by providers through comparison of data supplied by the MCEs and information obtained from Optum, the vendor that manages Indiana Medicaid's data warehouse.

Additionally, to supplement the validation of the performance measures related to PMP assignment and new member health screenings discussed in Section III of this report, B&A also reviewed policies and procedures and compared them to contractual requirements of the MCEs related to PMP assignment and member health screenings.

In general, the MCEs all have robust policies related to PMP assignment. Each MCE outlined to B&A their processes and workflows for PMP assignment logic which met the contractual requirements. However, when actual data was reviewed, it appears that while the MCEs have documented policies and procedures, they are not always implementing them effectively.

All three MCEs submitted policies and procedures regarding Health Risk Assessment (HRA) completion that meet the contractual requirements of Indiana Medicaid for member health screenings. In addition to completing the HRA, each MCE has systematic algorithms to identify members that may have disease management, case or care management (DM/CM) needs. It appears that, while the MCEs attempt to

complete the HRA, the MCEs rely heavily on their own system logic to identify members with at-risk needs, e.g. claims and authorization analyses and predictive modeling.

B&A also examined the rate of referral to DM/CM from the HRA for the same new members noted above. While each MCE does have other modes of referral to DM/CM, such as algorithms to examine claims history, the contract specifically states that the HRA should be a referral source.

While MDwise had the highest completion rate of HRAs, MHS has the highest referral rate to DM/CM from the HRA. While the referral rate does not indicate if the member was ever actually enrolled in DM/CM, it does indicate that the initial screening identified factors that non-clinical staff felt clinical staff should evaluate to determine if DM/CM would be appropriate. Anthem had both the lowest completion rate and the lowest referral rate.

Focus Study on Provider Services Staff and Communication with Providers

During the CY 2013 field interviews with providers, B&A discovered that provider feedback on HHW and HIP ranged from satisfaction to frustration. As a result of these findings, the OMPP requested that B&A review the experience requirements and training protocols for the staff at each MCE who interact with providers face to face or by telephone (provider relations staff and customer service staff). These are referred to as provider-facing staff in this section of the report. B&A also reviewed employee evaluation methods and how best practices are identified and implemented throughout MCE departments.

B&A also interviewed the MCEs regarding recommendations made to them in last year's EQR from the results of the field interviews with providers. Some initiatives have already been adopted as a result of these recommendations. The section of the report on this focus study covers these topics and describes one of the changes made by Anthem that can be considered a best practice for the other MCEs to consider with regard to provider relations.

Additionally, B&A conducted phone interviews with 200 providers throughout the state to determine if the actions taken by the MCEs since last year's EQR have improved providers' perceptions. In general, it appears providers are as satisfied or more satisfied with their MCE provider representatives than they were during interviews one year prior. Providers feel it is easier to reach their provider representative this year while provider representative follow-up has remained steady for two of the three MCEs (Anthem and MHS) but improved for MDwise. However, a significant number of providers do not know who their provider representative is, which was also noted as a concern during the CY 2013 EQR.

When providers were asked to prioritize which method of communication with the MCEs was most helpful to them (provider representative, the provider helpline, both or neither), more than half indicated "the provider representative" for each MCE while slightly more than one quarter indicated "both the provider representative and the provider helpline". MHS was the only MCE that did not have any providers respond "neither".

Focus Study on Third Party Liability

Members that have HHW coverage could have other insurance that will pay for their healthcare claims, which is known as Third Party Liability (TPL). Medicaid is designed to be the payer of last resort for healthcare claims and the TPL carrier is typically considered primary. However, there are times when a Medicaid member may have TPL coverage and Medicaid would still pay for covered benefits. The OMPP has defined expectations in its contract with the MCEs of how TPL should be handled.

During the CY 2013 EQR, providers frequently cited TPL as one of their challenges. Due to the concerns expressed in face-to-face interviews with providers, the OMPP requested that B&A evaluate this subject in this year's EQR. B&A examined the following questions to ensure the MCEs are following the expectations defined by Indiana Medicaid related to TPL:

- Who manages each MCE's TPL process?
- How does TPL affect the MCE's filing limit?
- What documentation does each MCE require from providers?
- What are the processes MCEs take for coordinating care?
- How do the MCEs manage TPL for newborns?
- What are the MCE practices for evaluating the primary insurance denials?
- How do the MCEs coordinate benefits with Medicare?
- What does each MCE do when the information that is in their files does not match in the state's portal?
- How long does it take the MCEs to update their TPL records?

Although all three MCEs provided evidence of policies and procedures regarding the treatment of TPL as part of this review, B&A did uncover variances between the MCEs in the areas of documentation required of providers, timeframes for submission, managing TPL for newborns and coordination of benefits with Medicare. As such, B&A offers recommendations to both the MCEs and Indiana Medicaid regarding procedures in place for administering TPL in HHW.

Providers interviewed as part of the CY 2013 EQR stated that the TPL carrier information provided by the State's web-portal, Web interChange (managed by HP), often did not match the MCEs' records. To quantify this concern noted by providers, B&A compared the documented TPL information in the State's data warehouse to the documented TPL information noted by the MCEs to identify the level of variance between them.

Even though Indiana Medicaid and the MCEs all share the same vendor to obtain TPL information, there was variance found between the TPL information noted in the Indiana Medicaid data warehouse and the MCEs' systems. Specifically, there were 11,316 members noted by the MCEs as having TPL that were not identified in the State's data warehouse as having TPL, which is a 26 percent variance overall. The highest level of variance was seen with Anthem at a 41 percent mismatch rate. MHS was the lowest at 9 percent. MDwise's overall mismatch rate was at the statewide average of 26 percent. As a result of this finding, B&A recommends that each MCE should determine the root cause of the variance that they have with the State's portal. In cooperation with Indiana Medicaid, the MCEs should work with the TPL vendor when new information is collected about a member's third party coverage so that all parties are kept up to date in their information systems.

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

Introduction

As the state agencies responsible for Indiana's Medicaid program, the Family and Social Services Administration (FSSA) and the Indiana Office of Medicaid Policy and Planning (OMPP)[1] have implemented two managed care programs using Section 1115 waiver authority. The Hoosier Healthwise (HHW) program began in 1994. By the end of 2005, all Medicaid members that had previously been enrolled in the HHW Primary Care Case Management (PCCM) system were transitioned into managed care entities (MCEs).[2] Effective January 1, 2008, the HHW program was subsumed under the state's Section 1115 waiver.

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

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

Additionally, HHW is offered to the following:

- Pregnancy-related coverage is provided to women whose income is below 200 percent of the federal poverty level (FPL) (Benefit Package B).
- SCHIP benefits (Benefit Package C) are available to children in families whose income is 151 percent to 250 percent (CHIP II & III) of the FPL. Package C requires premiums to be paid depending on income and family size factors.

Also part of the January 2008 Section 1115 approval was the creation of the Healthy Indiana Plan (HIP). The HIP covers two expansion populations:

- Uninsured custodial parents and caretaker relatives of children eligible for Medicaid or the Children's Health Insurance Program (CHIP) with family income up to 200 percent of the FPL but are not otherwise eligible for Medicaid or Medicare (the "Caretakers" category); and

[1] FSSA and OMPP are collectively referred to as Indiana Medicaid throughout this report.

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

- Uninsured noncustodial parents and childless adults ages 19 through 64 who are not otherwise eligible for Medicaid or Medicare with family income up to 200 percent of the FPL (the "Adults" category).

For both Caretakers and Adults, eligible members cannot have access to employer-sponsored health insurance and must be uninsured for at least six months prior to enrollment in the HIP.

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

Enrollment in HHW was 685,674 at the end of Calendar Year (CY) 2013 and enrollment in HIP was 34,562 at this time. Enrollment decreased for HHW children by 5.6 percent from 2012 to 2013, whereas enrollment increased 19.8 percent among HHW adults during this time period (refer to Exhibit I.1). The enrollment in HIP decreased 8.0 percent from the end of 2012 to the end of 2013.[3]

Exhibit I.1
Enrollment Trends in Hoosier Healthwise and HIP

	Hoosier Healthwise Children	Hoosier Healthwise Adults	HIP Members
December 2012	584,573	111,555	37,578
December 2013	552,050	133,624	34,562
Pct Change 12-13	**-5.6%**	**19.8%**	**-8.0%**

Source: Optum, State's Data Warehouse Vendor, provided enrollment data to B&A on June 25, 2014.

As seen in Exhibit I.2, as a percentage of all members, there are more minorities among HHW children than among the adults, but there is also a significantly higher proportion of minority adults in HHW than in HIP.

Exhibit I.2
Hoosier Healthwise and HIP Members by Race/Ethinicity
As of December 2013

	Hoosier Healthwise Children	Hoosier Healthwise Adults	HIP Members
Caucasian	60%	67%	83%
African-American	22%	25%	9%
Hispanic	14%	5%	3%
Other	3%	3%	5%

Source: Optum, State's Data Warehouse Vendor, provided enrollment data to B&A on June 25, 2014.

[3] Indiana Medicaid changed data warehouse platforms and vendors in early 2014, which could have resulted in slight variation in membership counts reported to B&A.

At the regional level, the proportion of members is consistent between HHW and HIP, with the exception that the Southwest Region has higher representation and the Central Region has lower representation in HIP than in HHW (refer to Exhibit I.3 below).

Exhibit I.3
Hoosier Healthwise and HIP Members by Region
As of December 2013

	Hoosier Healthwise Children	Hoosier Healthwise Adults	HIP Members
Northwest	13%	15%	13%
North Central	10%	9%	8%
Northeast	12%	11%	12%
West Central	8%	8%	7%
Central	31%	31%	25%
East Central	9%	10%	12%
Southwest	9%	9%	14%
Southeast	8%	8%	8%

Source: Optum, State's Data Warehouse Vendor, provided enrollment data to B&A on June 25, 2014.

MCEs Contracted in the Hoosier Healthwise Program and Healthy Indiana Plan

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

Indiana Medicaid entered into new contracts with the MCEs for the period effective January 1, 2011. Under this contract, the three MCEs that contract with Indiana Medicaid serve both HHW and HIP members under one combined contract. All three MCEs serve HHW and HIP members statewide.

Anthem

Anthem Blue Cross and Blue Shield is a licensed subsidiary of WellPoint which offers group and individual health benefits, life and disability products nationwide. In 2004, WellPoint Health Networks Inc. and Anthem, Inc. merged to create the largest commercial health benefits company in the United States. In 2012, WellPoint purchased Amerigroup to expand its coverage of Medicaid eligibles. WellPoint is headquartered in Indianapolis, Indiana. In Indiana, Anthem has been under contract with Indiana Medicaid for HHW since January 2007 and for HIP since the program's inception in January 2008.

MDwise

MDwise is a locally-owned, Indianapolis-based, non-profit MCE that has been participating in HHW since its inception. MDwise has contracted with Indiana Medicaid to serve HIP members since the program's inception in January 2008. In January 2007, MDwise obtained its own HMO license with the

State. MDwise subcontracts the management of services to eight delivery systems. One of these delivery systems serves members statewide while the other seven are regionally-based.

Managed Health Services (MHS)

MHS is a subsidiary of Centene Corporation, a St. Louis-based Medicaid managed care company founded in 1984. Centene created MHS in 1994 when it began serving the HHW population. MHS's headquarters is located in Indianapolis. MHS utilizes another Centene subsidiary, Cenpatico, for the management of behavioral health services. It also leverages other Centene-owned subsidiaries such as Nurse Wise (nurse hotline), Nurtur (disease management), U.S. Script (pharmacy) and OptiCare Managed Vision (vision).

Exhibit I.4 shows the distribution of the HHW and HIP enrollment as of December 2013 by MCE. MDwise has a higher proportion among the MCEs in the HHW child population while Anthem has 60 percent of the HIP members. There is also a small component of the HIP population (the Enhanced Services Plan, or ESP) that is excluded from managed care[4].

Exhibit I.4
Hoosier Healthwise and HIP Members by MCE
As of December 2013

	Hoosier Healthwise Children	Hoosier Healthwise Adults	HIP Members
Anthem	31%	37%	60%
MDwise	41%	38%	25%
MHS	29%	25%	11%
Other (HIP ESP)	N/A	N/A	4%

Source: Optum, State's Data Warehouse Vendor, provided enrollment data to B&A on June 25, 2014.

[4] The ESP was not reviewed in this EQR because this population is not served by the MCEs.

Benefit Package

The benefit package for the HIP is more limited in amount, duration and scope than the Package A HHW program. Exhibit I.5 below outlines the benefits in both programs and limitations in the HIP.

Dental services and pharmacy coverage are also available to HHW members, but these are not managed by the MCEs. Additionally, HHW members are eligible for Individualized Education Plans (IEPs) and early intervention services (First Steps), but these are also carved out of the MCE capitation payment.

Exhibit I.5
Benefit Package for Members in the Hoosier Healthwise Program and Healthy Indiana Plan

Benefit	HHW	HIP	Notes on Benefit for HHW and HIP or Limits if Covered in the HIP
Inpatient Medical/Surgical	X	X	
Emergency room services	X	X	Self-referral Co-pay for services for HIP members when the service is determined to be non-emergent
Urgent care	X	X	
Outpatient hospital	X	X	
Outpatient Mental Health and Substance Abuse	X	X	Medicaid Rehabilitation Option (MRO) and Psychiatric Residential Treatment Facility (PRTF) services are not the responsibility of the MCEs; Psychiatry is a self-referred service
Primary care physician services	X	X	
Preventive care services	X	X	
Immunizations	X	X	Self-referral
EPSDT services	X	X	In HIP, EPSDT screening for members age 19 and 20 only
Specialist physician services	X	X	
Radiology and pathology	X	X	
Physical, occupational and speech therapy	X	X	In HIP, 25-visit annual maximum for each type of therapy
Chiropractic services	X		Self-referral
Podiatry services	X		Self-referral
Eye care services	X		Self-referral; excludes surgical services
Prescription Drug (carved out of the MCE contract)	X	X	Brand name drugs are not covered where a generic substitute is available.
Home health/Home IV therapy	X	X	Excludes custodial care but includes case management
Skilled Nursing Facility	X	X	
Ambulance	X	X	Emergency ambulance transportation only
Durable Medical Equipment	X	X	
Family Planning Services	X	X	Self-referral; excludes abortions, abortifacients
Hearing Aids	X	X	In HIP, ages 19 and 20 only
FQHC and Rural Health Center Services	X	X	In HIP, subject to the benefit coverage limits
Disease Management Services	X	X	
Diabetes self-management	X		
Transportation	X		

HIP POWER Account

The Personal Wellness and Responsibility (POWER) Account is the feature of HIP that makes it unique among programs developed nationally for the low-income uninsured. The POWER Account is modeled on the concept of a Health Savings Account (HSA). A $1,100 allocation is contributed for each HIP member's POWER Account annually. These dollars are funded through contributions from the member, the State (with federal matching dollars) and, in some cases, the member's employer. The member's annual household income is calculated at eligibility determination. The member's contribution to the $1,100 balance is calculated based upon household income. The member is allowed to pay for his/her POWER account contribution in 12 monthly installments throughout the year.

A member's POWER Account contribution amount may be changed during the year due to extenuating circumstances causing a change in income or family size. At a minimum, the POWER Account contribution is reviewed annually at redetermination when household income or other eligibility criteria are also reviewed.

The POWER Account is intended for members to use to purchase health care services. However, in an effort to promote preventive care, the first $500 in preventive care benefits are covered by the MCE and are not drawn from a member's POWER Account.

There is a financial incentive for members to seek the required preventive care for their age, gender and health status. If a HIP member is deemed to be eligible upon redetermination 12 months after enrolling and there are funds remaining in the member's POWER Account, the funds are rolled over into the next year's account if the member had a doctor office visit in the prior year. This will effectively reduce the amount of the member's monthly POWER Account contribution in the next year.

If a member utilizes services in excess of the $1,100 in the POWER Account, she/he is not at risk. These costs are covered by the State.

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

Background

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

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

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

For the first activity, B&A completed a full review of compliance with all federal Medicaid managed care regulations as well as additional contractual requirements mandated by Indiana Medicaid in its contract with the managed care entities (MCEs) in the EQR conducted in 2012 covering Calendar Year (CY) 2011. B&A utilized the CMS Protocol *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al.* to complete this review. This periodic review was completed in 2012 because the OMPP entered into new contracts with the MCEs effective January 1, 2011 in which the requirements for administering the Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) programs were subsumed under one contract.

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

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

In CY 2010, B&A began the validation of MCE performance improvement projects (PIPs) for the Review Year (RY) 2009 (prior to this, PIPs were not required by the OMPP). In CY 2011, an update on the prior year's PIP validation activities was conducted rather than a full validation since the actual PIPs remained the same in all but one case at the MCEs. In CY 2012, the validation of PIPs was once again excluded from the review since PIPs were not required by the OMPP.

Exhibit II.1
EQR Focus Studies Conducted of MCE Operations in HHW and HIP, 2010 - 2013

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

EQRO Activities in CY 2014

B&A met with the OMPP in early 2014 and developed the following topics for this year's EQR:

- Validation of Performance Measures
- Validation of MCE Performance Improvement Projects (PIPs)
- Optional EQR Activity: Focus Study on Non-emergency Medical Transportation Services
- Optional EQR Activity: Focus Study on New Member Activities
- Optional EQR Activity: Focus Study on Provider Services Staff and Communication with Providers
- Optional EQR Activity: Focus Study on Third Party Liability (TPL)

For the validation of performance measures and PIPs, B&A utilized the September 2012 editions of CMS Protocols EQR Protocol #2: *Validation of Performance Measures* and EQR Protocol #3: *Validating Performance Improvement Projects* for guidance in completing these mandatory activities. For the four focus studies, B&A worked with the OMPP Quality Director to develop the elements of each study.

The details pertaining to each aspect of this year's EQR were released to the MCEs in an EQR Guide on May 5, 2014. The EQR Guide appears in Appendix A of this report. It contains information about the focus of each review topic in the EQR, the expectations of MCEs in the review, a document request list, and a schedule of events. For all review topics, a desk review, onsite reviews and post-onsite follow-up occurred. All of this year's EQR tasks were conducted during the period of April to September, 2014.

The EQR Review Team

This year's review team included the following staff:

- Mark Podrazik, Project Manager, Burns & Associates, Inc. Provided project oversight and participated in onsite reviews for this year's EQR. He has worked with the OMPP in various capacities since 2000. Previously, Mr. Podrazik has led the EQRs of HHW in CYs 2007-2013 as well as the EQRs for the HIP in CYs 2009-2013.

- Brian Kehoe, Senior Consultant, Burns & Associates, Inc. Participated in all aspects of the review and primary report author. Mr. Kehoe has nine years of experience working with Medicaid managed care programs. This is his second year as a member of the B&A EQR team. Mr. Kehoe is also the primary lead on B&A's project to write an independent evaluation of Indiana's Children's Health Insurance Program (CHIP) each year.

- James Maedke, SAS Programmer, Burns & Associates, Inc. Conducted all SAS analytical support for this year's EQR. Mr. Maedke is also the analyst on B&A's project to write an independent evaluation of Indiana's CHIP each year.

- Barry Smith, Analyst, Burns & Associates, Inc. Assisted in the tabulation of information related to the transportation focus study and the provider interviews. Mr. Smith has worked on the Data Analysis Team for the EQRs conducted in CYs 2009-2013.

- Rachel Chappell, Consultant, Burns & Associates, Inc. Assisted in the review of elements of the transportation focus study. Ms. Chappell has over 15 years of experience working with and oversight of state Medicaid agencies.

- Dr. Linda Gunn, AGS Consulting, Inc. Participated as a team member in the interviews of providers. Dr. Gunn also participated in B&A's EQRs for Indiana programs in CYs 2009-2013.

- Kristy Lawrance, Lawrance Policy Consulting. Participated as a team member in the validation of performance improvement projects and as a team member on the provider services staff and TPL focus studies. This year's EQR is the second year Ms. Lawrance has joined the B&A EQR team. She has previous experience with these programs having previously worked for the OMPP and for one of the contractors in the OMPP's Care Select program.

SECTION III: VALIDATION OF PERFORMANCE MEASURES

Introduction

In previous External Quality Reviews (EQRs), Burns & Associates, Inc. (B&A) has selected performance measures to validate from among the various reports that the Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) managed care entities (MCEs) submit to the Office of Medicaid Policy and Planning (OMPP) on a regular basis in the MCE Reporting Manual. In the 2012 EQR, a different approach was taken. All of the measures submitted on reports in the MCE Reporting Manual were reviewed first as a desk review by B&A and later presented as findings to a workgroup comprised of B&A, OMPP and MCE staff. Discussions occurred related to clarifying report definitions and instructions. In the 2013 EQR, B&A returned to its usual format for validating specific performance measures.

For this year's EQR, B&A selected three performance measures from among the many in the MCE Reporting Manual for review. B&A has followed the steps in the Centers for Medicare and Medicaid's (CMS's) EQR Protocol #2, *Validation of Performance Measures*, with some slight adjustments discussed with the OMPP. The sections below describe our validation activities in this protocol. At the end of this section, the results of our validation are shown by MCE for its HHW and HIP measures.

Activity 1: Pre-Onsite Visit Activities

In cooperation with the OMPP, B&A selected three measures from the MCE Reporting Manual for validation in this year's EQR.

1. Provider Helpline Performance (OMPP Report QR-P1)
2. PMP Assignments (OMPP Report QR-PMP1)
3. New Member Health Screenings (OMPP Report QR-HS1)

All three measures are applicable to both HHW and HIP, but the MCEs are required to report the results of these measures separately for each program. B&A validated the results of the measures reported on both the HHW and HIP reports.

In previous years B&A, with guidance from the OMPP, has selected measures that are linked to HEDIS® measures and utilized the analytics completed by the certified HEDIS® auditor. Because the measures reviewed this year are not linked to HEDIS®, B&A conducted the validation test by obtaining data extracts from the MCEs. Four data extracts were provided to B&A by the MCEs on June 16, 2014 for the CY 2013 experience period. The extracts included:

1. Provider call center statistics
2. PMP assignment activities
3. Member health risk screenings activities
4. New member contact activities

To supplement the data provided by the MCEs, B&A also obtained an extract from Indiana Medicaid's data warehouse vendor, Optum, of all encounters reported by the MCEs to Indiana Medicaid.

Since all of the analysis in this year's validation is based on the administrative method, there was no need to initiate the review of any medical record data collection.

In preparation for the onsite meetings with each MCE, B&A conducted the following steps.

1. B&A collected the reports submitted to the OMPP by the MCEs that contained the values submitted quarterly in CY 2013 for each measure that is being validated.

2. B&A tabulated the results from these reports into a data sheet for comparison to B&A's independent calculations.

3. Validation tests were completed when possible on the data extracts received from the MCEs by comparing data in the MCE file to data in the extract received from the OMPP data warehouse.

4. Validation tests were completed on the data extract received from the Indiana Medicaid data warehouse. For example, B&A examined the following:
    a. Frequency counts of claims by month date of service by claim type (institutional, professional and pharmacy).
    b. Frequency counts of member months by program (HHW and HIP) and eligibility aid category within program across the MCEs for consistency throughout the year.
    c. The demographic information in 4(b) was attached to each claim. Then, frequency counts of claims by eligibility aid category were run.

5. B&A's programmer, James Maedke, programmed the OMPP report specifications into a SAS program to tabulate the results for each measure. When information was reported on a quarterly basis, B&A built the programs to generate results so that each calendar quarter served as the anchor date of a 12-month service period.

6. The CY 2013 quarterly results were entered in a datasheet and compared to the MCE submitted values for each quarter.

Datasheets were prepared for each MCE showing the measures that were evaluated with the comparative data submitted by the MCE and the results computed by B&A. Separate results were compiled for HHW and HIP, where applicable. This validation exercise is intended to match B&A's results using the method for the quarterly submissions (administrative method only) against the results reported by the MCEs.

Activity 2: Onsite Visit Activities

On July 16 and 17, 2014, B&A's Project Lead Brian Kehoe walked through the results computed by B&A of each performance measure with the appropriate staff at each MCE who were responsible for the tabulation and submission of the measures to OMPP on the quarterly reports. Questions were asked by B&A that were specific to each MCE/measure in an effort to understand the potential root cause of differences between the MCE and B&A results. To help facilitate this discussion, B&A provided supporting documentation of B&A's calculation for each measure. This information was shown for each of the reporting periods studied so that MCEs could examine both the numerator and denominator used in each measure.

During the onsite meeting, the preliminary findings were reviewed which were the differences between how the MCE reported the measure and how B&A reported the measure. The MCEs were asked to identify potential items that could be reviewed on their end to help assist in identifying if adjustments needed to be made to either parties' figures.

Because all administrative data was used for the study period, there was no need to assess any sampling process.

Activity 3: Post-Onsite Visit Activities

This report serves as the submission of the validation report to the State. It incorporates all adjustments made by either B&A or the MCEs to complete the validation process.

A summary of the findings for each performance measure appear in the exhibits beginning at the bottom of this page. Each exhibit is laid out the same and shows three parts. Part 1 identifies the MCE and data description of the element within the performance measure being reported. Part 2 is the information as tabulated by the MCE and reported to the OMPP. Part 3 is the information as tabulated by B&A using the data provided by the MCEs and the calculated difference between the two parties. The full findings for each element reviewed, by MCE, can be found in Appendix B of this report.

In summary, the results were as follows:

- For QR-P1 – *Provider Helpline Report*, B&A was able to validate all items reported for all MCEs.
- For QR-PMP1 – *PMP Assignment Report*, B&A was not able to validate the items for any of the MCEs.
- For QR-HS1 – *New Member Health Screening Report*, B&A was able to validate the items for two of the three MCEs.

It should be noted that minor variations were to be expected in validation of performance measures related to member enrollment due to retroactive eligibility. B&A was able to compute all of the measures at the same time in July 2014. Any retroactive eligibility of members was accounted for in this tabulation. The MCEs are submitting their results to the OMPP on a quarterly basis with a 30-day lag after the end of the reporting period. To the extent that eligibility changes occurred more than 30 days after the end of the reporting period, these would be captured by B&A but not by the MCEs.

<u>QR-P1 – Provider Helpline Report</u>

The Provider Helpline report tracks the MCE's ability to monitor service to its providers through measures such as timeliness in answering phone calls and caller abandonment rates.

B&A was able to validate that each MCE is reporting the QR-P1 – Provider Helpline Report accurately to the OMPP for both HHW and HIP. Minimal variance was noted between what the MCEs reported to the State and the B&A calculation. Exhibit III.2 on the following page summarizes the results. The only notable difference was for MDwise in the Quarter 4 HHW report for Performance Measure #1. B&A computed a value of 92.1 percent. Although MDwise reported a value of 93.8 percent, the value of 92.1 is more in line with the value that both MDwise and B&A computed for the previous quarter.

Exhibit III.1
Summary of Validation of Performance Measures Reviewed
QR-P1 - Provider Helpline Performance

Part 1		Part 2		Part 3			
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR			
Experience Period >>		Q3 2013	Q4 2013	Verified Q3 2013		Verified Q4 2013	
Data Description	MCE	Result	Result	Result	Difference	Result	Difference
Hoosier Healthwise							
#1 Percent of Calls Answered in 30 Seconds	Anthem	95.0%	94.6%	96.1%	1.1%	95.4%	0.7%
	MHS	94.9%	94.7%	94.9%	0.0%	95.1%	0.4%
	MDwise	92.1%	93.8%	92.5%	0.4%	92.1%	-1.7%
#2 Percent of calls Abandoned	Anthem	0.9%	1.1%	0.9%	0.0%	1.1%	0.0%
	MHS	0.3%	0.3%	0.3%	0.0%	0.3%	0.0%
	MDwise	1.0%	1.1%	0.7%	-0.3%	0.7%	-0.3%
Healthy Indiana Plan							
#1 Percent of Calls Answered in 30 Seconds	Anthem	98.3%	98.0%	98.3%	0.0%	98.0%	0.0%
	MHS	96.3%	95.5%	96.3%	0.0%	95.8%	0.3%
	MDwise	92.3%	92.4%	93.3%	1.0%	93.0%	0.6%
#2 Percent of calls Abandoned	Anthem	0.1%	0.4%	0.1%	0.0%	0.4%	0.0%
	MHS	0.2%	0.2%	0.2%	0.0%	0.2%	0.0%
	MDwise	0.7%	0.5%	0.7%	0.0%	0.5%	0.0%

QR-PMP1 – PMP Assignment Report

The PMP Assignment report monitors the method and volume of PMP selection and assignment linkages between the MCE and its members. The focus of the report is how new members to the MCE are assigned to a PMP.

B&A was unable to validate the QR-PMP1 – PMP Assignment Report for either HHW or HIP. The results calculated by B&A varied significantly to what each MCE reported to the State. Conversations were held with each MCE and the OMPP to determine the root cause of this variance, which was determined to be potentially ambiguous wording in the reporting specification accompanied by different interpretations of the reporting specification. The narrative below provides examples.

Newly Assigned Plan Members

Item 1 of the QR-PMP1 report states in the report specification, "As of the last day of the reporting period, indicate the total number of members received on the enrollment roster during the reporting period. Enter a whole number." In the qualifications/definitions section of the same reporting specification, it states "This is a rolling 12-month report, due quarterly on the last day of the month following the experience period…A new member may be identified utilizing the 834 – Benefit Enrollment and Maintenance Transaction for those records with an 'INS03 012[5]' value."

B&A calculated members based on the 12-month experience period and counted each member one time. The MCEs, however, calculated new members each quarter then summed four quarters together to obtain a "rolling 12-month" calculation. Furthermore, each MCE calculated new members across quarters differently.

- Anthem counted members each quarter and, if the member was identified as new in a prior quarter, they were removed from the count as new in the prior quarter. Then, the four quarters were summed.
- MHS summed the four quarters and counted members each time they were identified as new. This meant that members could be counted as new not only across quarters but within a quarter.
- MDwise would only count a member as new once within a quarter, but that same member could be counted multiple times across quarters.

Member PMP Selection Methodology

Items 2 through 4 of the QR-PMP1 report identify the method in which members are assigned to their PMP: member self-selected a PMP (item 2), member assigned with the OMPP defined 'smart' logic (item 3), or member assigned with MCE defined default logic (item 4). B&A was provided one PMP assignment method per member from each MCE, which was used to determine the B&A result. However, when reporting to the OMPP, the MCEs counted multiple assignments if the member changed their PMP during the period of study. Here, too, each MCE is counting PMP assignments within a quarter then summing four quarters to determine a rolling 12-month figure. Additionally, the logic for how MCEs are counting PMP assignments differs. The report specification does not clearly define if MCEs should be counting the first PMP assignment, most recent PMP assignment, or all PMP assignments within the experience period; therefore, the MCEs' different interpretations produce varying

[5] While the reporting specification indicates INS03 012, the correct record type is INS03 021. All three MCEs indicated they disregarded the reporting specification and utilized record type INS03 021 to identify new members.

results. All methods used by the MCEs, however, could be considered "appropriate" based on the specification.

Exhibit III.2 on the following page summarizes the results.

Exhibit III.2
Summary of Validation of Performance Measures Reviewed
QR-PMP1 - PMP Assignment Report

Part 1		Part 2		Part 3			
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR			
Experience Period >>		Calendar Year 2013		Verified Calendar Year 2013			
Data Description	**MCE**	**Result**	**Percent of Total**	**Result**	**Difference**	**Percent of Total**	**Difference**
Hoosier Healthwise							
Newly Assigned Plan Members	Anthem	36,062		65,279	29,217		
	MHS	61,089		48,878	-14,285		
	MDwise	133,130		145,247	12,117		
Members who Self Selected a PMP	Anthem	23,611	65.5%	2,747	-20,864	4.2%	-61.3%
	MHS	11,700	19.2%	7,791	-3,909	15.9%	-3.2%
	MDwise	66,002	28.9%	12,680	-53,322	8.7%	-20.2%
Members Auto-Assigned with "smart" Logic	Anthem	26,516	43.4%	44,745	18,229	68.5%	25.2%
	MHS	27,064	44.3%	23,185	-3,879	47.5%	3.2%
	MDwise	98,148	43.0%	80,594	-17,554	55.5%	12.5%
Members Auto-Assigned with "default" Logic	Anthem	11,014	18.0%	17,787	6,773	27.3%	9.2%
	MHS	22,325	36.5%	17,902	-4,423	36.6%	0.0%
	MDwise	64,301	28.2%	51,973	-12,328	35.8%	7.6%
Healthy Indiana Plan							
Newly Assigned Plan Members	Anthem	1,085		5,704	4,619		
	MHS	2,172		1,609	-563		
	MDwise	2,485		2,528	43		
Members who Self Selected a PMP	Anthem	574	12.9%	986	412	17.4%	4.4%
	MHS	657	30.2%	486	-171	30.2%	0.0%
	MDwise	2,437	52.3%	77	-2,360	3.1%	-49.2%
Members Auto-Assigned with "smart" Logic	Anthem	3,285	73.9%	1,339	-1,946	23.5%	-50.5%
	MHS	489	22.5%	183	-306	11.4%	-11.1%
	MDwise	324	7.0%	0	-324	0.0%	-7.0%
Members Auto-Assigned with "default" Logic	Anthem	584	13.1%	3,379	2,795	59.2%	46.0%
	MHS	1,024	47.1%	940	-84	58.4%	11.3%
	MDwise	1,901	40.8%	2,451	550	97.0%	56.2%

Note: Anthem's values in Part 2 of this report for Hoosier Healthwise do not add up to 100%. This is how they were originally reported to the OMPP.

QR-HS1 – New Member Health Screening Report

The New Member Health Screening report monitors the MCE's ability to conduct health screenings for new members in order to effectively manage identified medical conditions.

Exhibit III.3 on the following page summarizes B&A's results from the validation of this report. B&A was able to validate that the results reported by MHS and MDwise were reported accurately to the OMPP based upon their source data. Although there is a variance noted between B&A's calculations and those reported by MHS and MDwise, the difference was attributable to two items: retroactive eligibility and completion of Notification of Pregnancy (NOP) forms. B&A had the benefit of more current eligibility data (including retro-eligibility) not available to the MCEs at the time that they were reporting the results that were used in the validation exercise. The NOPs were able to be counted as a completed Health Screening Assessment during the time period reviewed according to the MCE Policies and Procedures Manual. These NOPs were not available to B&A from the data provided by Optum for this EQR.

B&A was unable to validate the report produced by Anthem due to an error discovered by Anthem during the course of their investigation into the variance between Anthem's result and the calculation by B&A. Anthem noted, "Anthem has identified a process gap in the number of times we contact a member before they are internally classified as unreachable. Anthem is putting process improvements in where at least three attempts will be made to contact new members."

Exhibit III.3
Summary of Validation of Performance Measures Reviewed
QR-HS1 - New Member Health Screening Report

Part 1		Part 2		Part 3			
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR			
Experience Period >>		Q3 2013	Q4 2013	Verified Q3 2013		Verified Q4 2013	
Data Description	MCE	Result	Result	Result	Difference	Result	Difference
Hoosier Healthwise							
#1 Percent Screened Within 90 Days (all except Terminated)	Anthem	13.4%	25.1%	11.8%	-1.6%	14.4%	-10.7%
	MHS	26.9%	22.8%	26.7%	-0.2%	23.0%	0.2%
	MDwise	78.9%	76.4%	71.7%	-7.1%	73.7%	-2.7%
#2 Percent Screened Within 90 Days (excluding Terminated and Unreachable)	Anthem	19.9%	25.7%	23.7%	3.9%	28.5%	2.8%
	MHS	44.5%	40.4%	43.6%	-0.9%	41.0%	0.6%
	MDwise	100.0%	99.7%	94.8%	-5.2%	98.2%	-1.5%
Healthy Indiana Plan							
#1 Percent Screened Within 90 Days (all except Terminated)	Anthem	12.7%	25.9%	8.1%	-4.7%	9.7%	-16.2%
	MHS	37.5%	31.8%	37.3%	-0.2%	31.8%	0.0%
	MDwise	82.0%	84.1%	75.0%	-7.0%	84.4%	0.3%
#2 Percent Screened Within 90 Days (excluding Terminated and Unreachable)	Anthem	12.7%	25.9%	12.9%	0.1%	18.4%	-7.6%
	MHS	66.7%	59.3%	65.5%	-1.2%	59.4%	0.1%
	MDwise	100.0%	100.0%	91.2%	-8.8%	100.0%	0.0%

While B&A was able to replicate the results for two of the three MCEs using the source data submitted by the MCEs, B&A was not able to validate the accuracy of the source data itself. In particular, one item that is required on the report is as follows: "Indicate the number of new members enrolled with the MCE during the reporting period that are determined to be unreachable. 'Unreachable' is defined as a minimum of three outreach calls using the information provided to the MCE by OMPP for which there is no response from the member."

B&A was able to replicate the total number of unreachable members as documented on the quarterly submission to the OMPP utilizing the summary data provided by the MCEs. However, B&A also requested documentation to verify that each member was contacted three times with outreach calls. From this additional file, it appears that the MCEs may not always be identifying "unreachable" appropriately when submitting this report. The inflated count of unreachable members reduces the denominator for the measure which, thus, can overstate the value for the percent of members screened. Exhibit III.4 below shows the variance between unreachable members as defined by each MCE compared to the calculation of unreachable members as tabulated by B&A from the three contacts verification file provided by the MCEs.

Exhibit III.4
Summary of Validation of Performance Measures Reviewed
Verification of Unreachable Members for the QR-HS1 Report

	Anthem		MHS		MDwise	
	HHW	HIP	HHW	HIP	HHW	HIP
Number of Matched Unreachable Members Reported by MCEs	18,739	1,366	7,116	171	5,925	161
Number of Unreachable Members with Three Contacts Documented	15,691	1,243	6,388	140	3,380	114
Number of Unreachable Members with Less Than Three Contacts Documented	3,048	123	728	31	2,545	47
Percent with Three Attempts	84%	91%	90%	82%	57%	71%

While the definition of "unreachable" appears clear in the report specification, there is still confusion among the MCEs about the definition. For example, some MCEs made less than three contact attempts because on the first phone call it was determined that the member's phone number was invalid. Other MCEs continued to use this invalid phone number in making three attempts to contact the member to meet the contract definition of unreachable.

Recommendations to the MCEs and the OMPP Related to Validation of Performance Measures

Based on the validations completed for the three reports selected for this year's study, B&A makes the following recommendations.

Recommendations to the MCEs

1. All MCEs should work with the OMPP when elements in the reporting specifications are not clear. Assumptions should not be made when compiling reports.

2. As evidenced by the need for some MCEs to recompile the quarterly reports that were being validated, all MCEs should ensure that reports are given a data quality check before submitting them to the OMPP. Validation statements are required by the OMPP when the reports are submitted and it appears that the internal processes of validating reports at each MCE could be improved.

3. For the New Member Screening report, all MCEs need to evaluate how they are calculating "unreachable" members so that the counts for unreachable are compliant with the State's definition and are not falsely reducing the denominator in the report formula.

4. For Anthem in particular, the MCE needs to ensure that the programming for computing the values is updated so that what is submitted to the OMPP is accurate.

Recommendations to the OMPP

1. The OMPP should update the specifications for the PMP Assignment Report to clarify ambiguous language related to how to calculate rolling 12-month for new members in item 1 and which PMP assignment(s) to count for items 2-4 (first, all, or most recent assignment) that results in varying interpretations of what is being requested.

2. Similarly, the OMPP should provide clearer language to the MCEs about how to track members that do not meet the definition of "unreachable member" as defined in the New Member Health Screening Report.

SECTION IV: VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

Introduction

Prior to 2009, the Office of Medicaid Policy and Planning (OMPP) did not require its managed care entities (MCEs) to report on the performance improvement projects (PIPs) that they were conducting. Because this is a mandatory component of the External Quality Review (EQR) required by the Centers for Medicare and Medicaid (CMS), and upon the recommendation of Burns & Associates (B&A) as its EQRO, the OMPP directed its MCEs to implement PIPs if they had none and then to report on them.

The State approached B&A for a recommendation on which format to have the MCEs present information on PIPs. B&A advised the OMPP it could design a form or could adapt or modify a form that had been used by the National Committee for Quality Assurance (NCQA) in the past. The OMPP chose to adopt the NCQA form.

Since this time, the MCEs under contract for the Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) have reported using that format. It has been found since this directive went into effect that the MCEs were expending resources on completing the forms without truly capturing the effectiveness of interventions utilized in their PIPs.

In the EQR conducted in 2013, B&A recommended the following:

> The OMPP should consider working with the MCEs to revise the PIP form so that it is most useful to the OMPP, the EQRO and the MCEs themselves. The new format should be more concise but should contain most all of the requirements included in NCQA's tool. B&A recommends that a revised tool could provide less information about methodology for HEDIS®-based PIPs and more information about the interventions. For example:
>
> - Categorize interventions by who they are directed to (beneficiaries, providers, the MCE).
> - Record quantitative information, where appropriate, when describing interventions to help assess the effectiveness of the intervention going forward.
> - Where possible, for PIPs related to HEDIS® measures, crosswalk those members in the numerator to determine if they received a specific intervention. Alternatively, crosswalk those members in the denominator only for the HEDIS® measure to determine if they did or did not receive an intervention. These analyses will also assist the MCE in measuring the effectiveness of the intervention.
>
> Source: External Quality Review of Indiana's Hoosier Healthwise Program and Healthy Indiana Plan for the Review Year 2012– Page IV-20

Based on this recommendation, for this year's EQR the OMPP asked B&A to collaborate with the OMPP and the MCEs to create a new form for PIP submissions. The result of this effort is what is being named the Quality Improvement Project (QIP) Report. The OMPP selected the QIP term to differentiate between it and the Performance Improvement Projects that it requires of MCEs resulting from Corrective Action Plans. Before the implementation of this tool, the State and the MCEs used the terms "QIPs" and "PIPs" synonymously in the HHW and HIP programs. Going forward, the OMPP will use the term "QIP" when referring to the Quality related improvement projects. The QIP Report will be effective January 1, 2015.

Even though a new QIP form is being implemented, B&A did conduct a validation of QIPs in this year's EQR as well. Unlike in prior years, the QIPs selected for validation were not all HEDIS®-based. In prior

years, our findings yielded high confidence in the measures examined in the QIPs because the results were compiled by certified HEDIS® auditors. In this year's review, B&A found that overall there was not always high confidence in the validity of the QIPs because the data collected on QIPs, particularly related to interventions, was not always as complete as the OMPP would like.

This year's review, therefore, was primarily used as a continuous quality improvement exercise with the MCEs to collaboratively design the revised QIP Report and to test the completion of the tool on this year's PIPs before it is officially launches in January 2015.

Development of the New QIP Report

The process that B&A used to develop the QIP Report was interactive. B&A developed a draft of the new tool in Microsoft Excel that combined elements from the NCQA Quality Improvement Project Form and elements from the CMS EQR Protocol 3: *Validating Performance Improvement Projects*. B&A then scheduled a series of meetings with the MCEs.

- June 25, 2014: B&A presented the tool and asked the MCEs to take it back to their organizations, test it, and send questions back to B&A.
- June 25-26, 2014: B&A held individual discussions with the MCEs to review their PIPs and consider how their existing interventions could be presented in the form.
- July 16, 2014: Upon receipt of feedback from the OMPP and the MCEs, B&A reassembled the MCEs to discuss revisions made to the tool.
- July 25, 2014: B&A finalized the tool and instructed the MCEs to resubmit information on this year's PIPs in the new QIP Report format.
- August 15, 2014: MCEs completed the QIP Reports to B&A for this year's three PIP areas of study.
- September 3, 2014: B&A met individually with each of the MCEs to review the revised submissions and to discuss technical questions related to completing the tool.

Historically, the OMPP tracked QIP activity on both the annual NCQA Quality Improvement Project Form submission to the EQR as well as quarterly updates to the MCE Quality Work Plan submitted to the OMPP. Because many elements of the MCE Quality Work Plan are now incorporated into the QIP Report, the OMPP will be updating the MCE Quality Work Plan template for CY 2015 as well. The new QIP Report template is included in Appendix C.

Feedback from the MCEs after their initial beta-testing of the QIP Report has been positive. Comments such as "it forced us to increase the rigor of our quality initiatives" and "we had to re-think the projects in a way that could be measured" were conveyed over the course of this exercise.

<u>Key Features of the QIP Report</u>

The QIP Report template was built in Microsoft Excel with tabs representing different sections of the tool. Each section is a separate worksheet within a single Excel workbook (file) and each worksheet is formatted for printing as one page. The QIP Report is intended to allow for use across multiple years if the MCE chooses to continue the QIP across years. For example, if the QIP is a multi-year initiative, there is opportunity to report results from measures as well as interventions over time.

It is anticipated that the QIP Report will be an annual submission. Since many QIPs of the MCEs are tied to HEDIS® measures, the current suggestion is that the QIP Reports will be due to the OMPP on August 15 of each year to allow for HEDIS® annual measure results to be incorporated. In other words, the QIP

Report submitted in August 2015 will be reporting on information pertaining to activity that occurred from January 1, 2014 through December 31, 2014. Although not every QIP of the MCE will be tied to HEDIS®, the OMPP proposes to require that all QIP Reports be due at the same time to be consistent.

The QIP Report is divided into the following sections:

1. Introduction. This section identifies key attributes of the QIP (e.g., when it began, if it will continue in subsequent years).

2. Measure Definitions. In this section, the MCE defines the specific measures that will be used in the QIP to assess outcomes. Both the numerator and denominator are described in narrative format. The MCE indicates if the measure will be used for the HHW population, the HIP population, or both. Additionally, the data used to compute the measure is specified (HEDIS®-based or not). MCEs may choose to use multiple measures for a QIP. Some of these may cover the entire population while others may address a subpopulation. For example, one QIP may be for breast cancer screening. One measure that the MCE may track in this QIP is the HEDIS® measure for breast cancer screening. Separately, the MCE may choose to create a measure that is HEDIS®-like but is specific to African American women. To the extent possible, the MCE is encouraged to tie interventions back to measures to determine if and how specific interventions may impact a measure.

3. Measure Results. This section contains tables to report the results of each measure defined in the previous section. The OMPP asks that each measure begin with a baseline much like the NCQA form did. The results from subsequent periods will be continually added to the table as time goes on. The MCEs enter the numerator and denominator values and the calculated rate (if the measure is a rate). For other measures, the result is entered (e.g., a whole number). A Goal and a Benchmark value are required to be filled in for each reporting period, and comparisons between the current year's results and the goal and benchmark for the year are evaluated. Like the NCQA form, the OMPP is requesting that tests for statistical significance be completed.

4. Intervention Definitions. One of the main reasons for modifying the QIP Report template was to enable better reporting on interventions. The use of the term "intervention" as it pertains to this template is active engagement with the members based on something that can be measured. The term "activity" in this QIP Report template is intended to define an action that may assist in the improvement of measures in a QIP but, in and of itself, cannot be quantified to assess its effectiveness. For example, a targeted intervention to conduct follow-up calls to members who accessed the emergency department (ED) for non-emergent reasons within 48 hours after they present in the ED would be counted as an intervention since the MCE can quantify its effectiveness. They can measure how many members were actually spoken to in a live call after an ED visit and what their ED use is after the call. An example of an activity would be promotion of the MCE's nurse line in a member newsletter to educate members that the nurse line can help them distinguish between emergencies and non-emergencies.

   In this section of the tool, each intervention for the QIP is identified and a study question is posed related to the intervention. In other words, what is the intervention trying to do or address and to whom? It is anticipated that if an MCE conducts a QIP over multiple years, the interventions related to the QIP will change over time. It is also possible that even if an intervention remains over multiple years in a QIP, it is possible that the study question related to the intervention could change each year as the focus of the intervention was adjusted.

5. Intervention Results. This section is set up similar to the Measure Results section. MCEs identify the specific data in narrative format that will be used to assess the intervention. What is different here from the Measure Results section is that the MCE may or may not have baseline data against which they can measure the intervention results. Therefore, baseline data is not mandatory. Likewise, since interventions may occur sporadically throughout the life of a QIP, the time period of the intervention is not expected to always be annual. While the QIP Report is designed to show change from period to period, it can also be used to show a comparison to a control group.

6. Qualitative Assessment. The final section of the tool allows the MCE to provide feedback in a narrative format about its QIP. Specifically, the tool asks MCEs to address any activities that were conducted for this QIP in addition to the interventions; any barriers to implementing interventions and what was done to alleviate the barrier; any barriers to computing results from measures or interventions and what was done to alleviate the barriers; and successes, challenges and the MCE's overall assessment of the QIP for the year of study.

Review of Performance Improvement Projects

The OMPP gave each MCE the choice from a menu of mandatory QIPs to select from as a minimum set for their Quality Management and Improvement Plan (QMIP). The choices were the same to all MCEs. Part of the OMPP's rationale in doing this was to ensure that the HHW and HIP MCEs have program-wide initiatives that correspond to the State's Quality Plan. Each MCE, however, can (and does) also have other QIPs in addition to the minimum required by the OMPP.

In prior years, B&A validated the results from the mandatory QIPs. This year, B&A chose to validate other items from each MCE's QMIP. Because the Indiana Medicaid contract has pay-for-outcome (P4O) incentives tied to these QIPs, all three MCEs defined the following QIPs in its QMIP. These were the QIPs selected for validation this year:

- Postpartum Care (HHW only)
- Emergency Room Utilization (HHW and HIP for Anthem and MHS, HHW only for MDwise)
- Smoking Cessation (HHW and HIP)

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

Activity 1: Assess the Study Methodology

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

Activity 2, Verify Study Findings, is an optional activity and was not completed as part of this year's external quality review (EQR). Activity 3, Evaluate and Report Overall Validity and Reliability of QIP Results, is presented in this section of the EQR report.

B&A completed the Centers for Medicare and Medicaid's (CMS's) *EQR Protocol 3, Attachment A, PIP Review Worksheet* for each QIP reviewed as part of the validation. These worksheets appear in Appendix D. It should be noted that B&A did adjust some of the components in the PIP Review Worksheet.

A subset of components, but not all of them, was selected for review in Steps 1 through 6 of Protocol 3. More of the focus of this year's QIP validation centered on Step 7 of Protocol 3- Assess the MCE's Improvement Strategies. In particular, interventions were reviewed in depth for each QIP to determine if distinct interventions were measureable, and how the MCEs measure their interventions and outcomes.

Desk Review

MCEs were asked to submit descriptions of their QIP which included the study question, the methodology used, interventions chosen, and results from both the benchmark period and any remeasurement periods. Information was reported by each MCE using a draft of the new QIP Report developed as part of this year's EQR. Two members from B&A's EQR Review Team, Mark Podrazik and Kristy Lawrance, each reviewed these materials and independently completed a draft of the EQR PIP Review Worksheet. After meeting to compare results, areas that could not be fully assessed on the PIP Review Worksheet were identified. The team members created customized interview protocols for each MCE/QIP for the onsite meeting in order to have a full assessment to complete the PIP Review Worksheets.

Onsite Meeting

The MCEs were instructed to have representatives from their team who were the leads for each QIP and those that could speak to the specific QIP interventions available for the onsite interviews. The EQR team members jointly met with MCE representatives to go over the questions in the customized interview protocols for each QIP. Items from the NCQA Quality Improvement Activity Form were also clarified as needed. In some instances, the MCEs brought supplemental information to the meeting to either explain more fully analytics completed on QIP measure results or to share collateral materials on interventions.

Post-Onsite Evaluation

The EQR team members re-reviewed their responses to each PIP Review Worksheet and supplied justifications to each of components on the tool. This was done independently by each reviewer and then responses were shared to confirm concurrence between the reviewers so that each PIP Review Worksheet could be finalized.

Anthem QIP Findings

Postpartum Care

Anthem began its QIP for Postpartum Care in HEDIS® Rate Year (RY) 2012 (services dates in 2011). B&A examined results through Remeasurement Year (RM) 2 (HEDIS® RY 2014).

Postpartum Care is one of the current pay-for-outcome (P4O) measures that the OMPP has in its contract with the MCEs. For this QIP, Anthem elected to include one measure to determine the efficacy of its QIP

activities: the percentage of women that received a postpartum care visit on or between 21 and 56 days after delivery.

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

Interventions

To try to improve scores on this HEDIS® measure, Anthem has modified their interventions over the course of this QIP. Anthem originally had one intervention which was to identify members who were in their ninth month of pregnancy and send them a mailer to remind them to obtain postpartum care. In November 2011, Anthem added an intervention which was to conduct automated calls members to remind them to complete their postpartum care visit. In 2013, Anthem added an additional intervention of individual live-voice calls to members to remind them to complete their postpartum care visit.

Results

Exhibit IV.1 shows that while RM1 showed improvement, it was not statistically significant and RM2 showed statistically significant decrease. The benchmark for this measure is the HEDIS® 90th percentile.

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

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

Anthem reported barriers it has seen that are limiting improvement in this measure:

1. Identifying those members that still need to complete their postpartum visit and then outreaching to them within the narrow 21-56 day timeframe
2. Provider office availability to provide the service within the 21-56 day timeframe

<u>Emergency Room Utilization</u>

Anthem began its QIP for Emergency Room Utilization in CY 2012. B&A examined results through RM Year 1 (CY 2013).

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

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

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

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

Interventions

In 2013, Anthem had one intervention, their ER Action Campaign, which consisted of educational mailings sent to members who use the emergency room more than twice in 180 days. However, due to data issues in quarters two and three in 2013, there was a significant drop in the number of mailings being sent. In 2013 quarter four, mailings returned to normal volume.

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

Results

Exhibit IV.2 below shows that improvement was made in RM1 (a lower rate is desired for this measure). However, Anthem did not have specific goals or benchmarks as part of their QIP. And because the interventions were not active for two quarters of 2013, it is unknown if the intervention impacted results or if other factors improved the score.

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

Measure #1: Rate of member ages 18 and over who visit the ER two times within 180 days								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	CY 2012	13,165	49,766	26.4	NA	-	NA	NA
RM1	CY 2013	4,974	49,103	10.0	-	-	NA	-
Measure #2: Rate of member under age 18 who visit the ER two times within 180 days								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	CY 2012	20,138	167,122	12.0	NA	-	NA	NA
RM1	CY 2013	11,791	168,150	7.0	-	-	NA	-

Smoking Cessation

Anthem began its QIP for Smoking Cessation in CY 2012. B&A examined results through RM1 (CY 2013).

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

1. Increase the percent of members who were advised by their doctor or other health professional to quit smoking in the last six months
2. Increase the percent of members whose provider recommended medication to assist with smoking cessation
3. Increase the percentage gap of members whose provider recommend other strategies to assist with smoking cessation

All of these measures are based upon responses from members when asked questions during the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS).

In 2013, an additional measure was added to monitor the prescribing patterns of nicotine replacement therapies to pregnant women.

Interventions

In 2013, Anthem had one intervention to try and improve these measures, which was to provide an education mailing to members who smoke and offer a smoking cessation kit.

To supplement the smoking cessation kits, Anthem plans to add three more interventions in 2014 and 2015:

1. Follow-up with members that request smoking cessation quit kits
2. Measure the prescribing patterns of nicotine replacement therapies
3. Follow-up with members that received nicotine replacement therapies to determine if they were helpful and if the member stopped smoking

Results

Exhibit IV.3 shows that improvement was made for HHW members on measures one and two, and Exhibit IV.4 shows improvement was made for HIP members on measures one, two, and three. Anthem did not conduct a test to determine if the change was statistically significant. While Anthem provided the EQRO with the rate for each measure, they did not provide the numerator of denominator for each measure.

After the continuous quality improvement exercise of developing the new QIP report during this year's EQR, Anthem has noted that it needs to better define its measures for this QIP.

Exhibit IV.3
Results Reported for Anthem Quality Improvement Project
Smoking Cessation
Hoosier Healthwise

Measure #1: Increase the percent of members who were advised by their doctor or other health professional to quit smoking in the last six months								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CY 2012	99	137	72.3	NA	-	NA	NA
RM1	CY 2013	-	-	77.4	75.0	75.2	2012, 50th	-
Measure #2: Increase the percent of members whose provider recommended medication to assist with smoking cessation								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CY 2012	-	-	35.5	NA	-	NA	NA
RM1	CY 2013	-	-	39.2	52.7	56.7	2012, 90th	-
Measure #3: Increase the percentage gap of members whose provider recommend other strategies to assist with smoking cessation								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CY 2012	-	-	44.9	NA	-	NA	NA
RM1	CY 2013	-	-	39.3	41.2	41.2	2012, 50th	-

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

Measure #1: Increase the percent of members who were advised by their doctor or other health professional to quit smoking in the last six months								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CY 2012	160	199	80.4	NA	-	NA	NA
RM1	CY 2013	-	-	81.9	75.0	75.2	2012, 50th	-
Measure #2: Increase the percent of members whose provider recommended medication to assist with smoking cessation								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CY 2012	-	-	55.8	NA	-	NA	NA
RM1	CY 2013	-	-	57.0	52.7	56.7	2012, 90th	-
Measure #3: Increase the percentage gap of members whose provider recommend other strategies to assist with smoking cessation								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CY 2012	-	-	42.6	NA	-	NA	NA
RM1	CY 2013	-	-	44.8	41.2	41.2	2012, 50th	-

MHS QIP Findings

Postpartum Care

MHS began its QIP for Postpartum Care in HEDIS® Rate Year (RY) 2014 (services dates in 2013). Because this QIP is new, B&A only reviewed the baseline year data.

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

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

Interventions

To try to improve scores on this HEDIS® measure, MHS has four interventions planned:

1. Case Management staff will call members two weeks after delivery

2. Monitor the number of postpartum assessments compared to the number of deliveries
3. Hold baby shower events and monitor attendees' postpartum visit rates
4. Provide CentAccount rewards to members to complete their postpartum visit

Results

Exhibit IV.5 shows the baseline year information for MHS.

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

Measure #1: Percentage of Women that Received a Postpartum Care Visit on or between 21 and 56 Days after Delivery								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	HEDIS 2014	320	451	70.9	73.8	73.8	2013, 90th	NA

Emergency Room Utilization

MHS began its QIP for Emergency Room Utilization in HEDIS® Rate Year (RY) 2014 (services dates in 2013). Because this QIP is new, B&A only reviewed the baseline year data.

Emergency Room Utilization is one of the current pay-for-outcome (P4O) measures that the OMPP has in its contract with the MCEs. For this QIP, MHS elected to include one measure to determine the efficacy of its QIP activities: the Emergency Room Utilization Rate. MHS uses the current HEDIS® definition for the measure and updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year.

Interventions

MHS has two interventions planned for this measure:

1. ER Diversion counseling facilitated by their medical case management team
2. Identification of members for enrollment in the Right Choices Program (RCP)

Intervention number one will focus on members with three or more emergency room visits over a six month period, while intervention number two will focus on members with narcotics overutilization and frequent emergency room visits.

Results

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

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

Measure #1: Emergency Room Visits per 1,000 Member Months								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator (per 1,000 member months)	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	HEDIS 2014	157,272	2,355	66.8	44.6	44.6	2013, 10th	NA

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

Measure #1: Emergency Room Visits per 1,000 Member Months								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	HEDIS 2014	3,613	44,517	81.2	44.6	44.6	2013, 10th	NA

Smoking Cessation

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

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

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

Interventions

MHS began with one intervention in 2012, which was referring members to the quit line via an automated outreach call. Pregnant women who smoke were also advised of the quit line by case management staff.

In 2013, MHS added an additional intervention for pregnant women who smoke. These members will now be referred to the Puff-Free Pregnancy Program.

Results

Exhibit IV.8 on the following page shows that improvement was made, but it was not statistically significant.

Exhibit IV.8
Results Reported for MHS Quality Improvement Project
Smoking Cessation
Hoosier Healthwise and Healthy Indiana Plan

Measure #1: Increase the percent of members who were advised by their doctor or other health professional to quit smoking in the last six months								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CAHPS 2012	336	465	72.3	79.4	81.4	2011, 90th	NA
RM1	CAHPS 2013	375	521	72.0	76.6	81.3	2012, 90th	No
RM2	CAHPS 2014	332	450	73.8	pending	pending	2013, 90th	No

MDwise QIP Findings

Postpartum Care

MDwise began its QIP for Postpartum Care in HEDIS® Rate Year (RY) 2012 (services dates in 2011). B&A examined results through RM2 (HEDIS® RY 2014).

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

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

Interventions

To try to improve scores on this HEDIS® measure, MDwise has one intervention, which is to offer pregnant women who get their postpartum care visit Reward Points. MDwise has additional passive activities that are not measurable, such as mailing a pregnancy booklet and providing educational calls that stress the importance of postpartum care to newly pregnant members.

Results

Exhibit IV.9 shows that while RM1 showed improvement, it was not statistically significant and RM2 showed a decrease, but it too was not statistically significant. The benchmark for this measure is the HEDIS® 90th percentile.

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

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

Emergency Room Utilization

MDwise began its QIP for Emergency Room Utilization in HEDIS® Rate Year (RY) 2012 (services dates in 2011). B&A examined results through RM 2 (HEDIS® RY 2014).

For this QIP, MDwise elected to include one measure to determine the efficacy of its QIP activities: the Emergency Room Utilization Rate. MDwise uses the current HEDIS® definition for the measure and updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year.

In 2013, two additional measures were added to monitor inappropriate emergency room use and emergency room visits per 1,000 members for high emergency room utilizers (four plus visit per year).

MDwise does not use HEDIS® definition for these two additional measures and developed its own logic for computing results each remeasurement year.

Interventions

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

1. Automated calls for inappropriate use of emergency room
2. Case management outreach to high utilizers
3. Identification of members for enrollment in the Right Choices Program (RCP)

For intervention number one, MDwise would like to determine if timely education after inappropriate emergency room use will influence subsequent behavior. For intervention number two, MDwise would like to determine if live-outreach by a case manager will influence subsequent behavior. And for intervention number three, MDwise would like to determine if restricting a member to one hospital, one doctor, and one pharmacy will impact emergency room use behavior.

Results

Exhibit IV.10 on the following page shows MDwise made slight improvement in RM1, and saw a slight decrease in RM2; however, neither change was statistically significant.

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

Measure #1: Emergency Room Visits per 1,000 Member Months								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator (per 1,000 member months)	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	HEDIS 2012	203,020	3,302	61.5	NA	63.3	2011, 50th	NA
RM1	HEDIS 2013	207,537	3,336	62.2	61.0	63.2	2012, 50th	No
RM2	HEDIS 2014	205,870	3,324	61.9	61.0	65.7	2013, 50th	No
Measure #2: Inappropriate Emergency Room Usage								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	CY 2013	145,557	3,299	44.1	NA	NA	NA	NA
Measure #3: Emergency Room Visits per 1,000 Member Months for High Utilizers (4+ visits/year)								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator (per 1,000 member months)	Rate	Comparison Goal	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Statistically Significant Change?
Baseline	CY 2013	82,002	148	553.3	NA	NA	NA	NA

Smoking Cessation

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

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

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

Interventions

MDwise has two interventions for HHW members, both began in 2012:

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

Only the second intervention is used for HIP members.

Results

Exhibit IV.11 for HHW and Exhibit IV.12 for HIP below show that improvement was made, but it was not statistically significant.

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

Measure #1: Rate of member ages 18 and over who visit the ER two times within 180 days								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CAHPS 2012	242	353	68.6	70.0	73.0	-	NA
RM1	CAHPS 2013	294	404	72.8	70.0	73.0	-	No
RM2	CAHPS 2014	314	419	75.0	73.0	73.0	-	No

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

Measure #1: Rate of member ages 18 and over who visit the ER two times within 180 days								
Measurement Period	Time Period Measurement Covers	Numerator	Denominator	Rate	Comparison Goal	Comparison Benchmark Value	Comparison CAHPS Year, Percentile	Statistically Significant Change?
Baseline	CAHPS 2012	365	453	80.4	82.0	76.0	-	NA
RM1	CAHPS 2013	415	501	82.8	84.0	76.0	-	No
RM2	CAHPS 2014	408	489	83.4	84.0	76.0	-	No

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

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

Recommendations to the MCEs

1. All three plans should be prepared to supply all data elements of the new QIP Report in futures years. If standardized measures such as HEDIS® or CAHPS are not utilized, then the MCEs need to be sure to include a goal and benchmark as defined by the MCE. Since there was significant discussion about the development of measureable interventions in this EQR, B&A looks forward to reviewing the results of these interventions in next year's review.

Recommendations to the OMPP

1. Implement the new QIP Report and updated Quality Work Plan by January 1, 2015.

SECTION V: FOCUS STUDY ON NON-EMERGENCY MEDICAL TRANSPORTATION

Introduction

Non-emergency medical transportation (NEMT) is a benefit for Hoosier Healthwise (HHW) members and is not a benefit for members in the Healthy Indiana Plan (HIP); therefore, this focus study is limited to members in HHW.

The managed care entities (MCEs) are responsible for providing members with transportation to and from services covered by the MCE as well as for services covered only under fee-for-service. The three MCEs have subcontracted with transportation brokers to administer this benefit. All three MCEs met expectations regarding delegation oversight on previous EQR reviews (CY 2011 and CY 2012), but during the CY 2013 EQR, providers noted several concerns with transportation vendors such as long wait times, no interpretation services, access and availability issues for members, and refusal of same-day appointments. These concerns prompted OMPP to request a focused study of NEMT for this year's EQR. The study contained the following elements.

- Indiana's NEMT benefit compared to neighboring states
- MCE oversight of transportation vendors
- NEMT utilization trends

Indiana's NEMT Benefit Compared to Neighboring States

B&A reviewed the NEMT benefit in HHW against information found for Medicaid NEMT benefits in other CMS Region 5 states (Illinois, Kentucky, Michigan, Ohio and Wisconsin).

Covered Services

There is little variance in benefit coverage for NEMT services in the comparison group states. In all six states, medically necessary transportation is covered when going to or from a covered benefit. Michigan NEMT services are available to members to obtain medical advice or to receive any Medicaid covered service from a Medicaid enrolled provider, including chronic and on-going treatment, picking up prescriptions, obtaining medical supplies and one-time use, or occasional and ongoing visits for medical care. Illinois, Kentucky, Ohio and Wisconsin provide NEMT services to and from a covered service only if the member has no other available means of transportation. For all states in the comparison group, NEMT is provided through transportation brokers who utilize various means of transporting members including taxis, service cars, Medi-cars, vans, and public transportation.

Prior Authorization

In Indiana, prior authorization is required for trips of more than fifty (50) miles and trips where the member has exceeded their allotment of 20 transports annually.

The comparison group states also require prior approval before using NEMT services. Prior approval typically involves verification of the member's Medicaid eligibility, the medical necessity of the trip, and the member's lack of alternative transportation options. Michigan requires members to obtain prior authorization for out-of-state travel, overnight travel and expenses, special allowances when two or more attendants are medically necessary and methadone treatment that extends beyond 18 months. In Illinois, Kentucky, Ohio and Wisconsin, prior authorization is required for all NEMT services.

Reimbursement Methodologies

Not only in the comparison states, but in 23 of 26 states reviewed by B&A, transportation brokers are the model used by the state or its managed care organizations to deliver NEMT. The most common method to reimburse transportation brokers is by means of a per member per month (PMPM) arrangement. Payments made on a fee-for-service (FFS) basis (such as a fully loaded per mile rate) are also used instead of the PMPM method or, in some states, in addition to the PMPM method in limited circumstances (e.g., rural counties).

In Indiana, the three MCEs all have a PMPM capitation arrangement with their contracted broker in the HHW program. Within Region 5 states, Kentucky, Ohio and Wisconsin use a PMPM reimbursement method with rates that can vary by county. Michigan uses a PMPM in its three most populous counties (with rates that vary by county), but FFS reimbursement is used in the remaining counties. Illinois only employs FFS rates, and these rates can vary by county.

MCE Oversight of Transportation Vendors

All three MCEs subcontract their NEMT responsibilities to a transportation broker. Anthem and MHS both subcontract with LCP Transportation, LLC (LCP), while MDwise subcontracts with Ride Right, LLC.

Section 2.8 of the Indiana Medicaid contract with the MCEs mandates that if an MCE subcontracts out any portions of its contract, the MCE remains responsible for the performance and oversight of all the requirements designated within the contract. As such, there are several requirements outlined within the Indiana Medicaid Statement of Work which hold MCEs accountable in regards to this arrangement with their transportation brokers. For the purpose of this focused study, B&A chose to review the vendor oversight and debarment requirements.

Vendor Oversight

Indiana Medicaid requires MCEs to have a written agreement in place specifying subcontractor responsibilities as well as providing an option for revoking delegation if performance is inadequate. MCEs must demonstrate oversight and monitoring of the vendors they subcontract with and submit an annual report on compliance, corrective actions and outcomes of their monitoring activities. Additionally, federal and state disclosure requirements related to ownership and controlling interests are outlined in the Indiana Medicaid Statement of Work. In accordance with 42 CFR 455.100-104, the Contractor must notify Indiana Medicaid of any person or corporation with five percent or more of ownership or controlling interest in the Contractor and must submit financial statements for these individuals or corporations. To validate this requirement, each MCE submitted a copy of their delegation agreement or contract, as well as copies of delegation oversight audits they conducted on their transportation brokers.

All three MCEs have written policies and procedures for contract monitoring and vendor oversight of their transportation brokers. Each of the MCEs hold some type of monthly meeting with their broker, and all three receive monthly reports on a variety of measures, including member utilization and complaints, provider trip summaries and vendor validations. Exhibit V.1 on the following page highlights the oversight mechanisms that the MCEs utilize to track and monitor the activities of the transportation brokers in addition to the monthly meetings and other communications that occur.

Exhibit V.1
MCE Vendor Oversight Tools

Document/ Report Name	Anthem	MHS	MDwise
Oversight Process Charter	X	X	X
Transportation Services Agreement	X	X	X
Delegated Entity Oversight Audits	X	X	X
Driver Credentialing Processes	X	X	X
Transportation Broker Credentialing Policy and Procedures	X	X	X
Transportation Broker Credentialing Application	X	X	X
Vendor Oversight Corrective Action Plan	X	X	X
Compliance Reports	X	X	X
Helpline Reports	X	X	X
Member Utilization Reports	X	X	X
Bus Pass Report	X	X	X
Emergency Urgent Care Report	X	X	X
Long Distance Report	X	X	X
Member Less Than 20 Trips Report	X	X	X
Member No Show Report	X	X	X
Provider Validation Reports	X	X	X
Monthly Trip Summary Report	X	X	X
Monthly Validation Reports	X	X	X
Monthly Meeting Minutes	X	X	X
Encounter Validation Certification	X	X	X
Disclosure of Ownership and Controlling Interest	X	X	

All three MCEs have contractual requirements with their transportation brokers which lay out the expectations each has for network provider oversight, the tracking and handling of member complaints, and overall monitoring of the NEMT contract. Although there are required policies and procedures in place, there are a few vulnerabilities with the implementation of these approaches.

Anthem

While Anthem meets the contractual requirements of vendor oversight and monitoring, areas of vulnerability were identified during the on-site interview.

Anthem appears to have limited interaction with LCP. LCP does supply Anthem with monthly monitoring reports and monthly conference calls are held between Anthem and LCP. However, Anthem admitted that these meetings are not formalized and no minutes are documented during the meetings. If action items develop during a meeting, the only documentation is emails between Anthem and LCP.

Anthem does not appear to be reviewing the transportation encounter data for any trending or utilization reviews. Anthem also appears to lack knowledge regarding the vendor's operations. An example of this occurred during the on-site interview with Anthem and LCP on July 16, 2014, when Anthem responded that they are not performing any verification that services were provided to their members. LCP, who was on the telephone for the interview, interjected that they actually conduct a monthly member survey, in which 20 percent of the previous month's members are randomly polled, and their trips are reviewed for a number of variables.

Anthem does collect ownership and controlling interest information from LCP; however, this information is only used to confirm that LCP has no other business interest that exists within Anthem's other lines of business that may conflict with the scope of the Anthem HHW NEMT contract. Anthem is not using the information provided on the ownership and disclosure document to verify that those individuals are not listed on the HHS-Office of Inspector General (OIG) List of Excluded Individuals or Entities (LEIE) or on the Excluded Parties List System (EPLS)[6] lists of debarred or excluded individuals.

MHS

While both MDwise and MHS are actively engaged in monitoring their transportation broker activities, MHS showed best practices in this area. Monthly face-to-face meetings with LCP allows MHS to more quickly identify potential issues, discuss concerns, and address those areas requiring immediate action, such as complaints or provider relations. Open lines of communication are evident between the two organizations. MHS reported that during last winter's bad storms which caused delays and closings, MHS and LCP were able to communicate by cell phone when key staff members were unable to make it to the office, ensuring HHW members continued receiving services uninterrupted.

In regards to the validation of encounter data and verification of services, however, MHS is vulnerable. They are not currently reviewing their NEMT encounter data for any trending or utilization patterns, and they are not independently verifying with their members if NEMT services are being provided. They rely solely on their transportation broker to conduct oversight and monitoring of the network providers.

MHS does collect ownership and controlling interest information from LCP and verifies those on the list are not debarred or excluded individuals.

MDwise

MDwise is actively engaged with the transportation broker, Ride Right. Their broker supplies MDwise with monthly monitoring reports and regular meetings are held between the two organizations. However, MDwise's oversight of their vendor is not as robust as it should be, as evidenced by Ride Right contracting with a non-IHCP provider that went unnoticed by MDwise until it was brought to their attention by the EQRO, which is discussed in the next section in more detail.

MDwise was the only MCE that was performing data analytics on NEMT claims data (e.g., trips per 1,000 members). However, the data analytics appeared to be limited to a specific special project. They do not appear to be regularly reviewing their NEMT encounter data for any trending or utilization patterns, nor independently verifying with the members if NEMT services are being provided.

MDwise does not collect ownership and controlling interest information from their transportation broker; therefore, MDwise is unable to verify that Ride Right does not have any owners or those with controlling interest listed on the OIG's LEIE or EPLS lists.

<u>Debarment</u>

There are federal and state requirements that prohibit the MCE from knowingly having a relationship with an individual who is debarred, suspended or excluded from participating in federal health care programs or participating in procurement activities. The relationships include directors, officers or partners of the

[6] These programs are detailed in the Debarment section of this chapter.

contractor, persons with beneficial ownership of five percent or more of the contractor's equity, or persons with an employment, consulting or other arrangement with the contractor for the provision of items and services that are significant and material to the contractor's obligations under the contract.

When the HHS-OIG has excluded a provider, contractors are encouraged to check the System for Award Management (SAM) database which contains information from the following databases: the Central Contractor Registry (CCR), the Federal Agency Registration (Fedreg), the Online Representations and Certifications Application and the Excluded Parties List System (EPLS).

In addition to debarments and exclusions, the MCEs must also have a credentialing process in place for their network providers, which would include their NEMT providers. Furthermore, OMPP requires that any provider enrolled with and reimbursed by the MCEs is also enrolled as an IHCP provider. B&A reviewed each MCE's policies and procedures and asked follow-up questions to determine if the MCEs were compliant with these requirements.

All of the MCEs have contract language with their vendors as well as policies and procedures in place to ensure that their transportation brokers are following both federal and state requirements for network provider credentialing and screening.

To verify if the MCEs and their transportation vendors were compliant with federal and state requirements as well as with their own policies and procedures, B&A requested a list of each MCE's contracted transportation providers. This list was compared to the federal exclusions list as well as the IHCP provider file. Both Anthem and MHS were compliant as none of their NEMT providers were federally excluded and all NEMT providers were IHCP enrolled providers.

MDwise, however, had one contracted provider that was not an approved IHCP provider. When investigated by MDwise and Ride Right, it was determined that this provider was indeed not an IHCP contracted provider. The approximately $3,600 earned by the provider over the seven months they were under contract is being recouped by Ride Right.

This incident brings into question whether MDwise is reviewing their rejected encounter submission from the State. Since this provider was paid by MDwise, an encounter should have been submitted to the OMPP. Indiana Medicaid would have rejected the encounter because the provider was not an approved IHCP provider. This encounter rejection should have alerted MDwise of the issue with this provider's IHCP status; however, MDwise was unaware of this violation until brought to their attention by the EQRO.

NEMT Utilization Trends

B&A utilized encounter data submitted by the MCEs to the Indiana Medicaid data warehouse as well as supplemental claims files from LCP to conduct analysis and trending of NEMT claims. The supplemental files were required from LCP for Anthem and MHS claims because only a base rate code is submitted as an encounter to the Indiana Medicaid data warehouse and mileage codes, which were not submitted to the Indiana Medicaid data warehouse, were also required for analysis. Since B&A obtained raw claims data from the LCP system, we did compare the raw LCP claims file to the encounters in the Indiana Medicaid data warehouse and there was a 1:1 match for each NEMT base code. This suggests that for both Anthem and MHS, LCP is transmitting all encounters to the MCEs and both MCEs are transmitting all encounters to Indiana Medicaid. MDwise submitted NEMT encounters with all codes that were billed to the Indiana Medicaid data warehouse so a supplemental file was not required.

Specific analyses conducted for this study included:

- NEMT utilization across regions within the HHW population
- Average distance travelled for a NEMT trip
- Purpose (services going to obtain) in conjunction with the NEMT
- Access to NEMT providers

Number and Distance of Transports

B&A reviewed the total number of NEMT trips per MCE to determine trends in utilization of the benefit. To normalize the data and account for varying memberships in each county, B&A calculated utilization per 1,000 member months within each MCE. The overall utilization in the State varies by MCE for both actual number of transports as well as utilization per 1,000 member months with MHS members having the lowest utilization and MDwise members having the highest utilization, as can be seen in Exhibit V.2 below.

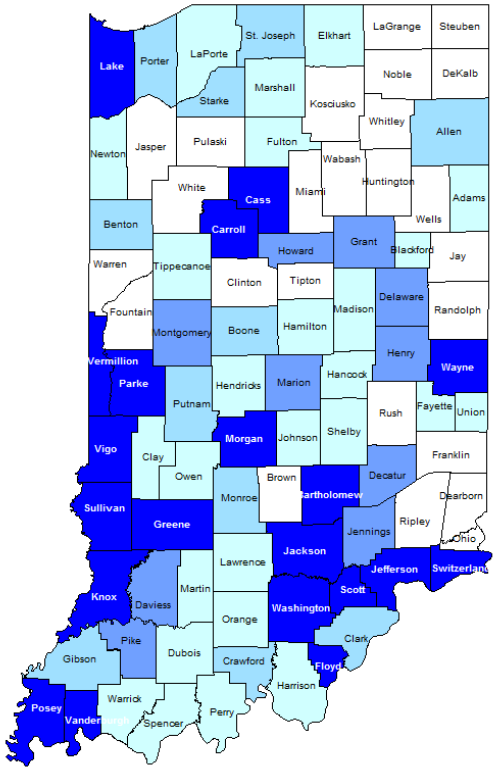
Exhibit V.2
Utilization of NEMT Benefit in CY 2013
Hoosier Healthwise

	Anthem	MHS	MDwise
Total Transports	43,892	31,682	72,012
Transports per 1,000 member months	16.6	13.4	21.6

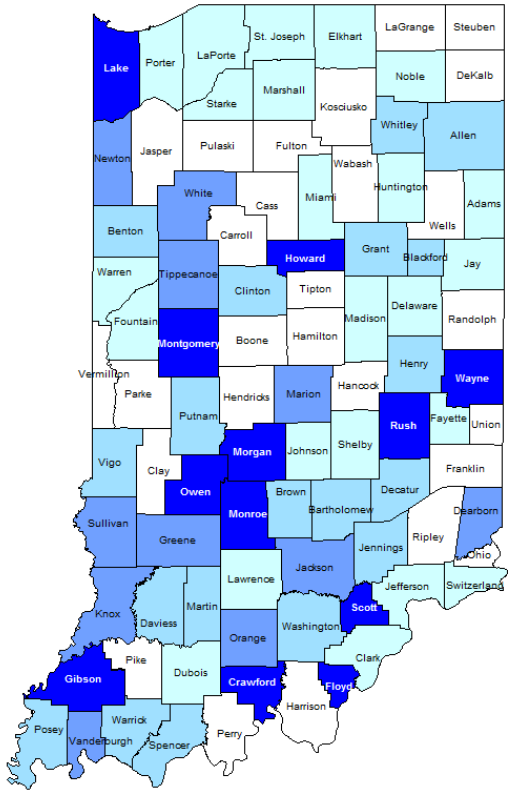
B&A then reviewed the data by county to determine if specific portions of the State have a higher utilization. For all three MCEs, the utilization tends to be higher in Lake County (in the Northwest region), and southern portions of the state as a whole. Exhibit V.3 on the following page displays the utilization per county for each MCE. This visual depiction illustrates how MDwise member NEMT utilization is generally higher throughout the state while MHS and Anthem both have select counties with higher utilization. The notable exceptions are Lake County in the northwest region, Wayne County in the east central region, and Floyd and Scott counties in the southeast region which have high utilization for all MCEs.

Exhibit V.3
Hoosier Healthwise NEMT Transports in CY 2013 per 1,000 Member Months, by MCE

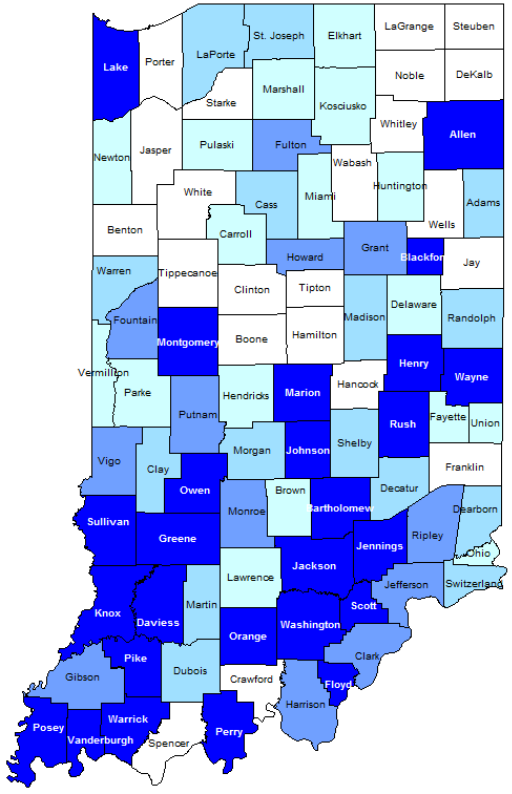
Anthem



MHS



MDwise



Transports/1,000 Member Months		(Number of Counties) Anthem	MHS	MDwise
	0 - 5	(25)	(27)	(22)
	6 - 10	(26)	(23)	(17)
	11 - 15	(11)	(19)	(15)
	16 - 20	(10)	(11)	(12)
	20+	(20)	(12)	(26)

B&A examined the average number of miles per transport as well to determine if specific counties typically resulted in higher distances travelled. This could indicate limited local service providers available. Trips originating[7] from approximately half of the 92 counties in the state had an overall distance of 20 miles or less (refer to Exhibit V.4 below). Trips originating in close to 10 percent of the counties had distances in excess of 40 miles. As anticipated, the longer distance trips typically originated from more rural counties throughout the state, as illustrated in Exhibit V.5 on the following page. Counties in this category across all MCEs include LaGrange County in the northeast region, and across two MCEs include Pulaski and Starke counties in the north central region, Franklin and Howard counties in the east central region, and Martin and Spencer counties in the southwest region.

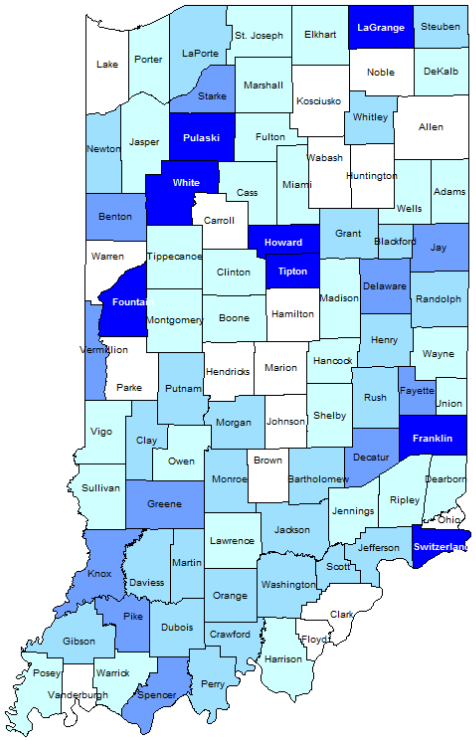
Exhibit V.4
Average Distance Traveled per Trip per County
CY 2013 Hoosier Healthwise

Number of Miles	Percent of Counties		
	Anthem	MHS	MDwise
0 to 10	20%	16%	12%
11 to 20	33%	28%	36%
21 to 30	27%	33%	34%
31 to 40	12%	13%	7%
41+	9%	10%	12%

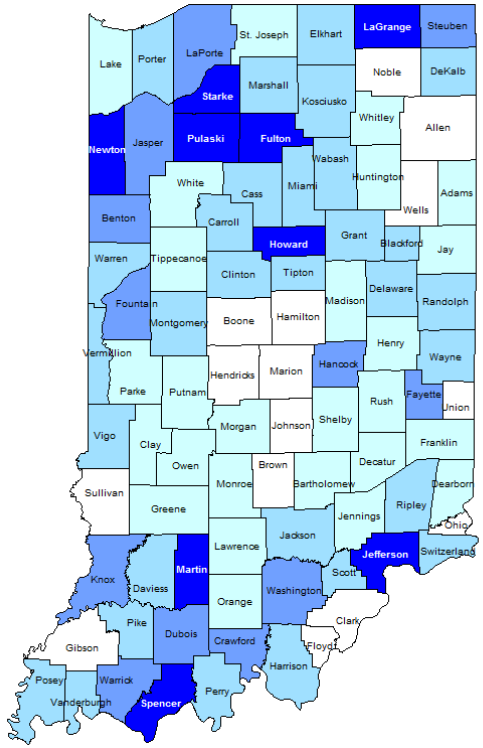
[7] Trip origin based on the members' home address on file in the OMPP data warehouse.

Exhibit V.5
Average Miles per Transport among Hoosier Healthwise NEMT Transport in CY 2013, by MCE

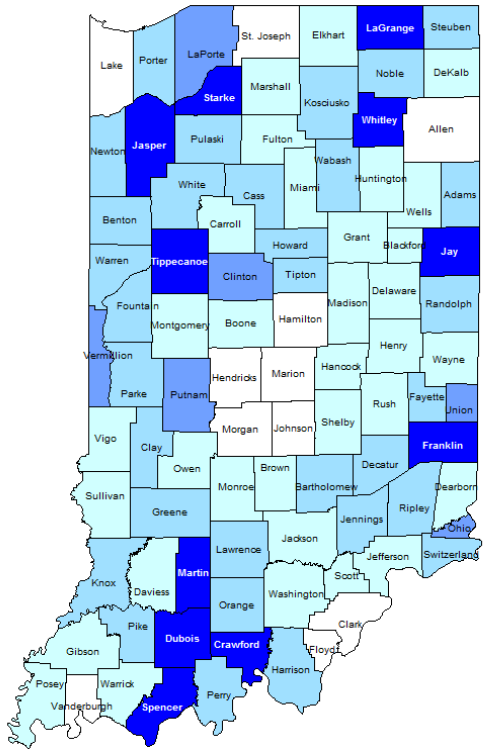
Anthem



MHS



MDwise



Miles	(Number of Counties) Anthem	MHS	MDwise
0 - 10	(18)	(15)	(11)
11 - 20	(30)	(26)	(33)
21 - 30	(25)	(30)	(31)
31 - 40	(11)	(12)	(6)
41+	(8)	(9)	(11)

The OMPP requires that the MCEs submit an encounter claim for every service rendered to a member. MCEs must also have a system in place not only for monitoring and reporting the completeness of claims and encounter data, but also for verifying and ensuring that providers are not submitting claims or encounter data for services that were not provided. The MCE contract states on page 9-6:

> The MCE must maintain an efficient utilization management program that integrates with other functional units and supports the Quality Management and Improvement Program. The utilization management program must have policies and procedures in place that:
> • Identify aberrant provider practice patterns (especially related to emergency room visits, inpatient services, **transportation,** drug utilization, preventive care, and screening)

During interviews with the MCEs on July 16 and 17, Anthem and MHS indicated that they have not been evaluating transportation utilization and comparing it to other services to ensure members are appropriately utilizing the transportation benefit. And while MDwise indicated they have evaluated transportation utilization, it was only for a special project and has not continued. The transportation brokers for the MCEs, however, all indicated they have processes in place to ensure members are utilizing the transportation benefit appropriately, such as documenting what provider the member is being transported to and verifying with a random selection of providers that the member attended the appointment.

To evaluate the effectiveness of these processes and to evaluate if members are being transported to a covered service, B&A reviewed all NEMT encounters submitted for trips rendered in CY 2013 and then reviewed the encounters contained in the Indiana Medicaid data warehouse to determine if the member had another service on the same date as the NEMT trip. Another "service" included all other provider types, such as: hospital, clinic, chiropractor, therapist, mental health provider, physician, or pharmacy. It should be noted that services included both those delivered by the MCEs (reported as encounters) and services paid directly by the State (reported as FFS claims). Results are noted in Exhibit V.6 below. Based on the analysis, it appears that members are either utilizing NEMT to take trips to non-covered services or that not all of the service encounters that accompany NEMT trips are available in the Indiana Medicaid data warehouse (because they were not submitted by the MCE or some other reason). The MCEs indicated that they do allow members an enhanced NEMT benefit to certain non-covered services, such as to eligibility re-determination meetings or to obtain women, infant and children (WIC) benefits. However, the EQRO questions if trips to these approved non-covered services would account for 29-35 percent of all NEMT provided to HHW members in CY 2013 (the percentage of NEMT trips identified without an associated covered service).

Exhibit V.6
Billed Claim in State's Data Warehouse
in Addition to NEMT Claim
CY 2013 Hoosier Healthwise

	Yes	No
Anthem	65%	35%
MHS	71%	29%
MDwise	68%	32%

B&A reviewed the members that received NEMT services when another service was not located in the OMPP data warehouse to determine if any patterns were evident. Overall, these members were predominantly female with 74 percent of Anthem members, 66 percent of MHS and 70 percent of MDwise members being female. Additionally, MDwise had the tightest geographic concentration of these members with 56 percent of the members residing in Lake or Marion counties (10 percent and 46

percent, respectively). Anthem members were not as concentrated with 51 percent residing in Lake, Marion, or Vanderburgh counties (17 percent, 25 percent and 9 percent, respectively). MHS members were the least concentrated with 49 percent of members residing in Elkhart, Howard, Lake, Marion or St. Joseph counties (5 percent, 5 percent, 19 percent, 14 percent, and 6 percent, respectively).

B&A also reviewed the members that received NEMT services when the other service was not located in the Indiana Medicaid data warehouse to determine if these members ever have other services that accompany an NEMT trip. Fifty-five percent of Anthem and MDwise members and 56 percent of MHS members that ever had a NEMT service billed without another service in the OMPP data warehouse also had at least one other NEMT service that was billed with another service.

B&A also examined the median miles billed for members that did and did not have a claim for a non-transportation covered service on the same day as a NEMT service. When there was not a claim for a another service in the Indiana Medicaid data warehouse, transportation providers typically billed slightly more miles for the transport, as seen in Exhibit V.7 below.

Exhibit V.7
Median Miles Billed for NEMT with and without Companion Claim for Non-transportation Service

	Had Billed Claims in Addition to Transportation	
	Yes	**No**
Anthem	8.6	11.1
MHS	13.0	13.2
MDwise	10.5	12.3

For those members that did utilize NEMT to travel to a covered service, B&A reviewed the destination provider to determine which provider types the members visit while utilizing NEMT. The results were generally consistent across the MCEs and indicate that most members are using NEMT to visit a physician, clinic, hospital, or mental health provider, as seen in Exhibit V.8 below. The notable exception is MDwise where 35 percent of the trips made by its members were to a covered service other than the ones mentioned above.

Exhibit V.8
Type of Provider Visited by Members That Utilize the NEMT Benefit

Provider Type	Percent of Transports		
	Anthem	**MHS**	**MDwise**
Physician	46%	41%	29%
Clinic	19%	24%	14%
Hospital	12%	15%	20%
Mental Health Provider	7%	8%	2%
All Others	16%	12%	35%

B&A also reviewed members that utilized the NEMT benefit to visit their PMP to determine if there is variance when the distance from the member's address to the PMP's address is more than 30 miles. For Anthem and MDwise the rate of NEMT utilization is proportional to the distance PMP distance. For MHS, an increased PMP distance resulted in higher than proportional NEMT utilization, as seen in Exhibit V.9 on the following page.

Exhibit V.9
Members that Utilized NEMT to Visit Their PMP
CY 2013 Hoosier Healthwise

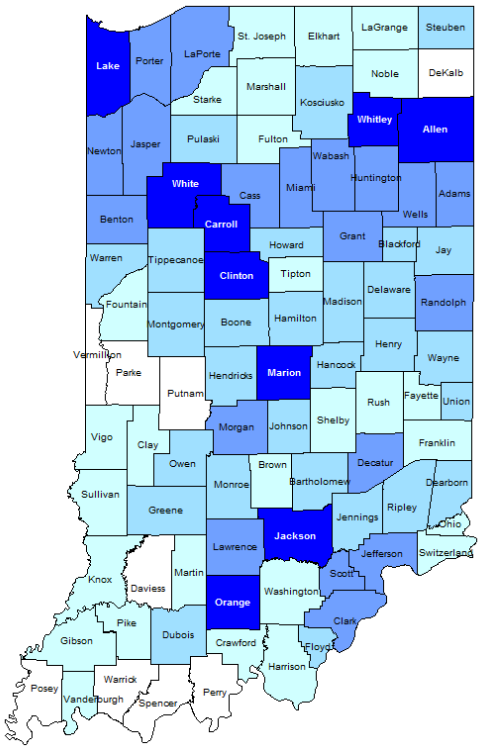
	PMP 30 Miles or Less from Member		PMP More than 30 Miles from Member	
	Percent of Members	Percent of Members that Utilized NEMT to Visit Their PMP	Percent of Members	Percent of Members that Utilized NEMT to Visit Their PMP
Anthem	80%	79%	20%	21%
MHS	78%	68%	22%	32%
MDwise	76%	77%	24%	23%

NEMT Provider Networks

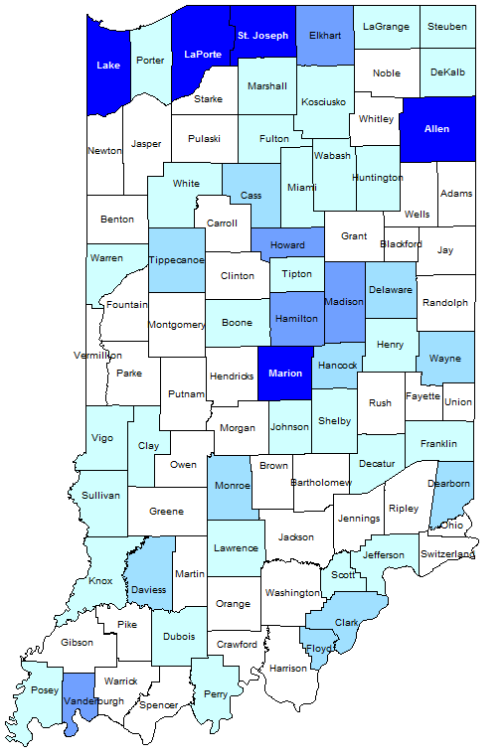
In our field interviews with providers during the CY 2013 EQR, it was noted that long wait-time was often a problem with the NEMT benefit. Therefore, B&A reviewed the NEMT provider network for each MCE to determine if certain counties appear to lack NEMT providers. This analysis is illustrated in Exhibit V.10 on the following page. Because Anthem and MHS both contract with LCP and LCP contracts with the same providers for both MCEs, one map is displayed for these two MCEs.

Exhibit V.10
Hoosier Healthwise NEMT Providers per MCE

Anthem/MHS



MDwise



No. of Providers	Anthem/MHS (Number of Counties)	MDwise (Number of Counties)
0 - 1	(9)	(43)
2	(27)	(29)
3	(28)	(10)
4	(19)	(5)
5+	(9)	(5)

Anthem and MHS (LCP) have a more robust NEMT provider network with 90 percent of counties having two or more NEMT providers and 30 percent of counties having four or more NEMT providers available for members. This compares to MDwise (Ride Right) where 88 percent of counties have two or more NEMT providers but only 18 percent of counties have four or more NEMT providers available for members.

To further analyze utilization and provider availability, B&A looked at three calculations per county:

1. NEMT Trips per 1,000 Member Months – A high number in this calculation may indicate there are not enough NEMT providers to manage the demand for NEMT in a county. B&A calculated the statewide 90th percentile for this measure as 28 trips per 1,000 member months to determine when the number of NEMT trips may need to be monitored.
2. NEMT Providers per 1,000 Member Months – A low number in this calculation may indicate there are not enough NEMT providers for the MCEs population in a county. So, while actual utilization may be low, this may be because there are not enough NEMT providers to render the NEMT service. B&A calculated the statewide 90th percentile for this measure as 0.05 providers per 1,000 member months to determine when the number of NEMT providers may need to be monitored.
3. Average Distance per NEMT Trip – A high number in this calculation may indicate there are not enough local service providers in a county and the NEMT provider has to travel greater distance, which limits the actual number of NEMT trips that the NEMT providers can perform. Less availability for trips may indicate there are not enough NEMT providers to manage the demand for NEMT in a county. B&A calculated the statewide 90th percentile for this measure as 57 miles to determine when the distance of NEMT trips may need to be monitored.

While exceeding the threshold in any one category may not be an indication of a supply/demand issue, when an MCE exceeds the threshold in two or more categories, it may indicate a supply/demand concern. Exhibit V.11 below highlights when one or more of the MCEs exceeded two or more of the thresholds described above. The calculation for these three categories for every county is located in Appendix E. A limitation of the values for Providers per 1,000 Member Months known to B&A is that on the data provided to B&A of NEMT providers in each county, there was no indication if each provider had multiple vehicles/drivers (indicating sufficient volume to deliver the service).

Exhibit V.11
Two or More NEMT Threshold Measures Above the Statewide 90th Percentile per MCE, by County

	Anthem	MHS	MDwise
Allen			X
Bartholomew			X
Clinton			X
Jennings			X
Lake	X	X	
Marion			X
Switzerland	X		
Tippecanoe			X
Vanderburgh	X		
Whitley			X

Recommendations to the MCEs and Indiana Medicaid Related to Non-Emergency Medical Transportation

Based on our review of Non-Emergency Medical Transportation (NEMT) policies and procedures and examination of data pertaining to NEMT, B&A has developed specific recommendations to each MCE and to Indiana Medicaid.

Recommendations to the MCEs

1. MDwise should ensure their transportation broker does not enroll providers that are non-IHCP providers and monitor rejected encounters to identify potential issues.

2. Anthem, MHS, and MDwise should evaluate utilization to determine why it appears members are utilizing the NEMT benefit for non-covered services. Additionally, the MCEs should develop and enact a plan to ensure the NEMT benefit is utilized appropriately.

3. Anthem, MHS, and MDwise should regularly evaluate the demand for NEMT services, their memberships per county, and compare that to the available NEMT providers to alleviate access to care issues. An analysis such as the one shown in Appendix E in this report is one suggested method to conduct this evaluation on a periodic basis.

4. Anthem and MDwise should collect ownership and controlling interest documentation from their NEMT broker, and compare that list to federal excluded provider databases.

Recommendations to Indiana Medicaid

1. Indiana Medicaid may want to consider evaluating the basis of the capitation rate to the MCEs for NEMT. Low rates may contribute to a less robust benefit being delivered through the MCEs and their brokers, which may result in fewer providers willing to participate in the IHCP programs, ultimately causing problems with access and availability.

2. Indiana Medicaid should ensure that MCEs maintain appropriate oversight of their NEMT vendors.

3. Indiana Medicaid should monitor the MCEs' progress on ensuring appropriate utilization of the NEMT benefit.

SECTION VI: FOCUS STUDY ON NEW MEMBER ACTIVITIES

Introduction

During the External Quality Review (EQR) conducted by Burns & Associates (B&A) in CY 2013, 59 interviews were conducted with provider offices in the field. In these interviews, concerns were raised about the PMP assignment process 52 percent of the time. Providers also noted that there is often inconsistent PMP information for members when looking at Web interChange (the State's member eligibility system supported by HP) and the MCE's individual web portals. B&A, therefore, attempted to quantify these concerns noted by providers through comparison of data supplied by the MCEs and information obtained from Optum, the vendor that manages the Indiana Medicaid data warehouse.

Additionally, to supplement the validation of the performance measures related to PMP assignment and new member health screenings discussed in Section III of this report, B&A also reviewed policies and procedures and compared them to contractual requirements of the MCEs related to PMP assignment and member health screenings.

Methodology Related to PMP Assignments

The MCE Policies and Procedures Manual states (Page 5-3):

> The MCE must ensure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member's needs. Following a member's enrollment, the MCE must assist the member in choosing a PMP. Unless the member elects otherwise, the member must be assigned to a PMP within 30 miles of the member's residence.
>
> The MCE must document at least three telephone contacts made to assist the member in choosing a PMP. If the member has not selected a PMP within 30 calendar days of the member's enrollment, the MCE shall assign the member to a PMP. The member must be assigned to a PMP within 30 miles of the member's residence, and the MCE should consider any prior provider relationships when making the assignment. The OMPP must approve the MCE's PMP auto-assignment process prior to implementation, and the process must comply with any guidelines set for by the OMPP.
>
> Other considerations for PMP auto-assignment by the MCEs include:
>
> - If panel slots not available with appropriate scope of practice within 30 miles, the MCE must authorize out-of-network care to any IHCP provider.
> - Must consider PMP assignment history (HP provides 12 months of history and MCE claims history should be used).
> - Must take panel limits into consideration.
> - Must ensure provider scope of practice considered.
> - If member is in RCP [the Right Choices Program, a member lock-in program], assignment to the lock-in PMP must be maintained.

B&A reviewed each MCE's policies and procedures related to PMP assignment processes and compared these policies and procedures to their contractual requirements. B&A then selected specific requirements and analyzed data from the State's data warehouse to determine if PMP assignments adhered to contract requirements.

Findings Related to PMP Assignment

In general, the MCEs all have robust policies related to PMP assignment. Each MCE outlined to B&A their processes and workflows for PMP assignment logic which met the contractual requirements. However, when actual data was reviewed, it appears that while the MCEs have documented policies and procedures, they are not always implementing them effectively.

PMP Assignment within 30 Days

The MCE contract (section 6.2.2) states, "If the member has not selected a PMP within thirty calendar days of the member's enrollment, the Contractor shall assign the member to a PMP." B&A reviewed each new member's assignment date to the MCE then compared that information to when the member was assigned to a PMP. Exhibit VI.1 below highlights the variance between each MCE's ability to assign a member within 30 days. The results are consistent for both Hoosier Healthwise and Healthy Indiana Plan, so one combined exhibit is displayed.

Exhibit VI.1
Days from Member Assignment to MCE to Assignment of PMP

	Anthem	MHS	MDwise	TOTAL
30 Days or Less	77%	100%	99%	93%
31 to 60 Days	5%	0%	1%	2%
61 or More Days	18%	0%	0%	5%
TOTAL	100%	100%	100%	100%

MHS assigned 100 percent of members within 30 days and MDwise assigned 99 percent of members within 30 days.

Conversely, Anthem only assigned 77 percent of members within 30 days. In discussions with Anthem regarding this, it was determined that a potential explanation is that although their auto assignment logic which is programmed to activate at 27 days to auto-assign a member, it will not do so if there is not an available PMP within 30 miles. Therefore, when a member is assigned to Anthem, the member does not self-select a PMP, and there is not an open PMP panel within 30 miles, the member will not be assigned a PMP within 30 days. Instead, a list of these members is transferred to a report which is manually worked by staff to assign a PMP.

Assigning Family Members to the Same PMP

In the CY 2013 EQR, providers noted frustration with family members being assigned to different PMPs. Additionally, the OMPP requires the MCEs to consider if another member of the family/household is already assigned to a PMP. B&A reviewed the frequency of new family members being assigned to a different PMP. The results are shown in Exhibit VI.2 on the following page.

Exhibit VI.2
Newly Assigned Members Assigned to the Same or Different PMPs Than a Family Member

	Anthem		MHS		MDwise	
	HHW	HIP	HHW	HIP	HHW	HIP
Total New Members in 2013	63,746	646	46,127	1,584	142,528	2,408
Member Count When All Family Members Have the Same PMP	42,832	624	28,405	1,354	88,574	2,070
Member Count When Not All Family Members Have the Same PMP	20,914	22	17,722	230	53,954	338
Percent of Members When Not All Family Members Have the Same PMP	33%	3%	38%	15%	38%	14%

Over one third of newly assigned Hoosier Healthwise members assigned to the MCEs in CY 2013 were assigned to a PMP that was different than the PMP of another member within the household. There could be justifiable reasons for this, such as the newest member chose a different PMP, the existing PMP's panel was full, or the family composition is mother and children and the mother selected an OB/GYN and the selection for the children is a pediatrician.

All three MCEs stated that one reason for this disparity in PMP assignment among family members is that, for a significant number of members, they do not receive the member's Case ID on the 834 membership file. The Case ID is the number that identifies people within the same household. B&A analyzed the member files within the Indiana Medicaid data warehouse to determine if the Case ID was missing. On 99.998 percent of the member files within the data warehouse, the Case ID was assigned to the member. Therefore, the problem does not appear to be that the Case ID does not exist but, rather, somewhere in the data transfer between the enrollment broker and the MCE's 834 membership file members' Case IDs are inadvertently being removed and not transmitted to the MCEs.

PMP Assignment within 30 miles

The MCE Policies and Procedures Manual indicates that members should be assigned to a PMP less than 30 miles from their residence, unless a member self-selects a PMP greater than 30 miles from their residence. B&A analyzed the geodesic (straight line) distance between newly assigned members and their assigned PMP to determine median distance in miles. Exhibit VI.3 below shows the median distance between the home location of newly assigned members in CY 2013 and their PMP's office. While the geodesic distance is not the driving distance, because the median distance is well within the 30 mile requirement, further analysis was not conducted.

Exhibit VI.3
Median Geodesic Distance Between Members and Their PMP (in miles)

	Anthem	MHS	MDwise
HHW	6.7	7.3	7.5
HIP	7.4	7.4	10.3

It should be noted that the calculation above only takes into consideration those newly assigned members that have an address within Indiana or a contiguous state.

Comparing PMP Assignment between the State and MCE Portals

During the CY 2013 EQR, providers voiced concern that the State's member information portal, Web interChange, and the MCE portals do not consistently display the same PMP for members. To quantify the level of discrepancy between the two, B&A obtained each member's assigned PMP as of December 31, 2013 from both the Optum data warehouse (the source provided to B&A for information displayed on the State's portal) and from the MCEs' systems (the repository of the data displayed on the MCEs' portals). A comparison was conducted between the files and it was validated that there is minimal discrepancy between the State's data warehouse and the MCEs' systems for MHS and MDwise.

Anthem, however, had a 79% PMP match rate for HHW and B&A was unable to validate the Anthem HIP PMP match rate. The low HHW match rate and B&A's inability to confirm the HIP match rate was in part due to poor data files provided by Anthem. After three requests for the data, the MCE repeatedly did not provide the appropriate provider ID for each member which was required to compare the member's PMP as identified by the MCE to the Indiana Medicaid data warehouse.

One further step to the analysis that could be conducted in the future is to verify the PMP assignment as identified by HP, the vendor that manages the Web interChange portal, to ensure that HP has the same PMP information as the Indiana Medicaid data warehouse (Optum). The HP information was unavailable to B&A at the time of this review. Exhibit VI.5 shows the PMP match rate between the Indiana Medicaid data warehouse and the MCEs' systems.

Exhibit VI.4
PMP Match Rate Between State's Data Warehouse and MCE's Systems

	HHW	HIP
Anthem	79%	Unknown
MHS	97%	97%
MDwise	99%	95%

Methodology Related to Health Risk Assessment Screening

The MCE Policies and Procedures Manual requires that, "MCEs must conduct a health screening for new members that enroll in their plan. The health screening will be used to identify member's physical and/or behavioral healthcare needs, special healthcare needs, as well as the need for disease management, case management, and/or care management services" (page 5.11).

B&A requested that each MCE provide policies and procedures regarding health risk assessment (HRA) screenings to determine if the MCEs have documentation to support their contractual requirements. To determine if the MCEs are referring members to disease management, case management, and/or disease management services (DM/CM) based on the HRA results, B&A requested that each MCE provide extracts of HRA results for all members from July 1, 2013 to December 31, 2013. These results were stratified by multiple cohorts to determine if any trends could be found. Additionally, as mentioned in the Validation of Performance Measures, there were a high number of members that were classified as "unreachable" by the MCEs. These members were also stratified by multiple cohorts to determine if any trends could be found within this subpopulation.

Findings Related to Health Risk Assessment Screening

All three MCEs submitted policies and procedures regarding HRA completion that meet the contractual requirements of the OMPP. In addition to completing the HRA, each MCE has systematic algorithms to identify members that may have DM/CM needs. It appears that, while the MCEs attempt to complete the HRA, the MCEs rely heavily on their own system logic to identify members with at-risk needs, e.g. claims and authorization analyses and predictive modeling.

The MCEs expressed concern with the OMPP defined HRA tool, specifically that the HRA is more robust than necessary for an initial health assessment and some of the questions are not always age appropriate. Despite this, the MCEs then shared that the National Committee on Quality Assurance (NCQA) has recently published requirements related to Health Risk Screening. As Indiana Medicaid requires all MCEs to be NCQA accredited, the three MCEs will need to comply with the new NCQA requirements. The MCEs indicated that the current Indiana Medicaid mandated HRA will not meet all of the requirements of NCQA. The MCEs have formed a work group to develop a new standardized HRA that will meet the NCQA requirements and will be proposing recommended modification to the current HRA to Indiana Medicaid.

The QR-HS1 – *New Member Health Risk Screening Report* (as reviewed in Section III of this report) determines the number of HRAs completed within 90 days for members that are still active with the MCE at the end of 90 days and are not considered unreachable. B&A also calculated the raw HRA completion rate for members that were newly enrolled from July 1 to December 31, 2013 (in other words, inclusive of the unreachable population). These rates, while not directly related to the results from the QR-HS1, are the basis for the additional analysis conducted by B&A related to HRAs. Exhibit VI.6 below shows the HRA completion rate for new members assigned to an MCE from July 1 through December 31, 2014.

Exhibit VI.5
HRA Completion Rates

	HRA Completed	
	Yes	**No**
Anthem (n=41,003)	21%	79%
MHS (n=25,030)	23%	77%
MDwise (n=29,512)	69%	31%

For new members noted in Exhibit VI.6 that completed the HRA, B&A examined the completion rates by race, age, and region and determined there is no significant variance within each MCE among these cohorts, as outlined in Exhibit VI.7, VI.8, and VI.9 below.

Exhibit VI.6
Rate of HRA Completion
By Race

	Race			
	White	**African American**	**Hispanic**	**Other**
Anthem (n=8,608)	21%	20%	21%	20%
MHS (n=5,708)	24%	20%	21%	23%
MDwise (n=20,232)	68%	66%	74%	70%

Exhibit VI.7
Rate of HRA Completion
By Age

	Age (in years)				
	0 - 1	**2 - 12**	**13 - 21**	**22 - 40**	**41 +**
Anthem (n=8,608)	23%	21%	19%	19%	20%
MHS (n=5,708)	26%	19%	22%	24%	27%
MDwise (n=20,232)	71%	70%	67%	66%	70%

Exhibit VI.8
Rate of HRA Completion
By Region

	Region							
	North-west	North Central	North-east	West Central	Central	East Central	South-west	South-east
Anthem (n=8,608)	19%	19%	19%	19%	23%	20%	22%	19%
MHS (n=5,708)	19%	27%	22%	19%	22%	23%	21%	25%
MDwise (n=20,232)	70%	64%	70%	70%	67%	70%	59%	72%

B&A also examined the rate of referral to disease, case or care management (DM/CM) from the HRA for the same new members noted above. While each MCE does have other modes of referral to DM/CM, such as algorithms to examine claims history, the contract specifically states that the HRA should be a referral source. Additionally, HRAs could be a useful referral source prior to the MCE having claims history to run their algorithms. While MDwise had the highest completion rate of HRAs, MHS has the highest referral rate to DM/CM from the HRA. While the referral rate does not indicate if the member was ever actually enrolled in DM/CM, it does indicate that the initial screening identified factors that non-clinical staff felt clinical staff should evaluate to determine if DM/CM would be appropriate. Anthem had both the lowest completion rate and the lowest referral rate. Referral rates to DM/CM for new members from the HRA are noted in Exhibit VI.10 below.

Exhibit VI.9
New Members Referred
to DM/CM from HRA

	Referred to CM/DM	
	Yes	No
Anthem	1%	99%
MHS	26%	74%
MDwise	6%	94%

Recommendations to the MCEs and Indiana Medicaid Related to New Member Activities

Based on our review of new member policies and procedures and examination of data pertaining to new members, B&A has developed specific recommendations to each MCE and to Indiana Medicaid.

Recommendations to the MCEs

1. Anthem and MHS should consider examining the processes for attempting to obtain an HRA from members to increase the MCE's HRA completion rates.

2. Anthem and MDwise should consider examining the processes for referring members to DM/CM to increase referrals from the HRA tool.

3. Anthem should update the PMP auto-assignment logic to assign all members within 30 days, regardless of the PMP's distance. B&A would recommend Anthem keep the report that

generates for members assigned over 30 miles and continue to manually attempt to find a PMP within 30 miles after they are auto-assigned.

4. Anthem should conduct a focus study to determine their PMP match rate with the Indiana Medicaid data warehouse. If the match rate is not comparable to the other MCEs, Anthem should conduct a root cause analysis into the problem and remedy it.

Recommendations to Indiana Medicaid

1. Indiana Medicaid should work with HP to determine the root cause for the MCEs not receiving the members' Case ID on the 834 member file.

2. Indiana Medicaid is encouraged to work with the MCEs to update the OMPP required HSA so that it meets the State's needs as well as the needs of NCQA since the State requires all MCEs to be NCQA accredited.

3. Indiana Medicaid should consider assisting HP and the MCEs to coordinate a study to determine the PMP match rate between the MCEs' portals and the HP managed Web interChange portal.

SECTION VII: FOCUS STUDY ON PROVIDER SERVICES STAFF AND COMMUNICATION WITH PROVIDERS

Introduction

As part of the CY 2013 External Quality Review, Burns and Associates (B&A) conducted interviews with 59 Hoosier Healthwise Primary Medical Providers (PMPs), Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Community Mental Health Centers (CMHCs) across the State of Indiana. The interviews included anywhere from one to twelve provider staff members. Interviewees included physicians, nurses, practice managers, office managers, billing managers, client services managers, chief financial officers, chief executive officers, and other office staff.

During the CY 2013 field interviews with providers, B&A discovered that provider feedback on the Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) ranged from satisfaction to frustration. B&A analyzed the key factors related to provider satisfaction.

> Across the State, B&A found that providers' opinion of Medicaid, HHW, HIP, and individual MCEs is directly related to the quality, experience, and attentiveness of the provider representatives. Providers who have frequent contact with helpful, engaged, and responsive representatives are favorable to the programs. B&A could not identify the MCE that left the providers most satisfied because the MCE that would be highly favored in one region would be the least favored in another region. Differences cited by providers within a particular region in the State or within a provider type were consistently connected to the effectiveness of the individual provider representative that served the particular region of the State or provider type.
>
> Source: External Quality Review of Indiana's Hoosier Healthwise Program and Healthy Indiana Plan for the Review Year 2012– Page VI-15 to VI-16

As a result of these findings, the Office of Medicaid Policy and Planning (OMPP) requested that B&A review the experience requirements and training protocols for the staff at each managed care entity (MCE) who interact with providers face to face or by telephone (provider relations staff and customer service staff). These are referred to as provider-facing staff in this section of the report. B&A also reviewed employee evaluation methods and how best practices are identified and implemented throughout MCE departments.

Methodology Related to MCE Interviews and Document Review

On August 6 and 7, 2014, B&A External Quality Review (EQR) staff met with each of the MCE's Provider Relations staff as a means to inform the interviews that would be conducted with individual providers. B&A asked the MCEs questions regarding:

- Organizational structure
- Who is visiting provider offices
- Number of provider representatives
- Training
- Employee assessments and evaluations
- Performance standards for provider representatives
- Electronic access for representatives while in the provider offices
- Integration of provider services with other programs in the MCE

- First call resolution in provider call centers
- How the MCE ensures that providers get consistent answers
- Call monitoring
- Communicating changes in provider representatives to providers

In advance of the onsite meetings, B&A requested that each MCE submit the following documentation as part of this focused study:

- Training protocols/manuals
- Experience requirements/job descriptions
- Policies & procedures related to provider facing staff

B&A reviewed each document and compared them to the MCEs' contractual requirements. B&A then compared and contrasted the statements between MCEs.

Interview and Document Review Findings

Provider Relations Department

Anthem

Anthem serves its providers through several departments: Network Management, Operations, an Internal Resolution Unit (IRU), and Corporate Credentialing. The member and provider call centers are in the Operations Department. Corporate Credentialing manages the credentialing of Anthem HHW and HIP providers in addition to its commercial providers.

Network Management includes both Contracting and Provider Relations (PR). The Anthem Medicaid-specific PR department was new in August 2013. Previously, Anthem's approach was to use nurse practice consultants to go to provider offices. The addition of the PR staff allowed the nurse practice consultants to focus on clinical aspects of care rather than contracting and claims issues. This also addressed a provider concern that B&A learned of during its CY 2013 provider interviews when providers expressed that they needed more MCE time with claims experts rather than a clinical HEDIS® or Gaps in Care professional.

Anthem's PR department has seven regions. Five representatives serve the southwestern, southeastern, central, northeastern, and northwestern portions of Indiana. They are supported by two internal PR representatives. The PR staff members participate in provider in-service training sessions, conferences, Indiana Health Coverage Programs (IHCP) seminars and work with provider associations.

In addition to the PR team, other staff from Anthem visit provider offices including marketing representatives, outreach specialists, nurse practice consultants, behavioral health staff, quality/compliance staff, fraud and abuse investigators, and medical directors. Anthem also recently started having case managers visit provider offices. Each region has weekly or bi-weekly "pod" meetings to coordinate schedules, discuss issues that come up, highlight HEDIS®/Gaps in Care needs, address issues within the region, and schedule activities for the region. The provider relations representative, practice consultant, the marketing representative, and the outreach specialist attend these meetings.

In October 2013, Anthem began its Internal Resolution Unit (IRU). This group serves as the research backbone to the HHW and HIP programs by connecting Provider Services, Provider Relations, Claims and other areas of the organization. Their main focus is to research and analyze complex claim issues,

provide a response to the affected providers and then apply the "fix" to all affected providers (not just the one inquiring). When a claim processing error is identified, the IRU will do a claims sweep in both the HHW and HIP claims systems to look for the processing error and reprocess all the misprocessed claims. The organization prefers not to have field staff do the investigations. They want the research centralized within the IRU so that the answer can be dispersed to other affected providers.

MHS

At MHS, providers are serviced by two departments. The Operations Department includes Benefit Configuration, the Member Services call center, and the Provider Services call center. The Network Department includes Claims Research, Provider Data Management, Provider Relations, and Contracting. There is much interaction between the groups because they all sit next to one another in the corporate offices.

MHS has five regional PR representatives that serve the southwestern, southeastern, central, northeastern, and northwestern sections of the state. The regions are not equal in size due to driving distances and types of providers. In addition to the PR representatives, MHS sends Claims Liaisons, members of the Prior Authorization (PA) and Medical Management teams, and Quality staff into the field. MHS has a web specialist who visits providers to train provider staff to use the MHS provider portal. Managers of other MHS departments have gone with PR staff to provider visits for cross-training purposes. Cenpatico, MHS's behavioral health affiliate, has one statewide representative that visits CMHCs and inpatient psychiatric hospitals quarterly, attends provider orientations, and attends other meetings as needed.

MDwise

Due to its delivery system model, PR functions are split between the MDwise corporate office and its delivery systems. The MDwise corporate office performs provider relations duties for statewide behavioral health services. The delivery systems do all medical provider relations for both HHW and HIP. MDwise prefers that providers contact their delivery system provider representative before contacting the corporate provider representative, but providers can elevate problems to the corporate office if needed.

In addition to the field PR staff visits to provider offices, MDwise corporate has an active Network Improvement Program (NIP) team which works with delivery system quality and provider relation teams on HEDIS® and other Quality Improvement Projects. MDwise case managers visit behavioral health practices and claims department staff will visit large providers to work through problem claims face-to-face.

To unify the provider relations staff at the delivery systems with the staff at corporate, MDwise organizes various meetings. The monthly Member-Provider meetings include corporate Provider Relations, NIP, delivery system PR, delivery system quality, member services and other corporate departments. There is another monthly meeting between corporate PR and the delivery system PR departments to discuss system-wide large scale issues and initiatives. Individually, corporate PR meets with each delivery system monthly to discuss individual subjects.

<u>Provider Relations Qualifications</u>

The OMPP contract states that each MCE must have a Provider Services Manager who is dedicated full-time to the MCE's Indiana product line. This individual is responsible for the provider services helpline, provider recruitment, contracting, credentialing, dispute resolution, the provider manual, educational

materials, and developing outreach programs. The contract does not have experiential or degree requirements for this key staff member.

The contract also suggests that the MCEs have provider representatives who "develop the Contractor's network and coordinate communications between the Contractor and contracted and non-contracted providers." These employees are suggested but not mandatory. There is no mention of provider services call center staff under the suggested staff.

The MCEs have staffed the provider-facing positions required in the contract as well as additional staff not required in the contract as follows:

Exhibit VII.1
Profile of Provider-facing Staff at each MCE for HHW and HIP

Position	OMPP Requirement		Anthem Requirement	MHS Requirement	MDwise Requirement
Provider Services Manager	**Education**	Not defined	Bachelor's Degree required	Bachelor's degree required	Corporate: Bachelor's degree required, Master's degree preferred Delivery Systems: Varies - Associates to Master's degree
	Experience	Not defined	3 to 4 years	3 years	3 years
Provider Representatives (field staff)	**Education**	Not defined	Bachelor's Degree required	High School diploma required, Bachelor's degree preferred	Corporate: Bachelor's degree required Delivery Systems, Varies - High School Diploma to Bachelor's degree
	Experience	Not defined	3 years	3 years	Corporate: 3 years Delivery Systems: varies - 2 to 3 years
Customer Service Manager (call center)	**Education**	Not defined	Bachelor's Degree required	Bachelor's degree required	Bachelor's degree preferred
	Experience	Not defined	2-3 years of management experience, or 5 years customer service experience	3 years	3 years
Provider Services Representatives (call center)	**Education**	Not defined	High School diploma	Associates Degree	High School diploma required, Associates degree preferred
	Experience	Not defined	1 year	2 years	1-2 years

Provider Representative Training and Evaluation

Section 2.5.3 of the MCE contract with Indiana Medicaid requires the following for employee training:

- Appropriate education and experience to fulfill the requirements of the position
- On-going training
- Training in both HHW and HIP
- Additional training for utilization management and POWER Account staff

These training requirements apply to both the MCE and its subcontractors.

Anthem

All Anthem PR representatives are trained on both HHW and HIP. This training is a combination of self-training via a training binder, in-person training by subject matter experts, and shadowing other representatives in the field. New PR representatives have a two-week internal course followed by two weeks of shadowing. They then have two additional one-week internal courses separated by two weeks of shadowing. There is no written training test. The manager attends provider visits and presentations with new PR representatives. New PR staff cannot go in the field by themselves for at least six weeks. Staff members have a performance evaluation after 90 days and refresher training at six months.

Additionally, each representative has one-on-one meetings with the supervisor. The IRU, internal representatives, providers and associations also provide Anthem management with feedback on the new representative's knowledge base. Successful provider relations representatives are looked to for answers, given special projects and assignments, assigned leadership assignments, and are promoted.

MHS

MHS selects its PR Representatives "based on a demonstration of certain core competencies consisting of critical thinking/execution, communication/relationship development, adaptability/flexibility and technical knowledge." MHS trains the representatives on HHW and HIP policies and the IHCP manuals in addition to MHS policies and procedures. New representatives shadow experienced field representatives and spend time in other MHS departments. The goal is to give the representatives background information on all areas of the business so that they can convey that information to the provider network. The materials reviewed by provider representatives are the same ones used by the call center staff to ensure consistency of the message to providers. After the training, the MHS PR Director shadows the representative and calls the providers that they visited to gauge the quality of service provided. Training on new policies and initiatives continues at biweekly team meetings and quarterly training days to keep all team members current with State and department programs.

MDwise

Delivery systems staff members are invited to attend corporate provider relations training on both HHW and HIP. New PR representatives read training materials, attend presentations, and shadow other representatives for one month. There are no tests on this training. New employees are evaluated after 90 days and in annual performance reviews. They are evaluated based on job knowledge, presentation skills, and provider feedback.

Participation in the corporate training is not consistent among delivery systems. At minimum, the corporate HIP training is critical to the delivery system representative because corporate pays all HIP

claims, though delivery system representatives must educate the providers. Delivery system representatives are also invited to shadow departments at MDwise. It should be noted that MDwise has one statewide delivery system, but this entity does not typically send its staff to corporate training or shadow corporate departments.

Provider Representatives' Performance Standards

Anthem

Anthem has the following performance standards for its representatives:

- Each representative must average 8-10 visits per representative per week.
- A representative must meet with a new provider within one to two weeks of provider relations notification.
- Representatives must meet with hospitals monthly.
- Representatives must meet with Tier 1 providers (PMPs with panels exceeding 500 members, CMHCs, RHCs, and FQHCs) monthly.
- Representatives must meet with Tier 2 providers (PMPs with 150-500 members) quarterly or on-demand if requested by provider.
- Representatives must meet with Tier 3 providers (PMPs with fewer than 150 members) on-demand if requested by provider.
- Representatives must log all visits from the week into an online database by Monday of the next week.
- Representatives must return provider calls and e-mails within 48 hours.
- Representatives and the IRU must move issues with Tier 1 providers to the top of the priority list.

MHS

MHS has the following performance standards for its representatives:

- Representatives must meet with a minimum of 10 providers per week.
- Representatives must have a monthly face-to-face with PMPs with more than 600 members and key providers.[8]
- Representatives must have a quarterly face-to-face with key specialist groups and PMP groups with 250-600 members. They can meet more frequently at the provider's request.
- Representatives must have two face-to-face and 4 phone contacts per year for PMPs with less than 250 members.
- Representatives must complete the Provider Meeting Summary report within 48 hours. This report defines follow-up items, the responsible party, and deadlines. They then send it to the Vice President of Provider Contracting and the Network Director.
- Representatives must follow up on all issues within 14 days.
- Representatives must use the MHS Meeting Agenda form for onsite visits.

For behavioral health, MHS's subcontractor Cenpatico has one representative who has quarterly meetings with inpatient hospitals and CMHCs. The representative will also do individual onsite visits for other providers at orientation or other times when requested.

[8] A Key Provider is defined as having a medical delivery capability that supports significant MHS membership located in a geographic area essential to both the stability and continued growth of MHS.

MDwise

Corporate MDwise has the following performance standards for its representatives:

- Representatives must average five visits per representative per week.
- The representatives must complete delegation oversight responsibilities.
- 70 percent of the meetings the representatives have with the delivery systems are face-to-face.

MDwise delivery systems performance standards vary by delivery systems. When asked how the corporate office oversees the delivery system representatives, MDwise responded that the corporate office reviews the delivery systems' meeting agendas and files and attends on-sites and presentations with delivery system representatives. The results of this delegation oversight are presented to the compliance committee and trended. Additionally, the MDwise corporate office has a Network Improvement Program Team that monitors which providers the delivery system representatives are visiting.

Representatives are also required to complete other duties including maintaining network adequacy and access in the delivery systems, monitor PMP-to-member ratios, writing tasks, association relations, workshops and seminars.

Provider Services Training and Evaluation

Anthem

Anthem's provider services call center training course begins with classroom training which is evaluated via examinations. Anthem stated that HHW and HIP call center representatives are not fully cross-trained. However, all representatives can answer HHW questions and many can answer HIP questions as well. Anthem maintains separate toll-free phone numbers for HHW and HIP.

Anthem call monitoring is live. Call monitors and managers will listen to calls and even interrupt if the representatives are giving inaccurate information. Representatives giving wrong information will be pulled from the phones and retrained.

MHS

MHS staff members are trained on both HHW and HIP at the same time since the MCE stated there is little difference other than reimbursement and covered benefits. MHS requires for its new provider services call center employees to complete the new hire training class, successfully pass a Skill and Systems Demonstration test as well as a Cumulative Knowledge test (score 85 percent or better). If the employee does not pass the first test, he or she can retake it. If he or she does not pass on the retake, MHS will re-evaluate its relationship with the employee. All call center employees take a quarterly knowledge quiz. Their scores on these tests are tied to their performance bonuses.

MHS regularly audits incoming calls. The staff auditor listens to two calls per day for new hires for one month. Then the auditor listens to ten calls per month per provider service representative. He or she will listen to more if an employee has exhibited poor performance. The auditor monitors live calls. If the representative gives incorrect information, the auditor will consult with the representative before the call is completed. The results of each call are documented on the Witness Call Monitoring Calibration Tool. Representatives must score 89 percent or more. MHS compiles each employee's totals at the end of the month. A manager will meet with the representative before the 15th of the following month. If a representative does not meet the 89 percent standard two months in a row, an objective third party will

review five calls. If the representative does not score over 89 percent, the manager will develop a performance improvement plan for the employee.

In addition to the live call monitoring, the Provider Services Manager is in the process of implementing a call back program to members and providers to rate the quality of service provided. MHS hopes to implement an electronic satisfaction survey in 2015.

MDwise

MDwise's provider services call center staff are divided between corporate call center staff and delivery system call center staff. The corporate staff members are trained on both HHW and HIP. The delivery system staff members do not appear as well trained on HIP as the claims are processed by corporate and providers that are enrolled with a delivery system are often transferred to the corporate call center for their HIP questions.

New call center staff have one week of classroom training, one week of shadowing another staff member, then up to 30 days of their calls being monitored. Ad hoc call monitoring continues for all call center staff. Additionally, call center staff enter all call information into a call tracking system.

Coordination between Organizational Departments

B&A asked the MCEs how they coordinate with other departments in their organizations.

Anthem does so through its quarterly all-field staff meeting and the regional pod meetings. PR staff members are fully trained on both HHW and HIP. Anthem implemented a new process to have case managers going out to provider offices with provider representatives. Internal representatives interface with corporate credentialing to smooth that process for HHW and HIP providers.

MHS Operations and Network departments are integrated in several ways. In addition to physically sitting next to each other, they share training documentation, they have weekly meetings to discuss current issues and trends (once a month the utilization management department joins them at this meeting), and managers from other departments offer training to Operations and Network.

MDwise is removing the departmental silos by involving PR with the clinical departments on special projects and the CMHCs. To remove the silos between delivery systems and between the delivery systems and the corporate provider relations team, MDwise has a series of regular meetings:

- Monthly or bi-monthly meetings between corporate PR and each individual delivery system PR
- Monthly member provider meetings hosted by corporate PR which include all Delivery System Provider Relations teams, MDwise Customer Service, Quality, Compliance, and Claims
- Meetings between corporate Network Improvement Team Program team and individual delivery systems
- Delivery system quality meetings

Notable Provider Relations Practice Spotlight

As B&A reviewed the documentation and interviewed MCE staff, a process by the new Anthem PR department stood out as unique and may want to be adopted by the other MCEs.

Anthem's use of practice consultants has always been unique. Anthem employs licensed nurses with at least five years of managed care experience, at least two years of clinical experience, and at least two years of professional presentations to small and large audiences to provide Anthem practices with clinical support. Prior to October 2013, the practice consultants were the only ones visiting offices. When Anthem created its provider relations department, the practice consultants were freed from network development, contracting, and claims responsibilities so that they could focus on clinical aspects of patient care.

One of the first things that the new management did was to have the PR staff and the practice consultants complete a Strengths, Weakness, Opportunities, and Threats (SWOT) analysis of at least five of their key providers. The focus was FQHCs, CMHCs, and RHCs in the first round of SWOT analyses. The PR representative and the practice consultant performed an assessment of the practice and, based on those findings, worked with the provider to improve HEDIS®, medical record reviews, status as a Medical Home, and NCQA standards. For each practice analyzed, they created a provider-specific improvement plan.

The plan listed the provider's strengths, weaknesses, opportunities, and threats. They set goals with the provider for both the provider's staff and its members. The team evaluated the provider's panel capacity and HEDIS® results and documented barriers and best practices. They defined strategies and initiatives, scheduled follow-up dates and documented progress.

The practice consultants and PR representatives also assist the provider with practice optimization. This includes:

- Goal-setting
- Structuring of the work environment
- Implementing electronic medical records or electronic health records
- Updating or developing policies and procedures
- Developing a compliance plan and comprehensive practice tools
- Performing self-audits
- Executing preventive health tracking processes
- Completing the follow up for lab and diagnostic procedures
- Claim timeliness
- Cultural competency

This training can assist the practice in making improvements that go beyond its Medicaid business.

Methodology Related to Provider Phone Interviews

Determining the Sample

In May 2014, the three MCEs were asked to provide B&A with a list of every provider that the MCE provider relations staff visited face-to-face in the first quarter of CY 2014. A recent time period was selected to reduce the chance that providers may not remember the visit by the MCE staff when B&A conducted the interviews. Because many providers accept both HHW and HIP members, the provider visits were not stratified by program. The master list of provider visits was stratified, however, by the individual provider representatives that conducted the onsite visits. To remove sampling bias that may result from oversampling a particular MCE provider representative, a random sample of 50 percent of visits conducted by each MCE staff member was selected. This resulted in a total sample of 83 Anthem provider visits, 90 MHS provider visits, and 182 MDwise provider visits. An attempt was made to engage all 355 providers; however, some providers elected to not participate. The interview was completed by 200 providers: 48 Anthem providers, 51 MHS providers and 101 MDwise providers. This was approximately 57 percent of each MCE's random sample, and 28 percent of all providers visited by the MCEs in the first quarter of CY 2014.

Conducting the Telephone Interviews

One member of the B&A Review Team (Dr. Linda Gunn) conducted the telephone interviews. The interview included 14 questions where the provider could rank their MCE provider representative and/or the MCE provider helpline on a scale of one to five (one being low and five being high). Four additional questions that did not include this scoring scale were also asked. The interview guide is included in Appendix F.

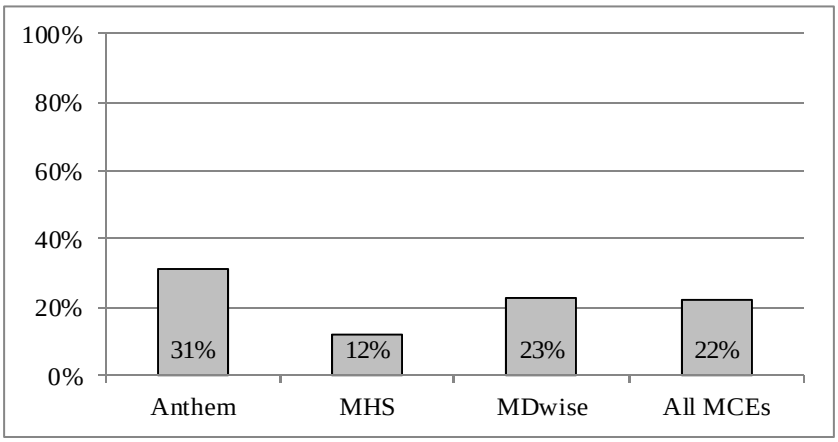
Findings Related to Provider Phone Interviews

In general, it appears providers are as satisfied or more satisfied with their MCE provider representatives than they were during interviews one year prior. Exhibit VII.2 below compares the results from the 2013 face-to-face interviews and the 2014 phone interviews. Providers feel it is easier to reach their provider representative this year while provider representative follow-up has remained steady for two of the three MCEs (Anthem and MHS) but improved for MDwise. However, a significant number of providers do not know who their provider representative is (Exhibit VII.3 on the following page), which was also noted as a concern during the CY 2013 EQR.

Exhibit VII.2
Year to Year Comparison of Provider Responses
Percent of Providers that Answered Somewhat or Very Easy

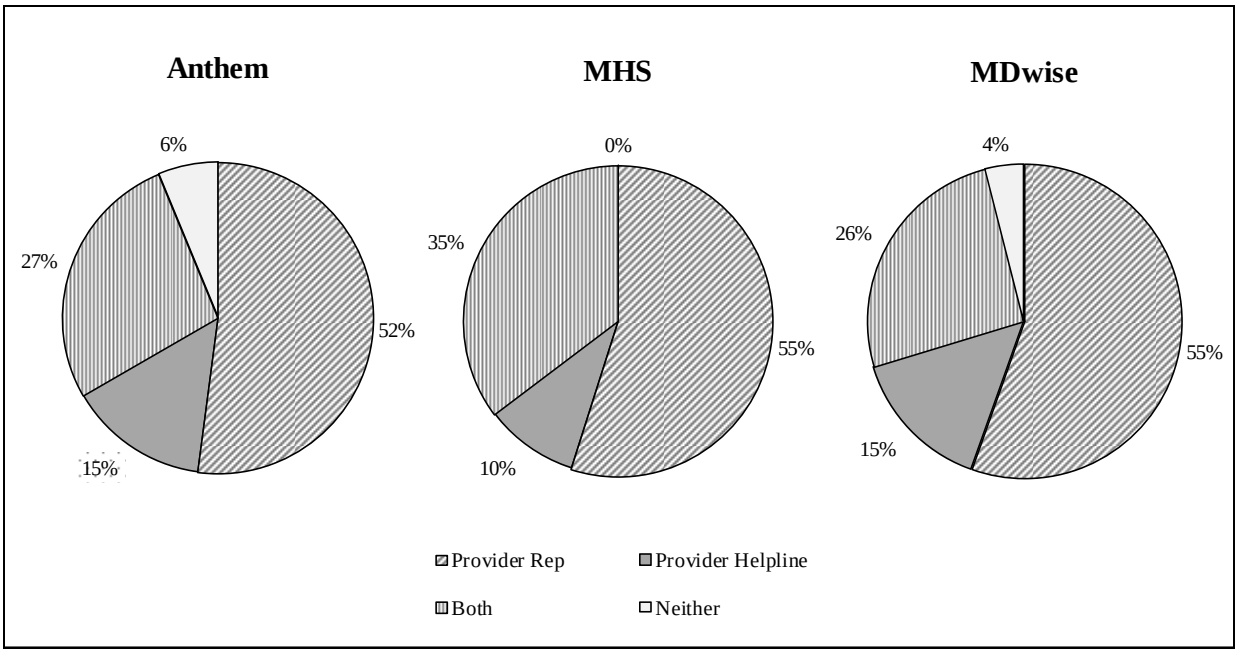
MCE	Anthem		MHS		MDwise	
Year Provider Interviewed	2013	2014	2013	2014	2013	2014
Ease of reaching your provider representative	63%	70%	81%	86%	81%	84%
Receiving appropriate follow-up from provider representative	67%	67%	81%	80%	79%	84%

Exhibit VII.3
Percent of Providers that answered "No" to interview question:
Do you know who your provider representative is?



When providers were asked to prioritize which method was most helpful to them (provider representative, the provider helpline, both or neither), more than half indicated "the provider representative" for each MCE while slightly more than one quarter indicated "both the provider representative and the provider helpline". MHS was the only MCE that did not have any providers respond "neither". Exhibit VII.4 below displays a summary of these results by MCE.

Exhibit VII. 4
Provider Response to Question: Which do you find more helpful?



When considering the responses to all questions, a pattern of general satisfaction was apparent. The average response to the 14 questions which requested providers respond on a scale of one (low) to five (high) was 4.24 points. It was also evident that satisfaction varies between the MCEs. MHS scored higher than the MCE average on 13 of the 14 questions and had an overall score of 4.40 points. MDwise scored higher than average on 9 of the 14 questions and had an overall score of 4.24 points. Anthem scored higher than average on 3 of the 14 questions and had an overall score of 4.09 points. While this

variance may appear significant at first, it should be noted that on any single question variance only ranged from 0.08 to 0.68 points between the lowest and highest scores. Providers are most satisfied with the availability of their provider reps (average score of 4.53 points). Providers are least satisfied with the helpfulness of the provider toll-free helpline (average score of 3.79 points). The results for each MCE on the 14 questions in the survey are shown in Exhibit VII.5 below. Scores that are higher than the MCE average for each question are in bold text.

Exhbit VII.5
Provider Interview Questions and Average Score per MCE

Question	Question Asked to Provider's Office	Anthem	MHS	MDwise	MCE Avg
1	How helpful are the visits from your provider representative, with 1 being not helpful and 5 being very helpful?	3.98	**4.44**	**4.37**	4.26
2	How knowledgeable is your provider representative, with 1 being not knowledgeable and 5 being very knowledgeable?	3.98	**4.62**	**4.39**	4.33
3	How easy is it to reach your provider representative, with 1 being very difficult to reach and 5 being easy to reach?	3.80	**4.37**	**4.27**	4.15
4	How well does your provider representative follow-up with you, with 1 being does not follow-up and 5 being always follow-up promptly?	4.00	**4.34**	**4.39**	4.24
5	Do you find that your provider representative is available to visit your office if you request a visit, with 1 being never available and 5 being always available?	4.33	**4.61**	**4.66**	4.53
6	How accommodating to your needs or requests is your provider representative, with 1 being not accommodating and 5 being very accommodating?	4.23	**4.61**	**4.44**	4.43
7	How often does your provider representative provide you with correct information, with 1 being never provides correct information and 5 being always provides correct information?	4.04	**4.67**	**4.57**	4.43
8	Does your provider representative keep you informed about new products, services, policies, and form, with 1 being does not keep you informed and 5 being always keeps you informed?	3.90	**4.46**	**4.35**	4.24
9	Are the materials provided to you by your provider representative useful, with 1 being materials are not useful and 5 being materials are very useful?	4.31	**4.42**	**4.40**	4.37
10	Does your provider representative assist you with referring members to specialists, with 1 being will not assist and 5 being always will assist?	4.00	**4.45**	3.77	4.08
11	Do you find that the toll-free provider helpline is helpful, with 1 being not helpful and 5 being very helpful?	**3.82**	**3.81**	3.74	3.79
12	Do you find that the toll-free provider helpline provides you with accurate information, with 1 being information is never accurate and 5 being information is always accurate?	3.92	**4.10**	3.87	3.96
13	Do you find that the toll-free provider helpline staff are polite and courteous, with 1 being never polite or courteous and 5 being always polite and courteous?	**4.47**	4.31	4.19	4.33
14	Does the toll-free provider helpline staff assist you with referring members to specialists, with 1 being will not assist and 5 being always will assist?	**4.50**	**4.36**	4.00	4.29
	Average Score	4.09	**4.40**	4.24	4.24

Topics Discussed as a Follow-up to the CY 2013 Report

Because the providers' view of the Indiana Medicaid Program is directly tied to their relationship with the MCEs, Indiana Medicaid is keenly interested in how the MCEs are responding to, and taking action on, the feedback gleaned from the face-to-face interviews conducted during the CY 2013 EQR. Although the MCEs had only a few months between learning the findings from the CY 2013 EQR and the CY 2014 EQR being conducted, B&A and Indiana Medicaid wanted to determine how quickly the MCEs were able to respond to the feedback from the CY 2013 EQR.

Access to Information

One of the concerns expressed to B&A during the 2013 provider on-site visits was that provider representatives did not have access to necessary information when they came on-site. B&A inquired of this to each of the MCEs.

- Anthem representatives have access to view claims but must route all questions and concerns to the IRU for investigation or claim modification.
- MHS representatives have access to the claims system and can make updates in the field. If the provider representative does not know the answer in the field, he or she is responsible to navigate internal departments to get the answer for the provider.
- MDwise corporate representatives have cell phones and computers with access to the claims paid by DTS (the internal MDwise corporate claims payment system), but they have no access to the claim systems from many of the delivery systems for HHW claims. Conversely, some delivery system representatives do not have access to HIP claims.
- The technological capabilities of the representatives at the MDwise delivery systems vary greatly, from remote access in the field via laptops with internet cards to no laptop use at all.

Provider Visits to a Decision-Maker versus a Non Decision-Maker

When B&A interviewed office and billing managers in CY 2013 about provider representatives scheduling visits, providers generally preferred that MCE representatives schedule a time to meet rather than just stopping by the office unannounced or dropping materials off with a receptionist.

When asked, the MCEs did not have clear policies on this topic. Anthem uses Salesforce.com to track contacts. The PR representatives log the names of the people they spoke with, the items discussed, related e-mails or documents, and follow-up activities. MHS has many standing meetings with providers. The representatives stop by other providers in the area to make the most use of time in the region. MHS stated that sometimes offices will not let its representatives see a decision-maker. They log both types of visits the same in their system. MDwise corporate representatives document each visit using a site visit report. The representative records who is seen and what they spoke about at the meeting. Its delivery system uses the site visit report, but corporate does not validate the accuracy of the report.

Credentialing and Provider Enrollment

Another finding expressed by providers in the CY 2013 EQR surrounded the amount of time it took to join an MCE.

PMPs, FQHCs and RHCs all shared that the HP provider enrollment process can take 90-180 days. HP will backdate the enrollment to the application date, but the MCEs will not backdate enrollment to the HP enrollment date to allow for retroactive payment for services.

Anthem stated that National Committee for Quality Assurance (NCQA) requirements for credentialing slow down their process after HP enrolls the provider. Anthem enrolls a provider 30 days after HP provides the provider's IHCP number. It does not back-date the provider's eligibility date back to the date HP enrolls the entity. Anthem's policy states "Contract dates are 30 days from receipt of contracts or 30 days after the credentialing date."

MHS tells providers that its credentialing process will be 45-60 days, but it usually takes around 30 days. Beginning in the middle of 2013, MHS began retroactively enrolling its providers back to the HP effective date.

MDwise's delivery systems manage credentialing for medical service providers. Intecare performs credentialing of all behavioral health providers. The providers' effective dates are when the credentialing is complete. The delivery systems report that their credentialing processes take anywhere from 21-120 days.

Managing Turnover

Office managers and billers build meaningful relationships with their representatives. Many can list the names of the last two or three representatives serving them at each MCE. Because of these relationships, they are unhappy when a trusted representative leaves an MCE or a delivery system and no notice or alternate contact name is sent to them. Nine interviewees in last year's face-to-face interviewers asked the reviewers who their representative was since they did not know. Also, during this year's telephone interview with providers, a significant percentage of providers still noted that they do not know who their provider representative is, which indicates this is an ongoing issue.

Anthem

Because the Anthem PR department only started in late CY 2013, there has not been much time to analyze turnover. They have only had one representative and one practice consultant leave their territories. Both were promoted within Anthem so that they could assist their replacement with the transition. The departures were communicated to providers by having the old representative visit providers with the new one. If this is not possible, Anthem will have an internal PR representative, a practice consultant or the manager cover the territory while the new representative is trained. Then the manager will make a face-to-face introduction of the new representative to the providers.

MHS

Similarly, MHS PR has not had a great deal of turnover. All except one MHS PR representatives has more than five years of tenure. The one individual that has been on the team for only three years worked for the provider services call center previously.

Should a representative leave, MHS will get the representative's contacts and access to their e-mail accounts and voice mail. The PR Director will notify the representative's providers that he or she is leaving. The Director will then send the providers a letter introducing the new representative. The Director will also visit all of the new representative's providers with him or her as a point of introduction.

MDwise

The MDwise turnover picture differs between the corporate office and the delivery systems. Since 2007, the corporate office has had only two representatives leave. One MDwise representative was promoted

and another left in 2008. When this happens, another representative immediately covers those providers since they have no assigned geographic territories.

Delivery systems have a higher turnover rate. When B&A mentioned that several Hoosier Alliance[9] providers had expressed concerns about the lack of notification that their representative was gone, MDwise's corporate office could not provide an explanation for why this happened. When asked about its vacancy coverage, Hoosier Alliance representatives stated that they have no standing policy. They stated that interim account executives are assigned. Once new account executives are assigned, they are required to introduce themselves to PMP groups within 90 days. Other delivery systems send e-mail messages or letters, announce it in their newsletters or on their website, or make phone calls. Only one of the delivery systems stated that it sends its Provider Relation Manager and/or an employee familiar with the office to accompany the new person to the physician office.

Disease Management/Case Management (DM/CM)

Findings from last year's field interviews were that few providers had any knowledge about the MCE DM/CM program (27 percent out of 59 interviewed). Of the providers that did know about the program, most only knew about it because they had received a letter about a particular patient. Even those providers that had any knowledge of the program typically did not know what the program was about, what they are to do to collaborate with the DM/CM team, or how to refer members to the programs. Only five providers indicated they knew of the ability to refer members to the DM/CM program.

When B&A shared this information with the MCEs, all of them were surprised that providers did not know more about the MCEs' DM/CM program. They all stated that they would actively evaluate how they are messaging information on their DM/CM program since their current messages do not appear to be effective.

Anthem has already implemented changes since last years' review and has been building out its case management department. In addition to telephonic case management, Anthem has been assigning specific case managers to specific providers. These case managers visit their assigned providers to help build a relationship between the Case Management department and the providers' offices. The case managers have been visiting all of Anthem's contracted hospitals, FQHCs and, now, CMHCs.

CMHC Revenue and Billing Meeting

It was found through the field interviews that the MCEs use the quarterly Revenue and Billing Committee meetings (which are sponsored by the CMHCs) as the primary method to communicate with the CMHCs. While the CMHCs appreciate having this forum, they stated that the meetings limit the number of questions that can be asked and often result in MCE responses of "we will get back to you with an answer."

When discussed this year, all of the MCEs believe that this meeting could be better organized. The MCEs noted that other multi-stakeholder meetings that they attend (such as those sponsored by Indiana State Medical Association) run more smoothly. The MCEs recommend that the CMHCs send their questions to the MCEs in advance of the Revenue and Billing Committee meetings so that the MCEs can conduct appropriate research and prepare comprehensive answers which would be delivered at the meetings.

[9] Hoosier Alliance is the largest, and only statewide, delivery system in the MDwise network.

However, since neither Indiana Medicaid nor the MCEs have control over the structure of the CMHC Revenue and Billing Meeting and it is currently the primary mode of communication to behavioral health providers by MCE provider services staff, the MCEs should consider developing a strategic plan for outreach to behavioral health providers outside the Revenue and Billing Committee.

Universal Prior Authorization (PA) Form

The issue of varying requirements was mentioned in the field interviews conducted in CY 2013. Even though the State implemented a universal PA form in CY 2011, B&A learned that some MCEs are requiring extra information to process PAs for their organization.

The disconnect between the providers and the MCEs appears to surround supplemental information. B&A discussed with the MCEs the possibility of convening a workgroup to investigate this further and, if needed, make recommendations to Indiana Medicaid for updating the universal PA form so MCE-specific supplemental forms will no longer be required. Additionally, the current universal PA form is for medical services only. A universal PA form specific to behavioral health services would also alleviate provider burden.

Gaps-in-Care/HEDIS®

Almost all of the providers interviewed in face-to-face meetings in CY 2013 liked the concept of a report defining which of their patients need well-care, vaccinations, laboratory tests, screenings, and other preventative care. However, two-thirds stated that the reports provided by the MCEs are out-of-date due to the claims lag and put unnecessary administrative burdens on the provider. Providers indicated that using the reports require significant staff time to first verify the accuracy of the reports and then staff time to contact the members.

Since last year's EQR, all three MCEs have indicated their Gaps-in-Care/HEDIS® reports are now available to providers on-line and are updated monthly. This is a considerable improvement and addresses many of the complaints providers noted last year.

First Call Resolution and Consistent Answers

During the CY 2013 on-site visits, B&A asked several questions about the quality of the MCE call centers. Several themes emerged:

- Providers indicated they are often transferred numerous times at each MCE and must repeat their questions multiple times.
- Providers consistently indicated they get different answers from different customer service representatives when asking the same question.
- Providers stated that one MCE only allows the discussion of three claims per call regardless of how many claims the provider would like to discuss.

Additionally, during this year's telephone interviews with providers, the providers indicated that they are least satisfied with the helpfulness of the provider helplines (as previously highlighted in Exhibit VII.5).

Anthem

Anthem admitted that their provider services department's ability to convey consistent answers could be strengthened. Different call center staff members have different levels of research skills and different levels of experience. The employees need more training to make sure that all know the policies.

Anthem has enhanced its call documentation. For example, previously when a provider called asking if a service required PA, the representative would answer the question and not log this in the system. Due to instances where providers were calling the commercial call center, asking the question, and getting incorrect responses from representatives not trained in HHW or HIP, representatives now document all PA calls in the customer service call tracking system.

Furthermore, Anthem has increased its internal training and call monitoring. They also have utilized the IRU findings for training. When the IRU staff members identify a trend, these "hot topics" are brought forward as training topics for the rest of the team.

MHS

MHS uses a dedicated trainer for both provider relations and provider services. Quality Specialists listen to calls with an increased emphasis on calls taken by new hires. Communication between staff occurs at weekly or bi-weekly team huddles and meetings. Each staff member has a monthly one-on-one meeting with a supervisor.

MHS internal staff communication is timely and transparent. All training material and resources are housed on a common SharePoint site. Management does not allow staff members to print out training materials or resources. This rule forces them to go to the SharePoint site and cite only the most recent material or training bulletin. There is also an area of the SharePoint site where employees can post questions to managers/team members. The entire team can see the answers.

MHS has a 95 percent first call resolution rate. MHS has a policy that its representatives will answer all claims questions on one call. After last year's EQR, they realized that staff members were not following this internal policy. The management team has recently reinforced the policy. This change has increased the call time but makes for happier providers. For calls that Provider Services cannot answer, they will work with PR to set up a visit or a call.

MDwise

MDwise representatives are trained to base answers on written documentation rather than providing incorrect information. The MDwise provider services department has a knowledge base from which they can find answers. They also have access to the DTS (internal) claims system which is used to adjudicate HIP claims and claims for some, but not all, of the delivery systems. For those delivery systems that do not use the corporate office's claims processing system, the MDwise corporate office must transfer callers to these delivery systems to answer HHW claim questions. MDwise could not quantify the volume of transfers like this.

Call center representatives log questions and responses into the customer service system. The system tracks all calls so a customer service representative will notice if a provider is answer shopping. They can then elevate the provider to the compliance department.

MDwise was the MCE that implemented the three-claims-per-call maximum. In response to this, MDwise stated that the 'three claims per call limit' was so they could answer provider calls efficiently

and effectively. In MDwise's view, calling in about claims questions should be the last resort after utilizing online resources or fax inquiries.

Recommendations to the MCEs and Indiana Medicaid Related to Provider Services Staff and Communication with Providers

Based on our review of policies and procedures and examination of data pertaining to provider services staff and communication with providers, B&A has developed specific recommendations to each MCE and to Indiana Medicaid.

Recommendations to the MCEs

1. The MCEs should convene a work group to investigate the barriers to using the universal PA form and potentially recommend an update to Indiana Medicaid.

2. The MCEs should convene a work group to investigate developing a universal Behavioral Health PA form.

3. The MCEs should evaluate the effectiveness of messaging to providers on DM/CM programs.

4. The MCEs should develop a strategic plan for outreach to CMHC/Behavioral Health providers that includes regularly scheduled onsite visits by MCE field staff.

5. The MCEs should not rely on the CMHC Revenue and Billing Committee meeting as the primary mode of communication with behavioral health providers.

6. Anthem and MDwise should evaluate ways to decrease time needed for the provider enrollment and credentialing processes. Consider retroactively enrolling back to the HP effective date.

7. Anthem should cross-train all customer service staff on both Hoosier Healthwise and HIP.

8. MDwise should ensure that all delivery systems have the same standards for employee qualifications, training, employee transition, and hiring.

9. MDwise should require delivery systems to send representatives to MDwise to learn corporate processes or have written documentation that all delivery system standards are up to par based on corporate requirements.

10. MDwise should ensure representatives from all delivery systems that do not utilize the corporate claims processing system (where HIP claims are processed) have the training and technology to answer HIP claims questions.

11. MDwise should consider an alternative to requiring its corporate Customer Service department to transfer calls to other delivery systems since the corporate staff does not have access to every claims processing system used in the MDwise network.

12. MDwise should mandate, or at least strongly encourage, the use of current technologies for its delivery system representatives so that the onsite provider experience can be enhanced (e.g. laptops with internet access).

Recommendations to Indiana Medicaid

1. Indiana Medicaid may want to set performance standards and contract expectations for Provider Representatives including:
    - Experience and education
    - The number of visits per year per provider type (including behavioral health providers)
    - What constitutes a visit (not simply dropping off materials)

2. Indiana Medicaid may want to set performance standards and contract expectations for Provider Enrollment and Credentialing.

3. Indiana Medicaid may want to set performance standards and contract expectations for the Provider Helpline staff including:
    - First call resolution
    - Transfer rates to another department within the MCE

SECTION VIII: FOCUS STUDY ON THIRD PARTY LIABILITY

Introduction

Members that have Hoosier Healthwise (HHW) coverage could have other insurance that will pay for their healthcare claims, which is known as Third Party Liability (TPL). Medicaid is designed to be the payer of last resort for healthcare claims and the TPL carrier is typically considered primary; however, there are times when a Medicaid member may have TPL coverage and Medicaid would still pay for covered benefits. For example, if a member does not have pregnancy coverage through her primary insurance but has HHW pregnancy coverage, Medicaid would cover the member's pregnancy related healthcare claims. Indiana Medicaid has defined expectations in its contract with the managed care entities (MCEs) of how TPL should be handled. This is also enumerated in the Hoosier Healthwise and Healthy Indiana Plan MCE Policies and Procedures Manual.

During the CY 2013 External Quality Review, providers frequently cited TPL as one of their challenges. Two items in particular were cited. First, many providers have had problems with claims denying for TPL when the patient no longer has outside coverage. The problem is exacerbated by the provider's ability to meet the requirement for timely filing of claims to the MCE. The time it takes to resolve these issues frequently exceeds the 90-day filing limit. Second, providers stated that the MCEs have advised them that their own (the MCE's) portal should be the main source of eligibility information. Providers indicated that the MCEs have refused to use printouts from Web interChange (the State's official portal for eligibility information) as proof of eligibility on appeal. Providers often must use both systems in order to get up-to-date TPL information.

Due to the concerns expressed in face-to-face interviews with providers, the OMPP requested that Burns & Associates (B&A) evaluate this subject in this year's External Quality Review. B&A examined the following questions to ensure the MCEs are following the expectations defined by Indiana Medicaid related to TPL:

- Who manages each MCE's TPL process?
- How does TPL affect the MCE's filing limit?
- What documentation does each MCE require from providers?
- What are the processes MCEs take for coordinating care?
- How do the MCEs manage TPL for newborns?
- What are the MCE practices for evaluating the primary insurance denials?
- How do the MCEs coordinate benefits with Medicare?
- What does each MCE do when the information that is in their files does not match in the state's portal?
- How long does it take the MCEs to update their TPL records?

Methodology for Reviewing Third Party Liability

As part of this focus study, B&A requested that each MCE provide B&A with all policies and procedures related to TPL. B&A reviewed each document and compared them to the MCEs' contractual requirements. B&A then compared and contrasted the statements between MCEs. In general, the MCEs documented policies and procedures aligned with the contractual expectations of Indiana Medicaid.

B&A EQR staff then met with claims and operations staff at each MCE to discuss TPL policies and procedures. In so doing, B&A wanted to confirm that each MCE was following their policies and procedure as written. Findings from these discussions are outlined in the next section.

Another aspect of the review was to determine if the MCEs and the State's data warehouse have consistent TPL carrier information documented. B&A requested that each MCE provide a data extract of all active members and include their TPL carrier information when applicable. B&A also obtained a data extract from the State's data warehouse for all members which included their TPL carrier information. A SAS program was developed that compared the TPL information documented in the State's data warehouse to the TPL information documented by the MCEs.

B&A also reviewed claim denial reasons to determine how frequently claims are being denied for TPL. B&A obtained a list of denial reason codes and denied claims from each MCE. Because there could be multiple TPL denial reasons and these reasons varied by MCE, B&A rolled all TPL denials into a "TPL Combined Reason" category to compare TPL denials across MCEs.

It should be noted that the HIP was excluded from the data analytics review of this study because a condition of eligibility for HIP is that a member does not have access to other insurance. Therefore, if TPL is discovered for a HIP member, the member is disenrolled from the program.

Interview and Document Review Findings

In all three MCEs, day-to-day TPL management occurs in the claims departments. The MCEs and Indiana Medicaid have contracts with HMS[10] for coordination of benefits and assistance with third party insurance coverage verification and validation. Each month, HMS provides each MCE and Indiana Medicaid with a file of other insurance that is known for Indiana Medicaid members.

MCE Documentation Requirements of Providers for TPL Claims

Anthem

Anthem requires that providers attach documentation of a third party denial with every claim when the member has other insurance. Providers can submit a third party Remittance Advice (RA) or a letter from the third party carrier explaining either the denial of coverage or reimbursement. When the other insurance does not have a benefit that is covered by Medicaid (e.g., pregnancy coverage), Anthem still requires that the provider submit a claim to the primary insurer for every claim and obtain a denial for non-covered service. The B&A interviewers informed Anthem that the other MCEs were more lenient and would accept a front end "non-covered benefit denial" and apply that denial to all subsequent related claims without a denial from the other insurance for every subsequent claim submitted. Anthem officials stated, "This is certainly something that Anthem will research and incorporate into our practices when possible."

MHS

MHS has a less stringent proof requirement than Anthem. MHS providers can document services never covered by primary insurance via a letter or by attaching a denied Explanation of Benefits (EOB). This is the same process as when the primary insurance does not respond within 90 days of the date of service.

[10] HMS is a healthcare analytics company that assists health insurance payers ensure healthcare claims are paid correctly and by the responsible party.

For services that primary insurers require to be bundled (e.g., prenatal services), but Medicaid allows unbundled billing, MHS allows the provider to attach one denial for the global code to justify all of the unbundled services. Unique to MHS is that instead of denying a claim for TPL, MHS will suspend the claim. The claims department will then manually work the claim to determine if the TPL is valid or not. MHS stated that coordination of care when a member has TPL is their top priority. In fact, MHS provided an example of when a member obtained TPL coverage during an inpatient stay and MHS called the other carrier to coordinate the care for the member so that the TPL carrier was able to seamlessly manage post-discharge care.

MDwise

MDwise policies and procedures clearly specify its documentation requirements. If a service that is repeatedly furnished to a member is not covered as a benefit by the third party carrier, a provider can submit photocopies of the original insurer's denial for up to one year from the date of the original denial. The provider must write "Blanket Denial" on the documentation submitted. MDwise clarified that this is for validated non-covered services (e.g., vision, pregnancy). For covered services, they require a denial for that date of service be submitted every time. For services that primary insurers require to be bundled, but Medicaid allows unbundled billing, the claims will deny for timely filing and then the provider can appeal or work with their provider representative to resolve the issue. For all but one of MDwise's delivery systems, providers can call in advance or make an inquiry and explain the situation. For MDwise's largest delivery system, however, the inquiry process is not permitted and providers are forced to bill to receive timely filing denial and then appeal.

MDwise TPL functions are performed in three claims payment departments. All of the delivery systems have similar policies and procedures, but MDwise has not analyzed delivery system TPL denials nor have they tracked or trended the amount of TPL per delivery system. MDwise has tested and audited the in-house corporate office system that was built in 2012. The MDwise corporate office performs the out-of-network disputes for all delivery systems. MDwise also stated TPL has not been one of their top five denial reasons unless the filing limit issues associated with it are counted. This comment, however, was not found in B&A's examination of the data which showed that for MDwise when all TPL reasons are combined into a general TPL denial reason, TPL is the fifth highest denial reason.

<u>Filing Limits and TPL</u>

When a provider receives an EOB from a TPL carrier which would require Medicaid cover some or part of the service, each MCE has unique criteria for how the provider should submit the claim to the MCE. Two of the MCEs (Anthem and MDwise) follow the same 90-day for in-network and 365-day out-of-network requirements in submitting a standard claim. MHS allows both in-network and out-of-network providers 365 days for TPL claims. Anthem and MHS start the claim submission timeline on the date the provider receives the TPL EOB, while MDwise uses the date the service was rendered. The differences are highlighted in Exhibit VIII.1 on the following page.

Exhibit VIII.1
TPL Filing Limits per MCE

MCE	In-Network	Out-of-Network
Anthem	90 days from TPL carrier EOB	365 days from TPL carrier EOB
MHS	365 days from TPL carrier EOB	365 days from TPL carrier EOB
MDwise	90 days from date of service	365 days from date of service

These variations can impact claims for services that primary insurers require to be bundled, but for which Medicaid allows unbundled billing (like prenatal care/delivery). Anthem must receive the claims within 90 days from the date on the other insurer's EOB. Anthem will then cover the services to the beginning of the episode that the primary insurance would have bundled. MHS allows 365 days from the other insurer's EOB; therefore, timely filing is typically not an issue. MDwise will deny claims submitted after 90 days from the date of service and require the provider to appeal.

Coordination of Care

Section 9.7.1 of the State's MCE contract, page 10-15 of the MCE Policies and Procedures Manual, and 42 CFR 438.208(b) all state that the MCEs must share information with other payers and coordinate care.

To determine how the MCEs meet this requirement, B&A asked each MCE what they do when the member has TPL coverage and the member wants to go to a provider that is in the TPL carrier's network but not the MCE's network.

Anthem

Anthem advised B&A it will pass prior authorizations on to the next MCE or the TPL carrier. They also work to help their members find a doctor that is in both the Anthem network and the TPL carrier's network. Anthem stated they will do single-case agreements with out-of-network providers if necessary.

MHS

MHS advised B&A it follows the 60-day coordination of care requirements when a member transfers to or from another MCE. MHS stated that it has never had a case where it has not been able to work with another insurer. MHS will do a single-case agreement if the provider is willing to enroll in the Indiana Health Coverage Program (IHCP). MHS has a detailed coordination of benefits (COB) policy. When an MHS member with TPL is hospitalized, MHS will call the primary carrier. MHS confirms the authorization number from the primary carrier and authorizes one to two days to cover the coinsurance. If the member becomes eligible for TPL during a hospital stay, MHS will cover the stay but begin coordination of post-discharge care with the new TPL carrier while the member is still in the hospital.

MDwise

MDwise advised B&A that it is rare that a member has a provider that accepts TPL coverage but does not accept Medicaid. They also advised they would be willing to do a single-case agreement if necessary. MDwise noted when trying to coordinate benefits for members with TPL coverage, their concern is the time it takes the State to disenroll a Package C or HIP member from the MCE when the member becomes ineligible due to TPL.

TPL and Newborn Members

Page 10-15 of the MCE Policies and Procedures Manual states, "MCEs must not deny claims for TPL for newborns less than 30 days old." None of the documentation submitted by the MCEs defined the MCEs' policy on this requirement.

Anthem

When B&A asked Anthem to explain their process, they advised they would have to research this. Upon researching its system, Anthem admitted to B&A, "Anthem identified that we are incorrectly denying for TPL newborn claims. We have paid back all claims identified in our claim sweep (24 total claims). Anthem is working to correct our configuration to properly adhere to the State contract."

MHS

MHS stated that if a newborn claim pends because there is a primary EOB attached or other COB information has been submitted on the claim, then the TPL team calls the primary insurer to determine if the parent's coverage also covers the newborn and will then take the appropriate action. If there is no indication of TPL, MHS will pay all newborn claims without review to TPL.

MDwise

MDwise stated that their system bypasses authorization and TPL edits for claims during a member's first 30 days of life.

Coordination of Benefits with Medicare

B&A also inquired about the MCEs' policies around coordination of benefits with Medicare. With the implementation of Hoosier Care Connect in 2015 (a Medicaid program that is replacing the Care Select program for aged, blind, or disabled (ABD) members) and the potential implementation of HIP 2.0 (an expansion of the HIP program to an estimated 334,000-598,334[11] members), this may become a larger issue for the State of Indiana. Even though there will not be Medicare-eligibles in any of the Indiana risk-based managed care programs, there are and will be cases where a member obtains Medicare coverage retroactively or the State takes some length of time for disenrollment from one of its programs. As an example, Anthem is currently in the middle of coordinating with Medicare for a high-cost HIP member who received retroactive Medicare coverage. At the time of this report, the State and Medicare were in negotiations about who should be the primary payer for these claims.

In the case of all three MCEs, Medicaid is always the payer of last resort. When Medicare is primary, the MCEs inform the provider that they are required to bill Medicare and the MCE recoups funds as necessary.

In the case of MDwise, the MCE identifies members who will turn 65 in the month prior to their birthday. MDwise takes cost avoidance steps by denying any claims received between the birthday and the end of the month.

[11] http://www.in.gov/fssa/hip/2445.htm

Differences in TPL Carrier Information

Because the file from HMS is sent to the MCEs monthly, it is inevitable that member TPL information may change before receiving an updated file. Therefore, B&A asked the MCEs what their practices are when their TPL records do not match the file provided by HMS.

Anthem

When a provider challenges the validity of Anthem documented TPL carrier information, the Internal Resolution Unit (IRU) researches the TPL insurance policy and will verify the information with HMS. To ensure Anthem-researched information is not overwritten by the next month's HMS file, Anthem maintains a coordination of benefits (COB) team that upon receipt of new data re-validates if conflicting TPL or new TPL information is received. The team then corrects membership information and enters comments on the source of new information. Anthem does not overwrite prior TPL, but creates a new adjudication level. For HIP members, Anthem provides a required regulatory report to the State which outlines HIP members who have been identified as having other health insurance.

MHS

When a provider challenges the validity of MHS documented TPL carrier information, MHS staff will work with the TPL carrier to determine the validity of the TPL coverage. To ensure the HMS file does not overwrite MHS-researched information, any differences between MHS's system and the HMS file are identified on a report which is then manually reviewed. The MHS-researched information is accepted as the valid TPL information. MHS then follows the State defined process of advising HMS of the variance by submitting a paper form requesting an update to the TPL file. MHS noted that the paper process is very cumbersome and would prefer an electronic solution to submit TPL differences rather than individual paper forms. For HIP members, MHS provides a required regulatory report to the State which outlines HIP members who have been identified as having other health insurance.

MDwise

When a provider challenges the validity of MDwise documented TPL carrier information, MDwise staff will validate each challenged TPL to determine if it is accurate. If the TPL is verified, MDwise will only substantiate it again in one year. If the insurance changes during the year via an update to the HMS file, MDwise will reprocess the claims. To ensure the HMS file does not overwrite MDwise-researched information, the system is designed to accept MDwise-researched information and disregard HMS information. If the MDwise and HMS information do not match and the MDwise information has not been validated, the HMS information is accepted as valid. MDwise indicated that while the delivery systems are to follow the corporate policies for TPL, they have not performed an audit of the delivery systems to ensure that these processes are being managed consistently across its delivery system.

Time to Update TPL

B&A asked the MCEs how long it took them to load the HMS data file once received on a monthly basis.

Anthem and MDwise load HMS files overnight. MHS does so within a few days of receipt. Provider-reported or member-reported differences are researched and are updated, when necessary, within 30 days by all MCEs.

Comparison of MCE and State's Data Warehouse TPL Carrier Information Findings

Providers interviewed as part of the CY 2013 EQR stated that the TPL carrier information provided by the State's web-portal, Web interChange (managed by HP), often did not match the MCEs' records. To quantify this concern noted by providers, B&A compared the documented TPL information in the State's data warehouse to the documented TPL information noted by the MCEs to identify the level of variance between them. As previously stated, the MCEs and Indiana Medicaid have contracts with HMS to assist with identifying TPL carrier information. HMS provides a monthly file update of TPL carrier information for Medicaid members to Indiana Medicaid and the MCEs.

Even though Indiana Medicaid and MCEs all share the same vendor to obtain TPL information, there was variance found between the TPL information noted in the Indiana Medicaid data warehouse and the MCEs' systems. Specifically, there were 11,316 members noted by the MCEs as having TPL that were not identified in the State's data warehouse as having TPL, which is a 26 percent variance overall. The highest level of variance was seen with Anthem at a 41 percent mismatch rate. MHS was the lowest at 9 percent. MDwise's overall mismatch rate was at the statewide average of 26 percent, as noted in Exhibit VIII.2 below.

Exhibit VIII.2
MCE to State's Data Warehouse
Members with TPL Comparison

	TPL Coverage Documented by MCEs also Found in State's Data Warehouse			
	Yes		No	
	Count	Percent	Count	Percent
Anthem	8,945	59%	6,309	41%
MHS	13,485	91%	1,389	9%
MDwise	10,122	74%	3,618	26%
Total	32,552	74%	11,316	26%

For those members documented as having TPL in both the State's and MCEs' systems, B&A attempted to verify if the same TPL carrier was listed. However, a common carrier identifier could not be located in all systems and each system had different naming conventions for the TPL carrier. Though it was not possible to discern an absolute TPL carrier match rate, it was evident that the TPL carriers noted by the MCEs and by the OMPP do not always match. In other words, even though the match rate between the State's data warehouse and the MCEs' systems for the presence of any TPL is 74 percent, the more specific match rate between the systems for the same TPL carrier would likely actually be less.

Since the MCEs and the OMPP all receive their TPL information from the same source, the root cause of this variance is unknown. It is also unknown if the State's data warehouse (HMS file feed) or the MCEs systems are correct, but the variance confirms providers' TPL concerns from the CY 2013 EQR because if a provider were to check Web interChange for TPL information, it would not always match the information provided by the MCEs. MHS stated that they actively work with HMS to update member TPL information after researching which may account for their higher match rate than the other MCEs.

In reviewing claim denials as supplied by the MCEs, it became evident that MHS denies far fewer claims than the other two MCEs, as well as far fewer claims for TPL reasons than the other two MCEs. Since MHS indicated during their interview that they suspend rather than deny TPL claims on the front end, while Anthem and MDwise deny a claim and require the provider to appeal, this result is not unexpected.

Exhibit VIII.3 below stratifies total TPL denials and compares the TPL denials as a percent of the top 20 denial codes reasons.

Exhibit VIII.3
MCE TPL Claim Denials from July 1 to Dec. 31, 2013
Compared to Top 20 Claim Denial Reasons

	Anthem	MHS	MDwise
Total Claims Denied - Top 20 Denial Reasons	266,182	38,434	85,835
Total Claims Denied for TPL	15,906	1,239	6,166
Percent of Claims Denied for TPL	6%	3%	7%

Recommendations to the MCEs and Indiana Medicaid Related to Third Party Liability

Based on our review of third party liability policies and procedures and examination of data pertaining to denials and third party liability, B&A has developed specific recommendations to each MCE and to Indiana Medicaid.

Recommendations to the MCEs

1. The MCEs should determine the root cause for the variance between the TPL information noted between the State's data warehouse, which comes from the HMS file feed, and the MCE's own systems. One suggestion would be to use one month of information as a test to see if there are differences among specific populations or if there are differences by TPL carriers.

2. If it is determined that the information in the HMS file feed is inaccurate/outdated, then the MCEs should provide the necessary information to HMS so HMS can update its systems. The MCEs should use the State defined processes to provide this information to HMS.

3. Anthem should ensure its system configurations are updated to adhere to the State's policy of not denying TPL for members' first 30-days of life.

4. Anthem should monitor denial rates and reasons to determine provider education opportunities to reduce claim denials. Having three to seven times the number of claim denials as the other MCEs is concerning to the EQRO and Indiana Medicaid.

5. Anthem and MDwise should consider suspending then working TPL identified claims on the front end instead of denying these claims and requiring providers to appeal.

6. MDwise should perform an audit of delivery system TPL procedures, processes, and denials to ensure consistency across its network.

Recommendations to Indiana Medicaid

1. Indiana Medicaid should consider applying a performance standard around researching and updating TPL both for HMS and for the MCEs. The mismatch between the two causes provider frustration and delay in payments.

2. Indiana Medicaid should work with HP/HMS to update the process of MCE submission of TPL information from the current paper process to an electronic solution.

APPENDIX A
2014 EXTERNAL QUALITY REVIEW GUIDE FOR THE HOOSIER HEALTHWISE AND HEALTHY INDIANA PLAN

2014 EXTERNAL QUALITY REVIEW GUIDE FOR THE HOOSIER HEALTHWISE AND HEALTHY INDIANA PLAN PROGRAMS
(Review of CY 2013 Operations)

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

Overview

Burns & Associates, Inc. (B&A) was hired by Indiana's Office of Medicaid Policy and Planning (OMPP) to conduct an External Quality Review (EQR) for both Hoosier Healthwise (HHW) and the Healthy Indiana Plan (HIP). This review will encompass activities in Calendar Year (CY) 2013 and information from early CY 2014.

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

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

There are many optional activities that EQROs may also complete under authority of 42 CFR 438.358. A comprehensive review of Activity #1 was completed in CY 2012. Therefore, B&A met with the OMPP to determine the topics selected for this year's EQR which include the following:

- Validation of Performance Measures related to Provider Services Helpline, PMP Assignment, and New Member Health Screening.
- Validation of MCE Performance Improvement Projects (still to be determined)
- Optional EQR Activity: Conduct a Focus Study on Transportation Services
- Optional EQR Activity: Examination of New Member Activities
- Optional EQR Activity: Examination of Training of Provider Services Staff and MCE Communication with Providers
- Optional EQR Activity: Conduct a Focus Study on Claim Denials

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

Timeline

The OMPP is requesting that B&A deliver the draft report for this EQR by September 30. The final report is due October 31. The schedule effectively begins with the release of this EQR Guide. The first items that are being requested from the MCEs are due May 26. Onsite meetings are scheduled during the weeks of June 23, July 14 and August 4, 2014. All data collection activities and MCE responsibilities are scheduled to be concluded by August 8. A full schedule may be found in Section C of this Guide.

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

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

The B&A Review Team

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

- Mark Podrazik, Project Director, B&A: Mark has previously conducted eight EQRs of the HHW program, five EQRs of the HIP and an external review of the Care Select program. He will oversee the entire project and final report.

- Brian Kehoe, Project Manager, B&A: Brian assisted on the 2013 EQR of the HHW and HIP programs. He has previous experience with multiple states' Medicaid and Managed Care Programs. He will participate in all administrative review sessions and manage the entire project and final report.

- Dr. CJ Hindman, MD, Kachina Medical Consultants: Dr. Hindman is an independent contractor who served as the Clinical Team Lead of the EQRs conducted in 2009-2013 for HHW and HIP and the Care Select review conducted in 2009. He was previously the Medical Director for Arizona's Medicaid program and also served as Medical Director of a Medicaid managed care program. He will lead the clinical portion of validation of MCE Performance Improvement Projects.

- James Maedke, SAS Programmer, B&A: James will be the lead on all encounters-related analyses for the focus study related to Transportation, Claim Denials, and New Member Activities.

- Rachel Chappell, Consultant, B&A: Rachel is new to the B&A team, but brings with her over 15 years of Medicaid experience, most recently providing oversight to multiples states' Medicaid programs with CMS. Rachel will assist with policy analysis and research.

- Barry Smith, Consultant, B&A: Barry has over 10 years of experience with financial analysis and data mining. Barry will assist with policy analysis.

- Derik Leavitt, Consultant, B&A: Derik joined the B&A team in 2011 with over 10 years of experience in budget and financial analysis. Derik will assist with database development and claims analysis.

- Dr. Linda Gunn, PhD, Subcontractor: Linda has assisted B&A on five previous HHW EQRs, four HIP EQRs and the Care Select review. She will participate in the examination of provider-facing staff and communication with providers.

- Kristy Lawrance, Subcontractor: Kristy assisted on the 2013 EQR of the HHW and HIP programs and has previous experience working for the OMPP on various projects as well as for Advantage under its contract with the OMPP for Care Select. She will participate in the validation of performance improvement projects as well as examination of provider-facing staff and analysis of claim denials.

B. Details on Topics in this Year's EQR

Topic #1— Validation of Performance Measures

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

The measures that are being validated include:

- QR-P1: Provider Helpline Performance
- QR PMP1: PMP Assignment Report
- QR-HS1: New Member Health Screening Report
- QR-CMPH1/CMBH1 – Complex Case Management Reports
- QR-CRPH1/CRBH1 – Care Management Reports
- QR-DMPH1/DMBH1 – Disease Management Reports

The measures will be computed for the HHW and HIP populations.

When applicable, B&A is using the encounters reported to the OMPP and stored in the OMPP data warehouse, FSSA Enterprise Data Warehouse, as of May 1, 2014 as the source data for this analysis. When source data is not stored in the OMPP data warehouse, B&A will request the source data from the MCEs. It is B&A's intention to share our results with each MCE individually and compare to what the MCE submitted. If large differences are found, we will work with the MCE to determine the root cause of the differences.

The QR-CMPH1/CMBH1, QR-CRPH1/CRBH1, QR-DMPH1/DMBH1, and HS1 report will be reviewed at a joint meeting with all three MCEs and B&A on June 25 at OMPP to discuss variation in definitions. The discussion of preliminary findings is scheduled in one-on-one onsite meetings with each MCE during the week of June 23. The QR-P1, QR-PMP1, and QR-HS1 measures will be discussed more in depth with each MCE individually during onsite meetings the week of July 16.

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

Topic #2— Validation of Performance Improvement Projects

The purpose for this review is to fulfill our requirement to validate the results of selected performance improvement projects (PIPs). B&A has received each MCE's initial Quality Management and Improvement Work Plan for CY 2013 (Report QR-Q3) from the OMPP as well as the Program Evaluations for CY 2013 directly from the MCEs. B&A will utilize CMS EQR Protocol 3, Attachment A (updated September 2012) as the basis for reporting our validation of three PIPs at each MCE. This will be accompanied by a brief write-up in the EQR report.

Because each MCE has selected PIPs unique to their delivery system, the validation of PIPs may be common across MCEs or may be MCE-specific. B&A is in the process of reviewing the initial work plans and the program evaluation documents to make the selection of the three PIPs for each MCE. It is our intention to notify each MCE of the PIPs that we have selected for their MCE by May 26. We will then request any ancillary documents or data analytics that may be relevant to our PIP validation process that was not included in the Program Evaluation document. These ancillary documents will be due to B&A by June 9. During the week of June 23, Mark Podrazik, Brian Kehoe and Kristy Lawrance will conduct onsite meetings with each MCE to go over the PIPs under review. This will include follow-up questions from our desk review as well as a discussion with the relevant staff that had primary responsibility for the interventions that were put in place for the PIPs that were selected. It is expected that the B&A Review Team will spend a half-day with each MCE (about one hour to discuss each PIP). If additional information is required, the MCEs will have the opportunity to provide this information to B&A by August 8. Additional meetings or conference calls may be scheduled in August if necessary.

Topic #3— Optional EQR Activity: Conduct a Focus Study on Transportation Services

This focus study will examine:

- Utilization trends and provider availability for transportation services
- MCE policies and procedures for transportation services
- MCE delegation oversight of transportation vendors

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

- A quantitative claims-based utilization analysis;
- A desk review of MCE policies and procedures; and
- A qualitative component that will include interviews with transportation brokers and the MCEs

<u>Steps of Review</u>

1. B&A will use the encounters reported to the OMPP for the experience period CY 2013 and stored in the OMPP data warehouse, FSSA Enterprise Data Warehouse, as of May 1, 2014 as the source data for this analysis to stratify utilization of transportation services by MCE for the HHW and HIP populations separately. Some of the ways that the data is intended to be stratified will be:
    a. By age
    b. By race/ethnicity
    c. By region (county or zip code)
    d. By number of trips
    e. By number of miles
    f. By combinations of a – e

2. B&A will ask each MCE for a file of their contracted transportation providers including provider name, provider number, provider address (city, state, zip), and provider type. This is due to B&A by May 26, 2014. Provider network data will be compared to analysis conducted in #1 above to determine demand versus availability trends.

3. B&A will ask each MCE for a file of their fee schedule for transportation services including HCPCS code, HCPCS code description, reimbursement amount, and any service limitations. This is due to B&A by May 26, 2014.

4. B&A will ask each MCE for a copy of their policies and procedures related to transportation services (including, but not limited to, scheduling a trip, no shows, interpretation services, and specialty population (i.e. neonatal) considerations). This is due to B&A by May 26, 2014.

5. B&A will ask each MCE for a copy of their delegation agreement with their transportation broker. This is due to B&A by May 26, 2014.

6. B&A will ask each MCE for a copy of any delegation oversight review/audit results of their transportation brokers. This is due to B&A by May 26, 2014.

7. B&A will be requesting the MCEs to schedule a meeting with their transportation broker during the B&A July onsite visits to answer any questions that develop from #1 – 6 above.

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

On an as needed basis, B&A will consult with each MCE about our findings for these measures. We would discuss findings with an MCE if we found that the results for an MCE differed greatly from the other MCEs. Most likely, these discussions would occur during our onsite meetings the week of July 14 when we are also discussing findings from our analysis in Topic #1. We will give each MCE notice of items we intend to cover in Topic #3 during this onsite meeting so that the appropriate staff can be available to answer questions.

Topic #4— Optional EQR Activity: Examination of New Member Activities

There are two primary focuses of this topic: PMP Assignment and Health Risk Screening/Assessment.

PMP Assignment

B&A will be reviewing each MCE's policies/procedures for member PMP assignment compared to contractual requirements outlined in both the MCE's contract with OMPP and the OMPP's Managed Care Policies and Procedures Manual. B&A will also be requesting each MCE to provide a copy of the new member welcome packets to B&A. Interviews will be conducted with the MCE staff (or vendor staff if applicable) regarding new member activities.

To verify compliance with contractual requirements, B&A will use the member files reported to the OMPP for the experience period CY 2013 and stored in the OMPP data warehouse, FSSA Enterprise Data Warehouse, as of May 1, 2014 as the source data for a quantitative analysis. In order to conduct further analysis of contractual requirements, B&A will be requesting each MCE to provide data that is not

housed in the OMPP data warehouse; for example, the number of attempts to reach a member, the type of attempts to reach a member, and if a member chose their PMP or was auto-assigned.

Health Risk Screening/Assessment (HRS/HRA)

B&A will be reviewing each MCE's policies/procedures for completion of the HRS. This includes strategies to have a member complete an HRS, how HRS data is used within the MCE, and how HRS data is stratified to determine members at risk.

In addition, B&A will be conducting a quantitative review of HRS completion rates and each MCE's definitions related to the completion of HRS. If differences in definitions are determined, B&A will standardize results by a common definition when possible to conduct analyses. Analyses will be completed to identify any differences in the rates reported in the following categories:

- Between MCEs on a statewide basis;
- Between race/ethnicities on a statewide basis;
- Between ages on a statewide basis;
- Between regions on a statewide basis;
- Between race/ethnicities within an MCE;
- Between ages within an MCE; and
- Between regions within an MCE.

B&A will report its preliminary findings to each MCE during the onsite meetings to be held the week of August 4. If follow-up discussion or analytics are required, these will be conducted during the month of August.

Topic #5— Optional EQR Activity: Examination of Provider Services Staff and Communication with Providers

As a continuation to the discussion which began last year related to our field interviews with providers, B&A will be reviewing experience requirements and training protocols for each MCE's provider-facing staff (provider relations field staff and customer service staff). This qualitative review will be conducted by B&A interviewing MCE staff and reviewing policies, procedures, and job descriptions related to provider-facing staff. B&A will also request the supervisors/managers of the provider-facing staff to detail how staff members are evaluated and how best practices are identified and implemented throughout their departments.

B&A will be requesting each MCE to provide a list of the providers visited in Q1 2014 by staff member that conducted the visit, delineated by the topics discussed and with whom at the provider's office these topics were discussed. B&A will then be conducting telephone interviews with those provider office staff to determine their impressions of the MCE's visit.

A quantitative analysis will be conducted on call center phone statistics comparing the results to contractual requirements. B&A will request each MCE provide call center data for this analysis to be conducted.

B&A will report its preliminary findings to each MCE during the onsite meetings to be held the week of August 4. If follow-up discussion or analytics are required, these will be conducted during the month of August.

Topic #6— Optional EQR Activity: Conduct a Focus Study on Claim Denials

This focus study will examine:

- Denial trends by denial reason
- MCE policies and procedures for Third Party Liability (TPL) and timely filing
- Syncing of HP and MCE TPL information

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

- A quantitative analysis of denied claims;
- A desk review of MCE policies and procedures
- Comparison of HP and MCE TPL information

Steps of Review

1. B&A will request each MCE to provide claims data for claims with a final disposition of denied. The data request elements are outlined in the extract guide that accompanies this EQR guide. The denied claims will be stratified by denial reason. This is due to B&A by June 16, 2014.

2. B&A will ask each MCE for a dictionary of their claim denial reason codes.

3. B&A will ask each MCE for a copy its policies and procedures related to TPL and timely filing. This is due to B&A by May 26, 2014.

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

On an as needed basis, B&A will consult with each MCE about our findings for these measures. We would discuss findings with an MCE if we found that the results for an MCE differed greatly from the other MCEs. Most likely, these discussions would occur during our onsite meetings the week of August 4. We will give each MCE notice if we intend to cover any of the measures in Topic #6 during this onsite meeting so that the appropriate staff can be available to answer questions.

C. Detailed Schedule and Document Request

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

Unless specifically requested below, MCE staff do not need to bring any materials to the interview sessions.

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

Date	Participants or Responsible Party	EQR Item
5-May	B&A	EQR Guide released to the MCEs.
19-May	MCEs	Deliver to B&A Request for Preferred Meeting Time Form
26-May	MCEs	Deliver to B&A Document Request items #1-8.
26-May	B&A	Confirmation of all onsite meeting times sent to the MCEs.
		Notification to the MCEs of the 3 PIPs selected for review.
9-Jun	MCEs	Deliver to B&A any ancillary materials related to the PIPs selected for validation (Document Request item #9).
16-Jun	MCEs	Deliver to B&A Document Request items #10-15.
25-Jun	MCEs, B&A	Onsite meetings with all MCEs to discuss: 1) PIP/QMIP Reporting Tools and potential revisions 2) QR-CMPH1/CMBH1/DMPH1/DMBH1/HS1 Reports
	Jun 25, 9:00 - 12:00	Location: OMPP, Conference Center Room 12
Jun 25 & 26	MCEs, B&A	Onsite interviews with each MCE to discuss: 1) Validation of PIPs (1 hour per PIP)
	Jun 25, 1:30 - 4:30	Meeting with MCE #1
	Jun 26, 9:00 - 12:00	Meeting with MCE #2
	Jun 26, 1:30 - 4:30	Meeting with MCE #3
Jul 16 & 17	MCEs, B&A	Onsite interviews with each MCE to discuss: 1) Validation of Performance Measures QR-HS-1, QR-P1, and QR-PMP1 (2 hours) 2) Validation of Transportation (with MCE and Transportation Broker) (90 minutes)
	Jul 16, 1:30 - 5:00	Meeting with MCE #1
	Jul 17, 8:30 - 12:00	Meeting with MCE #2
	Jul 17, 1:30 - 5:00	Meeting with MCE #3

Date	Participants or Responsible Party	EQR Item
Aug 6 & 7	MCEs, B&A	Onsite interviews with each MCE to discuss (45 minutes per topic): 1) Health Risk Screening Tool/Assessment Procedures 2) Validation of PMP Assignment Procedures 3) Validation of TPL Procedures 4) Training of provider-facing staff and implementation of best practices
	Aug 6, 9:00 - 12:00	Meeting with MCE #1
	Aug 6, 1:30 - 4:30	Meeting with MCE #2
	Aug 7, 9:00 - 12:00	Meeting with MCE #3
8-Aug	MCEs	Any follow-up materials requested from the MCEs from the meetings on PIPs that occurred June 25 and 26 delivered to B&A (Document Request Item 16).
	MCEs	Any follow-up materials requested from the MCEs from the meetings on Performance Measures that occurred July 16 and 17 delivered to B&A (Document Request Item 17).

Document Request

Because many documents do not include PHI, for convenience we ask that you submit most documents directly to Brian Kehoe at bkehoe@burnshealthpolicy.com. If a document must be transmitted securely due to PHI, then submit the information to Brian either:

(a) via the MCE's secure email system; or
(b) via the OMPP SharePoint site. If using OMPP's SharePoint, please upload your data under the \2014\EQR directory under your MCE name. ***Please place HHW-specific and HIP-specific information in the same location under the HHW section of SharePoint***.

Each desk review item has been numbered to assist in tracking. As we have asked in prior years, please include the desk review item number and your MCE name at the beginning of the electronic files that you are submitting. For example, list of contracted transportation providers should be titled, "Item 1 [MCE name] Transportation Provider List.xlsx". Files may be transmitted in Word, Excel, Powerpoint or PDF format with the exception of the items which B&A has given you an Excel template. In these cases, please return back in the Excel format provided.

If more than one file is required to satisfy a request item: Please number the electronic files with the item number but put a consecutive letter after each document [e.g. Item 1a.. , Item 1b.., etc.].

All documents can be uploaded into the OMPP SharePoint site. *If documents have been uploaded to SharePoint*, please email Brian Kehoe when they have been uploaded.

Also, please notify Brian Kehoe if some items are only available in hard copy format.

Item #	Item	Due to B&A	Review Period
1	A file of all contracted providers that are eligible to bill for transportation services. Use the Excel file format provided that accompanies this EQR Guide.	26-May	Active in 2013
2	A file of the MCE's fee schedule for transportation services. Use the Excel file format provided that accompanies this EQR Guide.	26-May	As of 12/31/13
3	Copy of delegation agreements/contracts with transportation brokers. Copy of all delegation oversight reviews/audits/tools conducted on transportation brokers in last three (3) years.	26-May	Current Agreement/ Most Recent Reviews
4	Copy of all policies/procedures regarding transportation services (both the MCE's and the Transportation vendor's).	26-May	Current
5	Copy of training protocols/experience requirements/policies/procedures related to provider-facing staff (field staff, customer service, provider relations, etc.).	26-May	Current
6	Copy of all policies/procedures regarding TPL and Timely Filing.	26-May	Current
7	Copy of policies/procedures related to new member PMP Assignment and to Health Risk Screening Tool.	26-May	Current
8	Copy of all materials sent to new members.	26-May	Current
9	Any ancillary materials related to the PIPs selected for validation.	9-Jun	Pending
10	File of claim denials and dictionary of denial code reasons. Use the Excel file format provided that accompanies this EQR Guide.	16-Jun	DOS 4/1/13 to 9/30/13
11	File of new member contacts. Use the Excel file format provided that accompanies this EQR Guide.	16-Jun	Contacts from 7/1/13 to 12/31/13
12	File of member PMP assignments. Use the Excel file format provided that accompanies this EQR Guide.	16-Jun	Assigned from 1/1/13 to 12/31/13
13	File of member Health Risk Screenings. Use the Excel file format provided that accompanies this EQR Guide.	16-Jun	Assigned from 7/1/13 to 12/31/13
14	File of provider call center statistics. Use the Excel file format provided that accompanies this EQR Guide.	16-Jun	Calls from 7/1/13 to 12/31/13
15	List of all providers that field staff visited from January 1 to March 31, 2014.	16-Jun	Visits from 1/1/14 to 3/31/14
16	Any follow-up materials requested related to the review of PIPs.	8-Aug	Pending
17	Any follow-up materials requested related to the review of Performance Measures.	8-Aug	Pending

APPENDIX B

VALIDATION OF PERFORMANCE MEASURE WORKSHEETS

Index of Reports

MCE Name: Anthem Hoosier Healthwise
Performance Measure: QR-P1 Provider Helpline Performance

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.	X			
Denominator	Data sources used to calculate the denominator were complete and accurate.	X			
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.	X			
Numerator	Data sources used to calculate the numerator are complete and accurate.	X			
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.	X			
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.	X			

MCE Name: Anthem Hoosier Healthwise
Performance Measure: QR-P1 Provider Helpline Performance

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. Number of Provider Calls Received	Total number of provider calls received by the MCE into the Provider Helpline ACD call queue during open hours of operations.	X			
2. Number of Provider Calls Answered	The number of provider calls answered on the Provider Helpline ACD call queue in the reporting quarter.	X			
3. Number of Provider Calls Answered Live Within 30 Seconds	The number of provider calls answered within 30 seconds by a live voice on the Provider Helpline in the reporting quarter.	X			
4. Percent of Calls Answered Live Within 30 Seconds	Number of provider calls answered live within 30 seconds divided by number of provider calls received.	X			
5. Number of Abandoned Calls	Number of calls received into the Provider Helpline during open hours of operations that were abandoned (disconnected) by the caller or the system before being answered.	X			
6. Percent of Abandoned Calls	Number of abandoned calls divided by number of provider calls received.	X			

Validation Findings
V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	V

QR-P1 - Provider Helpline Performance
Anthem: Hoosier Healthwise

Part 1		Part 2		Part 3					
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR					
	Experience Period >>	Q3 2013	Q4 2013	Verified Q3 2013			Verified Q4 2013		
Item No.	**Data Description**	**Count**	**Count**	**Count**	**Difference**	**Percent Difference**	**Count**	**Difference**	**Percent Difference**
1	Number of Provider Calls Received	24,507	24,779	24,507	0	0.0%	24,364	-415	-1.7%
2	Number of Provider Calls Answered	24,129	24,277	24,517	388	1.6%	24,333	56	0.2%
3	Number of Provider Calls Answered Live Within 30 Seconds	23,277	23,447	23,553	276	1.2%	23,233	-214	-0.9%
4	Performance Measure #1: Pct in 30 Seconds	95.0%	94.6%	96.1%	1.1%	1.2%	95.4%	0.7%	0.7%
5	Number of Abandoned Calls	219	276	221	2	0.9%	274	-2	0.7%
6	Performance Measure #2: Pct Abandoned	0.9%	1.1%	0.9%	0.0%	0.0%	1.1%	0.0%	0.0%

MCE Name: Anthem Healthy Indiana Plan
Performance Measure: QR-P1 Provider Helpline Performance

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.	X			
Denominator	Data sources used to calculate the denominator were complete and accurate.	X			
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.	X			
Numerator	Data sources used to calculate the numerator are complete and accurate.	X			
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.	X			
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.	X			

MCE Name: Anthem Healthy Indiana Plan
Performance Measure: QR-P1 Provider Helpline Performance

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. Number of Provider Calls Received	Total number of provider calls received by the MCE into the Provider Helpline ACD call queue during open hours of operations.	X			
2. Number of Provider Calls Answered	The number of provider calls answered on the Provider Helpline ACD call queue in the reporting quarter.	X			
3. Number of Provider Calls Answered Live Within 30 Seconds	The number of provider calls answered within 30 seconds by a live voice on the Provider Helpline in the reporting quarter.	X			
4. Percent of Calls Answered Live Within 30 Seconds	Number of provider calls answered live within 30 seconds divided by number of provider calls received.	X			
5. Number of Abandoned Calls	Number of calls received into the Provider Helpline during open hours of operations that were abandoned (disconnected) by the caller or the system before being answered.	X			
6. Percent of Abandoned Calls	Number of abandoned calls divided by number of provider calls received.	X			

Validation Findings
V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	V

QR-P1 - Provider Helpline Performance
Anthem: Healthy Indiana Plan

Part 1		Part 2		Part 3					
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR					
	Experience Period >>	Q3 2013	Q4 2013	Verified Q3 2013			Verified Q4 2013		
Item No.	**Data Description**	**Count**	**Count**	**Count**	**Difference**	**Percent Difference**	**Count**	**Difference**	**Percent Difference**
1	Number of Provider Calls Received	4,751	4,114	4,751	0	0.0%	4,114	0	0.0%
2	Number of Provider Calls Answered	4,746	4,099	4,746	0	0.0%	4,099	0	0.0%
3	Number of Provider Calls Answered Live Within 30 Seconds	4,671	4,031	4,671	0	0.0%	4,031	0	0.0%
4	Performance Measure #1: Pct in 30 Seconds	98.3%	98.0%	98.3%	0.0%	0.0%	98.0%	0.0%	0.0%
5	Number of Abandoned Calls	5	15	5	0	0.0%	15	0	0.0%
6	Performance Measure #2: Pct Abandoned	0.1%	0.4%	0.1%	0.0%	0.0%	0.4%	0.0%	0.0%

MCE Name: Anthem Hoosier Healthwise
Performance Measure: QR-PMP1 PMP Assignment Report

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.			X	
Denominator	Data sources used to calculate the denominator were complete and accurate.			X	
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.			X	
Numerator	Data sources used to calculate the numerator are complete and accurate.			X	
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.			X	
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.			X	Validation of the QR-PMP1 report was deemed not possible after large variances were discovered between the EQRO's calculations and the what the MCEs reported to the state. It was determined that the variance was due to different interpretations of the report specification as provided by the state to the MCEs. Ambiguous statements in the report specification were determined to the be the cause of the multiple interpretations of the report specification.

MCE Name: Anthem Hoosier Healthwise
Performance Measure: QR-PMP1 PMP Assignment Report

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. Newly Assigned Plan Members	As of the last day of the reporting period, the total number of members received on the enrollment roster during the reporting period.			X	Report validation was deemed not possible due to ambiguious report specifications.
2. Members who Self Selected a PMP	As of the last day of the reporting period, the total number of members who self selected a PMP during the reporting period.			X	Report validation was deemed not possible due to ambiguious report specifications.
3. Members Auto-Assigned with "smart" Logic	Indicate the number of members who were auto-assigned using system logic that includes the following: -Member's PMP assignment within the last 12 months -Family member's current PMP -Family member's previous PMP -PMP in previous group -PMP in family member's current group or previous group			X	Report validation was deemed not possible due to ambiguious report specifications.
4. Members Auto-Assigned with "default" Logic	The number of members who were auto-assigned using an approved default logic that does not include the described "smart" logic.			X	Report validation was deemed not possible due to ambiguious report specifications.
5. Members Assigned a PMP	As of the last day of the reporting period, the total number of members assigned a PMP during the reporting period. This number will not be an exact total of the assignment method counts. A member may have multiple types of assignments occur during the reporting period.			X	Line item validation not attempted by EQRO
6. Total Members Assigned a PMP	As of the last day of the reporting period, the total number of all members assigned a PMP regardless of when a PMP assignment was made.			X	Line item validation not attempted by EQRO
7. Total Members with Open Network status	The total number of members that have open network status either due to PMP assignment logic has not been applied, or due to lack of PMP availability within the required access targets.			X	Line item validation not attempted by EQRO

Validation Findings
V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	**NV**

QR-PMP1 - PMP Assignment Report
Anthem: Hoosier Healthwise

Part 1		Part 2		Part 3				
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR				
	Experience Period >>	Calendar Year 2013		Verified Calendar Year 2013				
Item No.	**Data Description**	**Count**	**Percent of Total**	**Count**	**Difference**	**Percent Difference**	**Percent of Total**	**Difference**
1	Newly Assigned Plan Members	36,062		65,279	29,217	81.0%		
2	Members who Self Selected a PMP	23,611	38.6%	2,747	-20,864	-88.4%	4.2%	-34.4%
3	Members Auto-Assigned with "smart" Logic	26,516	43.4%	44,745	18,229	68.7%	68.5%	25.2%
4	Members Auto-Assigned with "default" Logic	11,014	18.0%	17,787	6,773	61.5%	27.3%	9.2%
5	Members Assigned a PMP	61,141		**Section Not Validated**				
6	Total Members Assigned a PMP	246,255						
7	Total Members Assigned Open Network Status	1,309						

MCE Name: Anthem Healthy Indiana Plan
Performance Measure: QR-PMP1 PMP Assignment Report

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.			X	
Denominator	Data sources used to calculate the denominator were complete and accurate.			X	
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.			X	
Numerator	Data sources used to calculate the numerator are complete and accurate.			X	
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.			X	
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.			X	Validation of the QR-PMP1 report was deemed not possible after large variances were discovered between the EQRO's calculations and the what the MCEs reported to the state. It was determined that the variance was due to different interpretations of the report specification as provided by the state to the MCEs. Ambiguous statements in the report specification were determined to the be the cause of the multiple interpretations of the report specification.

MCE Name: Anthem Healthy Indiana Plan
Performance Measure: QR-PMP1 PMP Assignment Report

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. Newly Assigned Plan Members	As of the last day of the reporting period, the total number of members received on the enrollment roster during the reporting period.			X	Report validation was deemed not possible due to ambiguious report specifications.
2. Members who Self Selected a PMP	As of the last day of the reporting period, the total number of members who self selected a PMP during the reporting period.			X	Report validation was deemed not possible due to ambiguious report specifications.
3. Members Auto-Assigned with "smart" Logic	Indicate the number of members who were auto-assigned using system logic that includes the following: -Member's PMP assignment within the last 12 months -Family member's current PMP -Family member's previous PMP -PMP in previous group -PMP in family member's current group or previous group			X	Report validation was deemed not possible due to ambiguious report specifications.
4. Members Auto-Assigned with "default" Logic	The number of members who were auto-assigned using an approved default logic that does not include the described "smart" logic.			X	Report validation was deemed not possible due to ambiguious report specifications.
5. Members Assigned a PMP	As of the last day of the reporting period, the total number of members assigned a PMP during the reporting period. This number will not be an exact total of the assignment method counts. A member may have multiple types of assignments occur during the reporting period.			X	Line item validation not attempted by EQRO
6. Total Members Assigned a PMP	As of the last day of the reporting period, the total number of all members assigned a PMP regardless of when a PMP assignment was made.			X	Line item validation not attempted by EQRO
7. Total Members with Open Network status	The total number of members that have open network status either due to PMP assignment logic has not been applied, or due to lack of PMP availability within the required access targets.			X	Line item validation not attempted by EQRO

Validation Findings

V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	**NV**

QR-PMP1 - PMP Assignment Report
Anthem: Healthy Indiana Plan

Part 1		Part 2		Part 3				
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR				
	Experience Period >>	Calendar Year 2013		Verified Calendar Year 2013				
Item No.	**Data Description**	**Count**	**Percent of Total**	**Count**	**Difference**	**Percent Difference**	**Percent of Total**	**Difference**
1	Newly Assigned Plan Members	1,085		5,704	4,619	425.7%		
2	Members who Self Selected a PMP	574	12.9%	986	412	71.8%	17.4%	4.4%
3	Members Auto-Assigned with "smart" Logic	3,285	73.9%	1,339	-1,946	-59.2%	23.5%	-50.5%
4	Members Auto-Assigned with "default" Logic	584	13.1%	3,379	2,795	478.6%	59.2%	46.0%
5	Members Assigned a PMP	4,443		**Section Not Validated**				
6	Total Members Assigned a PMP	21,880						
7	Total Members Assigned Open Network Status	113						

MCE Name: Anthem Hoosier Healthwise
Performance Measure: QR-HS1 New Member Health Screening Report

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.	X			
Denominator	Data sources used to calculate the denominator were complete and accurate.	X			
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.	X			
Numerator	Data sources used to calculate the numerator are complete and accurate.		X		EQRO was unable to validate report item 6 (number of members screened) with data provided from MCE.
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.		X		MCE staff noted they identified a process gap in the number of times the MCE contacted members before defining them as unreachable (Item 4 of report specification).
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.		X		The process gap noted above cause items 4, 5, and 6 to be reported incorrectly to the state.

MCE Name: Anthem Hoosier Healthwise
Performance Measure: QR-HS1 New Member Health Screening Report

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. New Member Totals	The number of new members enrolled with the MCE during the reporting period that require a screening to be completed.	X			
2. Terminated Members	The number of new members enrolled with the MCE durin gthe reporting period that have since terminated within their first 90 days of enrollment.	X			Slight variation can be attributed to retro eligibility available at the time data was pulled for the EQRO that was not available at the time of reporting to the state.
3. New Members Net of Terminated	Calculation of total members identified in Item #1 minus total members identified in Item #2.			X	Field is auto-calculated by template provide by OMPP to the MCEs.
4. Unreachable Members	The number of new members enrolled with the MCE during the reporting period that are determined to be unreachable. "Unreachable" is defined as a minimum of three outreach calls using the information provided to the MCE by OMPP but for which there is no response from the member.		X		MCE staff noted they identified a process gap in the number of times the MCE contacted members before defining them as unreachable (Item 4 of report specification).
5. New Members Net of Terminated and Unreachable	Calculation of total members identified in Item #3 minus total members identified in Item #4.			X	Field is auto-calculated by template provide by state to the MCEs.
6. Total Screened	Indicate the number of new members identified in Item #1 that were screened within their first 90 days of enrollment.		X		EQRO was unable to validate figure reported to the state with data provided by the MCE. EQRO calculated 2013 Q3 11.4% less than MCE reported to the state. EQRO calculated 2013 Q4 42.4% less than MCE reported to the state.
7. Percent Screened (all except Terminated)	Calculation of the percentage of newly enrolled MCE members, net of terminated members that have had a health screening assessment completed within 90 days. Calculation is number in Item #6 divided by number in Item #3.			X	Field is auto-calculated by template provide by state to the MCEs.
8. Percent Screened (excluding Terminated and Unreachable)	Calculation of the percentage of newly enrolled MCE members, net of terminated and unreachable members that have had a health screening assessment completed within 90 days. Calculation is number in Item #6 divided by number in Item #5.			X	Field is auto-calculated by template provide by state to the MCEs.

Validation Findings
V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	NV

QR-HS1 - New Member Health Screening Report
Anthem: Hoosier Healthwise

Part 1		Part 2		Part 3					
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR					
	Experience Period >>	Q3 2013	Q4 2013	Verified Q3 2013			Verified Q4 2013		
Item No.	**Data Description**	**Count**	**Count**	**Count**	**Difference**	**Percent Difference**	**Count**	**Difference**	**Percent Difference**
1	Number of New Members Enrolled During the Reporting Period	18,659	19,609	18,659	0	0.00%	19,609	0	0.00%
2	Number of Members in Item #1 that Terminated Within their First 90 Days of Enrollment	3,410	3,726	3,259	-151	-4.43%	3,696	-30	-0.81%
3	New Members Net of Terminated	15,249	15,883	15,400	151	0.99%	15,913	30	0.19%
4	Number of Members in Item #1 that have been Classified as Unreachable	4,924	366	7,738	2,814	57.15%	7,850	7,484	2044.81%
5	New Members Net of Terminated and Unreachable	10,325	15,517	7,662	-2,663	-25.79%	8,063	-7,454	-48.04%
6	Number of Members in Item #1 that were Screened Within their First 90 Days of Enrollment	2,050	3,985	1,817	-233	-11.37%	2,294	-1,691	-42.43%
7	Performance Measure #1: Pct Screened Within 90 Days (all except Terminated)	13%	25%	12%	-2%	-12.2%	14%	-11%	-42.5%
8	Performance Measure #2: Pct Screened Within 90 Days (excluding Terminated and Unreachable)	20%	26%	24%	4%	19.4%	28%	3%	10.8%

MCE Name: Anthem Healthy Indiana Plan
Performance Measure: QR-HS1 New Member Health Screening Report

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.	X			
Denominator	Data sources used to calculate the denominator were complete and accurate.	X			
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.	X			
Numerator	Data sources used to calculate the numerator are complete and accurate.		X		EQRO was unable to validate report item 6 (number of members screened) with data provided from MCE.
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.		X		MCE staff noted they identified a process gap in the number of times the MCE contacted members before defining them as unreachable (Item 4 of report specification).
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.		X		The process gap noted above cause items 4, 5, and 6 to be reported incorrectly to the state.

MCE Name: Anthem Healthy Indiana Plan
Performance Measure: QR-HS1 New Member Health Screening Report

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. New Member Totals	The number of new members enrolled with the MCE during the reporting period that require a screening to be completed.	X			
2. Terminated Members	The number of new members enrolled with the MCE durin gthe reporting period that have since terminated within their first 90 days of enrollment.	X			Slight variation can be attributed to retro eligibility available at the time data was pulled for the EQRO that was not available at the time of reporting to the state.
3. New Members Net of Terminated	Calculation of total members identified in Item #1 minus total members identified in Item #2.			X	Field is auto-calculated by template provide by OMPP to the MCEs.
4. Unreachable Members	The number of new members enrolled with the MCE during the reporting period that are determined to be unreachable. "Unreachable" is defined as a minimum of three outreach calls using the information provided to the MCE by OMPP but for which there is no response from the member.		X		MCE staff noted they identified a process gap in the number of times the MCE contacted members before defining them as unreachable (Item 4 of report specification).
5. New Members Net of Terminated and Unreachable	Calculation of total members identified in Item #3 minus total members identified in Item #4.			X	Field is auto-calculated by template provide by state to the MCEs.
6. Total Screened	Indicate the number of new members identified in Item #1 that were screened within their first 90 days of enrollment.		X		EQRO was unable to validate figure reported to the state with data provided by the MCE. EQRO calculated 2013 Q3 36.5% less than MCE reported to the state. EQRO calculated 2013 Q4 62.7% less than MCE reported to the state.
7. Percent Screened (all except Terminated)	Calculation of the percentage of newly enrolled MCE members, net of terminated members that have had a health screening assessment completed within 90 days. Calculation is number in Item #6 divided by number in Item #3.			X	Field is auto-calculated by template provide by state to the MCEs.
8. Percent Screened (excluding Terminated and Unreachable)	Calculation of the percentage of newly enrolled MCE members, net of terminated and unreachable members that have had a health screening assessment completed within 90 days. Calculation is number in Item #6 divided by number in Item #5.			X	Field is auto-calculated by template provide by state to the MCEs.

Validation Findings

V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	NV

QR-HS1 - New Member Health Screening Report
Anthem: Healthy Indiana Plan

Part 1		Part 2		Part 3					
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR					
	Experience Period >>	Q3 2013	Q4 2013	Verified Q3 2013			Verified Q4 2013		
Item No.	**Data Description**	**Count**	**Count**	**Count**	**Difference**	**Percent Difference**	**Count**	**Difference**	**Percent Difference**
1	Number of New Members Enrolled During the Reporting Period	1,679	1,271	1,679	0	0.00%	1,271	0	0.00%
2	Number of Members in Item #1 that Terminated Within their First 90 Days of Enrollment	22	19	18	-4	-18.18%	19	0	0.00%
3	New Members Net of Terminated	1,657	1,252	1,661	4	0.24%	1,252	0	0.00%
4	Number of Members in Item #1 that have been Classified as Unreachable	1	2	619	618	61800.00%	593	591	29550.00%
5	New Members Net of Terminated and Unreachable	1,656	1,250	1,042	-614	-37.08%	659	-591	-47.28%
6	Number of Members in Item #1 that were Screened Within their First 90 Days of Enrollment	211	324	134	-77	-36.49%	121	-203	-62.65%
7	Performance Measure #1: Pct Screened Within 90 Days (all except Terminated)	13%	26%	8%	-5%	-36.6%	10%	-16%	-62.7%
8	Performance Measure #2: Pct Screened Within 90 Days (excluding Terminated and Unreachable)	13%	26%	13%	0%	0.9%	18%	-8%	-29.2%

MCE Name: MHS Hoosier Healthwise
Performance Measure: QR-P1 Provider Helpline Performance

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.	X			
Denominator	Data sources used to calculate the denominator were complete and accurate.	X			
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.	X			
Numerator	Data sources used to calculate the numerator are complete and accurate.	X			
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.	X			
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.	X			

MCE Name: MHS Hoosier Healthwise
Performance Measure: QR-P1 Provider Helpline Performance

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. Number of Provider Calls Received	Total number of provider calls received by the MCE into the Provider Helpline ACD call queue during open hours of operations.	X			
2. Number of Provider Calls Answered	The number of provider calls answered on the Provider Helpline ACD call queue in the reporting quarter.	X			
3. Number of Provider Calls Answered Live Within 30 Seconds	The number of provider calls answered within 30 seconds by a live voice on the Provider Helpline in the reporting quarter.	X			
4. Percent of Calls Answered Live Within 30 Seconds	Number of provider calls answered live within 30 seconds divided by number of provider calls received.	X			
5. Number of Abandoned Calls	Number of calls received into the Provider Helpline during open hours of operations that were abandoned (disconnected) by the caller or the system before being answered.	X			
6. Percent of Abandoned Calls	Number of abandoned calls divided by number of provider calls received.	X			

Validation Findings
V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	V

QR-P1 - Provider Helpline Performance
MHS: Hoosier Healthwise

Part 1		Part 2		Part 3					
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR					
	Experience Period >>	Q3 2013	Q4 2013	Verified Q3 2013			Verified Q4 2013		
Item No.	**Data Description**	**Count**	**Count**	**Count**	**Difference**	**Percent Difference**	**Count**	**Difference**	**Percent Difference**
1	Number of Provider Calls Received	11,690	11,031	11,689	-1	0.0%	11,003	-28	-0.3%
2	Number of Provider Calls Answered	11,658	10,999	11,657	-1	0.0%	10,971	-28	-0.3%
3	Number of Provider Calls Answered Live Within 30 Seconds	11,098	10,444	11,101	3	0.0%	10,444	0	0.0%
4	Performance Measure #1: Pct in 30 Seconds	94.9%	94.7%	94.9%	0.0%	0.0%	95.1%	0.4%	0.4%
5	Number of Abandoned Calls	32	32	32	0	0.0%	32	0	0.0%
6	Performance Measure #2: Pct Abandoned	0.3%	0.3%	0.3%	0.0%	0.0%	0.3%	0.0%	0.0%

MCE Name: MHS Healthy Indiana Plan
Performance Measure: QR-P1 Provider Helpline Performance

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.	X			
Denominator	Data sources used to calculate the denominator were complete and accurate.	X			
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.	X			
Numerator	Data sources used to calculate the numerator are complete and accurate.	X			
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.	X			
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.	X			

MCE Name: MHS Healthy Indiana Plan
Performance Measure: QR-P1 Provider Helpline Performance

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. Number of Provider Calls Received	Total number of provider calls received by the MCE into the Provider Helpline ACD call queue during open hours of operations.	X			
2. Number of Provider Calls Answered	The number of provider calls answered on the Provider Helpline ACD call queue in the reporting quarter.	X			
3. Number of Provider Calls Answered Live Within 30 Seconds	The number of provider calls answered within 30 seconds by a live voice on the Provider Helpline in the reporting quarter.	X			
4. Percent of Calls Answered Live Within 30 Seconds	Number of provider calls answered live within 30 seconds divided by number of provider calls received.	X			
5. Number of Abandoned Calls	Number of calls received into the Provider Helpline during open hours of operations that were abandoned (disconnected) by the caller or the system before being answered.	X			
6. Percent of Abandoned Calls	Number of abandoned calls divided by number of provider calls received.	X			

Validation Findings
V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	V

QR-P1 - Provider Helpline Performance
MHS: Healthy Indiana Plan

Part 1		Part 2		Part 3					
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR					
	Experience Period >>	Q3 2013	Q4 2013	Verified Q3 2013			Verified Q4 2013		
Item No.	**Data Description**	**Count**	**Count**	**Count**	**Difference**	**Percent Difference**	**Count**	**Difference**	**Percent Difference**
1	Number of Provider Calls Received	546	1,295	546	0	0.0%	1,294	-1	-0.1%
2	Number of Provider Calls Answered	545	1,293	545	0	0.0%	1,292	-1	-0.1%
3	Number of Provider Calls Answered Live Within 30 Seconds	526	1,237	526	0	0.0%	1,237	0	0.0%
4	Performance Measure #1: Pct in 30 Seconds	96.3%	95.5%	96.3%	0.0%	0.0%	95.8%	0.3%	0.0%
5	Number of Abandoned Calls	1	2	1	0	0.0%	2	0	0.0%
6	Performance Measure #2: Pct Abandoned	0.2%	0.2%	0.2%	0.0%	0.0%	0.2%	0.0%	0.0%

MCE Name: MHS Hoosier Healthwise
Performance Measure: QR-PMP1 PMP Assignment Report

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.			X	
Denominator	Data sources used to calculate the denominator were complete and accurate.			X	
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.			X	
Numerator	Data sources used to calculate the numerator are complete and accurate.			X	
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.			X	
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.			X	Validation of the QR-PMP1 report was deemed not possible after large variances were discovered between the EQRO's calculations and the what the MCEs reported to the state. It was determined that the variance was due to different interpretations of the report specification as provided by the state to the MCEs. Ambiguous statements in the report specification were determined to the be the cause of the multiple interpretations of the report specification.

MCE Name: MHS Hoosier Healthwise
Performance Measure: QR-PMP1 PMP Assignment Report

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. Newly Assigned Plan Members	As of the last day of the reporting period, the total number of members received on the enrollment roster during the reporting period.			X	Report validation was deemed not possible due to ambiguious report specifications.
2. Members who Self Selected a PMP	As of the last day of the reporting period, the total number of members who self selected a PMP during the reporting period.			X	Report validation was deemed not possible due to ambiguious report specifications.
3. Members Auto-Assigned with "smart" Logic	Indicate the number of members who were auto-assigned using system logic that includes the following: -Member's PMP assignment within the last 12 months -Family member's current PMP -Family member's previous PMP -PMP in previous group -PMP in family member's current group or previous group			X	Report validation was deemed not possible due to ambiguious report specifications.
4. Members Auto-Assigned with "default" Logic	The number of members who were auto-assigned using an approved default logic that does not include the described "smart" logic.			X	Report validation was deemed not possible due to ambiguious report specifications.
5. Members Assigned a PMP	As of the last day of the reporting period, the total number of members assigned a PMP during the reporting period. This number will not be an exact total of the assignment method counts. A member may have multiple types of assignments occur during the reporting period.			X	Line item validation not attempted by EQRO
6. Total Members Assigned a PMP	As of the last day of the reporting period, the total number of all members assigned a PMP regardless of when a PMP assignment was made.			X	Line item validation not attempted by EQRO
7. Total Members with Open Network status	The total number of members that have open network status either due to PMP assignment logic has not been applied, or due to lack of PMP availability within the required access targets.			X	Line item validation not attempted by EQRO

Validation Findings
V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	**NV**

QR-PMP1 - PMP Assignment Report
MHS: Hoosier Healthwise

Part 1		Part 2		Part 3				
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR				
	Experience Period >>	Calendar Year 2013		Verified Calendar Year 2013				
Item No.	**Data Description**	**Count**	**Percent of Total**	**Count**	**Difference**	**Percent Difference**	**Percent of Total**	**Difference**
1	Newly Assigned Plan Members	63,163		48,878	-14,285	-22.6%		
2	Members who Self Selected a PMP	11,700	18.5%	7,791	-3,909	-33.4%	15.9%	-2.6%
3	Members Auto-Assigned with "smart" Logic	27,064	42.8%	23,185	-3,879	-14.3%	47.5%	4.7%
4	Members Auto-Assigned with "default" Logic	22,325	35.3%	17,902	-4,423	-19.8%	36.6%	1.2%
5	Members Assigned a PMP	61,089		**Section Not Validated**				
6	Total Members Assigned a PMP	184,989						
7	Total Members Assigned Open Network Status	1,315						

MCE Name: MHS Healthy Indiana Plan
Performance Measure: QR-PMP1 PMP Assignment Report

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.			X	
Denominator	Data sources used to calculate the denominator were complete and accurate.			X	
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.			X	
Numerator	Data sources used to calculate the numerator are complete and accurate.			X	
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.			X	
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.			X	Validation of the QR-PMP1 report was deemed not possible after large variances were discovered between the EQRO's calculations and the what the MCEs reported to the state. It was determined that the variance was due to different interpretations of the report specification as provided by the state to the MCEs. Ambiguous statements in the report specification were determined to the be the cause of the multiple interpretations of the report specification.

MCE Name: MHS Healthy Indiana Plan
Performance Measure: QR-PMP1 PMP Assignment Report

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. Newly Assigned Plan Members	As of the last day of the reporting period, the total number of members received on the enrollment roster during the reporting period.			X	Report validation was deemed not possible due to ambiguious report specifications.
2. Members who Self Selected a PMP	As of the last day of the reporting period, the total number of members who self selected a PMP during the reporting period.			X	Report validation was deemed not possible due to ambiguious report specifications.
3. Members Auto-Assigned with "smart" Logic	Indicate the number of members who were auto-assigned using system logic that includes the following: -Member's PMP assignment within the last 12 months -Family member's current PMP -Family member's previous PMP -PMP in previous group -PMP in family member's current group or previous group			X	Report validation was deemed not possible due to ambiguious report specifications.
4. Members Auto-Assigned with "default" Logic	The number of members who were auto-assigned using an approved default logic that does not include the described "smart" logic.			X	Report validation was deemed not possible due to ambiguious report specifications.
5. Members Assigned a PMP	As of the last day of the reporting period, the total number of members assigned a PMP during the reporting period. This number will not be an exact total of the assignment method counts. A member may have multiple types of assignments occur during the reporting period.			X	Line item validation not attempted by EQRO
6. Total Members Assigned a PMP	As of the last day of the reporting period, the total number of all members assigned a PMP regardless of when a PMP assignment was made.			X	Line item validation not attempted by EQRO
7. Total Members with Open Network status	The total number of members that have open network status either due to PMP assignment logic has not been applied, or due to lack of PMP availability within the required access targets.			X	Line item validation not attempted by EQRO

Validation Findings
V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	**NV**

QR-PMP1 - PMP Assignment Report
MHS: Healthy Indiana Plan

Part 1		Part 2		Part 3				
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR				
	Experience Period >>	Calendar Year 2013		Verified Calendar Year 2013				
Item No.	**Data Description**	**Count**	**Percent of Total**	**Count**	**Difference**	**Percent Difference**	**Percent of Total**	**Difference**
1	Newly Assigned Plan Members	2,172		1,609	-563	-25.9%		
2	Members who Self Selected a PMP	657	30.2%	486	-171	-26.0%	30.2%	0.0%
3	Members Auto-Assigned with "smart" Logic	489	22.5%	183	-306	-62.6%	11.4%	-11.1%
4	Members Auto-Assigned with "default" Logic	1,024	47.1%	940	-84	-8.2%	58.4%	11.3%
5	Members Assigned a PMP	2,170		**Section Not Validated**				
6	Total Members Assigned a PMP	3,773						
7	Total Members Assigned Open Network Status	0						

MCE Name: MHS Hoosier Healthwise
Performance Measure: QR-HS1 New Member Health Screening Report

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.	X			
Denominator	Data sources used to calculate the denominator were complete and accurate.	X			
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.	X			
Numerator	Data sources used to calculate the numerator are complete and accurate.	X			
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.	X			
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.	X			

MCE Name: MHS Hoosier Healthwise
Performance Measure: QR-HS1 New Member Health Screening Report

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. New Member Totals	The number of new members enrolled with the MCE during the reporting period that require a screening to be completed.	X			
2. Terminated Members	The number of new members enrolled with the MCE durin gthe reporting period that have since terminated within their first 90 days of enrollment.	X			Slight variation can be attributed to retro eligibility available at the time data was pulled for the EQRO that was not available at the time of reporting to the state as well as NOPs that were deemed appropriate at time of orignal reporting.
3. New Members Net of Terminated	Calculation of total members identified in Item #1 minus total members identified in Item #2.			X	Field is auto-calculated by template provide by state to the MCEs.
4. Unreachable Members	The number of new members enrolled with the MCE during the reporting period that are determined to be unreachable. "Unreachable" is defined as a minimum of three outreach calls using the information provided to the MCE by OMPP but for which there is no response from the member.	X			
5. New Members Net of Terminated and Unreachable	Calculation of total members identified in Item #3 minus total members identified in Item #4.			X	Field is auto-calculated by template provide by state to the MCEs.
6. Total Screened	Indicate the number of new members identified in Item #1 that were screened within their first 90 days of enrollment.	X			
7. Percent Screened (all except Terminated)	Calculation of the percentage of newly enrolled MCE members, net of terminated members that have had a health screening assessment completed within 90 days. Calculation is number in Item #6 divided by number in Item #3.			X	Field is auto-calculated by template provide by state to the MCEs.
8. Percent Screened (excluding Terminated and Unreachable)	Calculation of the percentage of newly enrolled MCE members, net of terminated and unreachable members that have had a health screening assessment completed within 90 days. Calculation is number in Item #6 divided by number in Item #5.			X	Field is auto-calculated by template provide by state to the MCEs.

Validation Findings

V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	**V**

QR-HS1 - New Member Health Screening Report
MHS: Hoosier Healthwise

Part 1		Part 2		Part 3					
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR					
	Experience Period >>	Q3 2013	Q4 2013	Verified Q3 2013			Verified Q4 2013		
Item No.	**Data Description**	**Count**	**Count**	**Count**	**Difference**	**Percent Difference**	**Count**	**Difference**	**Percent Difference**
1	Number of New Members Enrolled During the Reporting Period	12,178	12,213	12,177	-1	-0.01%	12,191	-22	-0.18%
2	Number of Members in Item #1 that Terminated Within their First 90 Days of Enrollment	1,668	1,566	1,550	-118	-7.07%	1,599	33	2.11%
3	New Members Net of Terminated	10,510	10,647	10,627	117	1.11%	10,592	-55	-0.52%
4	Number of Members in Item #1 that have been Classified as Unreachable	4,161	4,628	4,134	-27	-0.65%	4,616	-12	-0.26%
5	New Members Net of Terminated and Unreachable	6,349	6,019	6,493	144	2.27%	5,976	-43	-0.71%
6	Number of Members in Item #1 that were Screened Within their First 90 Days of Enrollment	2,823	2,429	2,832	9	0.32%	2,436	7	0.29%
7	Performance Measure #1: Pct Screened Within 90 Days (all except Terminated)	27%	23%	27%	0%	-0.6%	23%	0%	0.8%
8	Performance Measure #2: Pct Screened Within 90 Days (excluding Terminated and Unreachable)	44%	40%	44%	-1%	-1.9%	41%	1%	1.6%

MCE Name: MHS Healthy Indiana Plan
Performance Measure: QR-HS1 New Member Health Screening Report

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.	X			
Denominator	Data sources used to calculate the denominator were complete and accurate.	X			
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.	X			
Numerator	Data sources used to calculate the numerator are complete and accurate.	X			
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.	X			
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.	X			

MCE Name: MHS Healthy Indiana Plan
Performance Measure: QR-HS1 New Member Health Screening Report

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. New Member Totals	The number of new members enrolled with the MCE during the reporting period that require a screening to be completed.	X			
2. Terminated Members	The number of new members enrolled with the MCE durin gthe reporting period that have since terminated within their first 90 days of enrollment.	X			Slight variation can be attributed to retro eligibility available at the time data was pulled for the EQRO that was not available at the time of reporting to the state as well as NOPs that were deemed appropriate at time of orignal reporting.
3. New Members Net of Terminated	Calculation of total members identified in Item #1 minus total members identified in Item #2.			X	Field is auto-calculated by template provide by state to the MCEs.
4. Unreachable Members	The number of new members enrolled with the MCE during the reporting period that are determined to be unreachable. "Unreachable" is defined as a minimum of three outreach calls using the information provided to the MCE by OMPP but for which there is no response from the member.	X			
5. New Members Net of Terminated and Unreachable	Calculation of total members identified in Item #3 minus total members identified in Item #4.			X	Field is auto-calculated by template provide by state to the MCEs.
6. Total Screened	Indicate the number of new members identified in Item #1 that were screened within their first 90 days of enrollment.	X			
7. Percent Screened (all except Terminated)	Calculation of the percentage of newly enrolled MCE members, net of terminated members that have had a health screening assessment completed within 90 days. Calculation is number in Item #6 divided by number in Item #3.			X	Field is auto-calculated by template provide by state to the MCEs.
8. Percent Screened (excluding Terminated and Unreachable)	Calculation of the percentage of newly enrolled MCE members, net of terminated and unreachable members that have had a health screening assessment completed within 90 days. Calculation is number in Item #6 divided by number in Item #5.			X	Field is auto-calculated by template provide by state to the MCEs.

Validation Findings

V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	**V**

QR-HS1 - New Member Health Screening Report
MHS: Healthy Indiana Plan

Part 1		Part 2		Part 3					
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR					
	Experience Period >>	Q3 2013	Q4 2013	Verified Q3 2013			Verified Q4 2013		
Item No.	**Data Description**	**Count**	**Count**	**Count**	**Difference**	**Percent Difference**	**Count**	**Difference**	**Percent Difference**
1	Number of New Members Enrolled During the Reporting Period	500	410	501	1	0.20%	409	-1	-0.24%
2	Number of Members in Item #1 that Terminated Within their First 90 Days of Enrollment	9	8	8	-1	-11.11%	10	2	25.00%
3	New Members Net of Terminated	491	402	493	2	0.41%	399	-3	-0.75%
4	Number of Members in Item #1 that have been Classified as Unreachable	215	186	212	-3	-1.40%	185	-1	-0.54%
5	New Members Net of Terminated and Unreachable	276	216	281	5	1.81%	214	-2	-0.93%
6	Number of Members in Item #1 that were Screened Within their First 90 Days of Enrollment	184	128	152	-32	-17.39%	127	-1	-0.78%
7	Performance Measure #1: Pct Screened Within 90 Days (all except Terminated)	37%	32%	37%	0%	-0.5%	32%	0%	0.0%
8	Performance Measure #2: Pct Screened Within 90 Days (excluding Terminated and Unreachable)	67%	59%	66%	-1%	-1.7%	59%	0%	0.2%

MCE Name: MDwise Hoosier Healthwise
Performance Measure: QR-P1 Provider Helpline Performance

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.	X			
Denominator	Data sources used to calculate the denominator were complete and accurate.	X			
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.	X			
Numerator	Data sources used to calculate the numerator are complete and accurate.	X			
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.	X			
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.	X			

MCE Name: MDwise Hoosier Healthwise
Performance Measure: QR-P1 Provider Helpline Performance

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. Number of Provider Calls Received	Total number of provider calls received by the MCE into the Provider Helpline ACD call queue during open hours of operations.	X			
2. Number of Provider Calls Answered	The number of provider calls answered on the Provider Helpline ACD call queue in the reporting quarter.	X			
3. Number of Provider Calls Answered Live Within 30 Seconds	The number of provider calls answered within 30 seconds by a live voice on the Provider Helpline in the reporting quarter.	X			
4. Percent of Calls Answered Live Within 30 Seconds	Number of provider calls answered live within 30 seconds divided by number of provider calls received.	X			
5. Number of Abandoned Calls	Number of calls received into the Provider Helpline during open hours of operations that were abandoned (disconnected) by the caller or the system before being answered.	X			
6. Percent of Abandoned Calls	Number of abandoned calls divided by number of provider calls received.	X			

Validation Findings
V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	V

QR-P1 - Provider Helpline Performance
MDwise: Hoosier Healthwise

Part 1		Part 2		Part 3					
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR					
	Experience Period >>	Q3 2013	Q4 2013	Verified Q3 2013			Verified Q4 2013		
Item No.	**Data Description**	**Count**	**Count**	**Count**	**Difference**	**Percent Difference**	**Count**	**Difference**	**Percent Difference**
1	Number of Provider Calls Received	43,629	39,954	43,624	-5	0.0%	39,952	-2	0.0%
2	Number of Provider Calls Answered	43,173	39,529	43,170	-3	0.0%	39,544	15	0.0%
3	Number of Provider Calls Answered Live Within 30 Seconds	40,171	37,473	40,475	304	0.8%	37,589	116	0.3%
4	Performance Measure #1: Pct in 30 Seconds	92.1%	93.8%	92.5%	0.4%	0.4%	92.1%	-1.7%	-1.8%
5	Number of Abandoned Calls	456	425	454	-2	-0.4%	408	-17	-4.0%
6	Performance Measure #2: Pct Abandoned	1.0%	1.1%	0.7%	-0.3%	-30.0%	0.7%	-0.3%	-27.3%

MCE Name: MDwise Healthy Indiana Plan
Performance Measure: QR-P1 Provider Helpline Performance

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.	X			
Denominator	Data sources used to calculate the denominator were complete and accurate.	X			
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.	X			
Numerator	Data sources used to calculate the numerator are complete and accurate.	X			
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.	X			
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.	X			

MCE Name: MDwise Healthy Indiana Plan
Performance Measure: QR-P1 Provider Helpline Performance

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. Number of Provider Calls Received	Total number of provider calls received by the MCE into the Provider Helpline ACD call queue during open hours of operations.	X			
2. Number of Provider Calls Answered	The number of provider calls answered on the Provider Helpline ACD call queue in the reporting quarter.	X			
3. Number of Provider Calls Answered Live Within 30 Seconds	The number of provider calls answered within 30 seconds by a live voice on the Provider Helpline in the reporting quarter.	X			
4. Percent of Calls Answered Live Within 30 Seconds	Number of provider calls answered live within 30 seconds divided by number of provider calls received.	X			
5. Number of Abandoned Calls	Number of calls received into the Provider Helpline during open hours of operations that were abandoned (disconnected) by the caller or the system before being answered.	X			
6. Percent of Abandoned Calls	Number of abandoned calls divided by number of provider calls received.	X			

Validation Findings
V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	V

QR-P1 - Provider Helpline Performance
MDwise: Healthy Indiana Plan

Part 1		Part 2		Part 3					
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR					
	Experience Period >>	Q3 2013	Q4 2013	Verified Q3 2013			Verified Q4 2013		
Item No.	**Data Description**	**Count**	**Count**	**Count**	**Difference**	**Percent Difference**	**Count**	**Difference**	**Percent Difference**
1	Number of Provider Calls Received	5,505	5,058	5,504	-1	0.0%	5,056	-2	0.0%
2	Number of Provider Calls Answered	5,464	5,031	5,467	3	0.1%	5,032	1	0.0%
3	Number of Provider Calls Answered Live Within 30 Seconds	5,082	4,675	5,146	64	1.3%	4,727	52	1.1%
4	Performance Measure #1: Pct in 30 Seconds	92.3%	92.4%	93.3%	1.0%	1.1%	93.4%	0.9%	1.0%
5	Number of Abandoned Calls	41	27	39	-2	-4.9%	24	-3	-11.1%
6	Performance Measure #2: Pct Abandoned	0.7%	0.5%	0.7%	0.0%	0.0%	0.5%	0.0%	0.0%

MCE Name: MDwise Hoosier Healthwise
Performance Measure: QR-PMP1 PMP Assignment Report

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.			X	
Denominator	Data sources used to calculate the denominator were complete and accurate.			X	
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.			X	
Numerator	Data sources used to calculate the numerator are complete and accurate.			X	
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.			X	
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.			X	Validation of the QR-PMP1 report was deemed not possible after large variances were discovered between the EQRO's calculations and the what the MCEs reported to the state. It was determined that the variance was due to different interpretations of the report specification as provided by the state to the MCEs. Ambiguous statements in the report specification were determined to the be the cause of the multiple interpretations of the report specification.

MCE Name: MDwise Hoosier Healthwise
Performance Measure: QR-PMP1 PMP Assignment Report

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. Newly Assigned Plan Members	As of the last day of the reporting period, the total number of members received on the enrollment roster during the reporting period.			X	Report validation was deemed not possible due to ambiguious report specifications.
2. Members who Self Selected a PMP	As of the last day of the reporting period, the total number of members who self selected a PMP during the reporting period.			X	Report validation was deemed not possible due to ambiguious report specifications.
3. Members Auto-Assigned with "smart" Logic	Indicate the number of members who were auto-assigned using system logic that includes the following: -Member's PMP assignment within the last 12 months -Family member's current PMP -Family member's previous PMP -PMP in previous group -PMP in family member's current group or previous group			X	Report validation was deemed not possible due to ambiguious report specifications.
4. Members Auto-Assigned with "default" Logic	The number of members who were auto-assigned using an approved default logic that does not include the described "smart" logic.			X	Report validation was deemed not possible due to ambiguious report specifications.
5. Members Assigned a PMP	As of the last day of the reporting period, the total number of members assigned a PMP during the reporting period. This number will not be an exact total of the assignment method counts. A member may have multiple types of assignments occur during the reporting period.			X	Line item validation not attempted by EQRO
6. Total Members Assigned a PMP	As of the last day of the reporting period, the total number of all members assigned a PMP regardless of when a PMP assignment was made.			X	Line item validation not attempted by EQRO
7. Total Members with Open Network status	The total number of members that have open network status either due to PMP assignment logic has not been applied, or due to lack of PMP availability within the required access targets.			X	Line item validation not attempted by EQRO

Validation Findings
V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	**NV**

QR-PMP1 - PMP Assignment Report
MDwise: Hoosier Healthwise

Part 1		Part 2		Part 3				
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR				
	Experience Period >>	Calendar Year 2013		Verified Calendar Year 2013				
Item No.	**Data Description**	**Count**	**Percent of Total**	**CY 2013 Count**	**Difference**	**Percent Difference**	**Percent of Total**	**Difference**
1	Newly Assigned Plan Members	133,130		145,247	12,117	9.1%		
2	Members who Self Selected a PMP	66,002	28.9%	12,680	-53,322	-80.8%	8.7%	-20.2%
3	Members Auto-Assigned with "smart" Logic	98,148	43.0%	80,594	-17,554	-17.9%	55.5%	12.5%
4	Members Auto-Assigned with "default" Logic	64,301	28.2%	51,973	-12,328	-19.2%	35.8%	7.6%
5	Members Assigned a PMP	228,451		**Section Not Validated**				
6	Total Members Assigned a PMP	274,569						
7	Total Members Assigned Open Network Status	11						

MCE Name: MDwise Healthy Indiana Plan
Performance Measure: QR-PMP1 PMP Assignment Report

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.			X	
Denominator	Data sources used to calculate the denominator were complete and accurate.			X	
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.			X	
Numerator	Data sources used to calculate the numerator are complete and accurate.			X	
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.			X	
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.			X	Validation of the QR-PMP1 report was deemed not possible after large variances were discovered between the EQRO's calculations and the what the MCEs reported to the state. It was determined that the variance was due to different interpretations of the report specification as provided by the state to the MCEs. Ambiguous statements in the report specification were determined to the be the cause of the multiple interpretations of the report specification.

MCE Name: MDwise Healthy Indiana Plan
Performance Measure: QR-PMP1 PMP Assignment Report

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. Newly Assigned Plan Members	As of the last day of the reporting period, the total number of members received on the enrollment roster during the reporting period.			X	Report validation was deemed not possible due to ambiguious report specifications.
2. Members who Self Selected a PMP	As of the last day of the reporting period, the total number of members who self selected a PMP during the reporting period.			X	Report validation was deemed not possible due to ambiguious report specifications.
3. Members Auto-Assigned with "smart" Logic	Indicate the number of members who were auto-assigned using system logic that includes the following: -Member's PMP assignment within the last 12 months -Family member's current PMP -Family member's previous PMP -PMP in previous group -PMP in family member's current group or previous group			X	Report validation was deemed not possible due to ambiguious report specifications.
4. Members Auto-Assigned with "default" Logic	The number of members who were auto-assigned using an approved default logic that does not include the described "smart" logic.			X	Report validation was deemed not possible due to ambiguious report specifications.
5. Members Assigned a PMP	As of the last day of the reporting period, the total number of members assigned a PMP during the reporting period. This number will not be an exact total of the assignment method counts. A member may have multiple types of assignments occur during the reporting period.			X	Line item validation not attempted by EQRO
6. Total Members Assigned a PMP	As of the last day of the reporting period, the total number of all members assigned a PMP regardless of when a PMP assignment was made.			X	Line item validation not attempted by EQRO
7. Total Members with Open Network status	The total number of members that have open network status either due to PMP assignment logic has not been applied, or due to lack of PMP availability within the required access targets.			X	Line item validation not attempted by EQRO

Validation Findings

V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	**NV**

QR-PMP1 - PMP Assignment Report
MDwise: Healthy Indiana Plan

Part 1		Part 2		Part 3				
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR				
	Experience Period >>	Calendar Year 2013		Verified Calendar Year 2013				
Item No.	**Data Description**	**Count**	**Percent of Total**	**CY 2013 Count**	**Difference**	**Percent Difference**	**Percent of Total**	**Difference**
1	Newly Assigned Plan Members	2,485		2,528	43	1.7%		
2	Members who Self Selected a PMP	2,437	52.3%	77	-2,360	-96.8%	3.1%	-49.2%
3	Members Auto-Assigned with "smart" Logic	324	7.0%	0	-324	-100.0%	0.0%	-7.0%
4	Members Auto-Assigned with "default" Logic	1,901	40.8%	2,451	550	28.9%	97.0%	56.2%
5	Members Assigned a PMP	4,662		**Section Not Validated**				
6	Total Members Assigned a PMP	8,622						
7	Total Members Assigned Open Network Status	0						

MCE Name: MDwise Hoosier Healthwise
Performance Measure: QR-HS1 New Member Health Screening Report

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.	X			
Denominator	Data sources used to calculate the denominator were complete and accurate.	X			
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.	X			
Numerator	Data sources used to calculate the numerator are complete and accurate.	X			
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.	X			
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.	X			

MCE Name: MDwise Hoosier Healthwise
Performance Measure: QR-HS1 New Member Health Screening Report

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. New Member Totals	The number of new members enrolled with the MCE during the reporting period that require a screening to be completed.	X			
2. Terminated Members	The number of new members enrolled with the MCE durin gthe reporting period that have since terminated within their first 90 days of enrollment.	X			Slight variation can be attributed to retro eligibility available at the time data was pulled for the EQRO that was not available at the time of reporting to the state as well as NOPs that were deemed appropriate at time of orignal reporting.
3. New Members Net of Terminated	Calculation of total members identified in Item #1 minus total members identified in Item #2.			X	Field is auto-calculated by template provide by state to the MCEs.
4. Unreachable Members	The number of new members enrolled with the MCE during the reporting period that are determined to be unreachable. "Unreachable" is defined as a minimum of three outreach calls using the information provided to the MCE by OMPP but for which there is no response from the member.	X			
5. New Members Net of Terminated and Unreachable	Calculation of total members identified in Item #3 minus total members identified in Item #4.			X	Field is auto-calculated by template provide by state to the MCEs.
6. Total Screened	Indicate the number of new members identified in Item #1 that were screened within their first 90 days of enrollment.	X			
7. Percent Screened (all except Terminated)	Calculation of the percentage of newly enrolled MCE members, net of terminated members that have had a health screening assessment completed within 90 days. Calculation is number in Item #6 divided by number in Item #3.			X	Field is auto-calculated by template provide by state to the MCEs.
8. Percent Screened (excluding Terminated and Unreachable)	Calculation of the percentage of newly enrolled MCE members, net of terminated and unreachable members that have had a health screening assessment completed within 90 days. Calculation is number in Item #6 divided by number in Item #5.			X	Field is auto-calculated by template provide by state to the MCEs.

Validation Findings

V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	**V**

QR-HS1 - New Member Health Screening Report
MDwise: Hoosier Healthwise

Part 1		Part 2		Part 3					
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR					
	Experience Period >>	Q3 2013	Q4 2013	Verified Q3 2013			Verified Q4 2013		
Item No.	**Data Description**	**Count**	**Count**	**Count**	**Difference**	**Percent Difference**	**Count**	**Difference**	**Percent Difference**
1	Number of New Members Enrolled During the Reporting Period	13,627	14,619	13,987	360	2.64%	14,665	46	0.31%
2	Number of Members in Item #1 that Terminated Within their First 90 Days of Enrollment	1,848	1,559	1,640	-208	-11.26%	1,482	-77	-4.94%
3	New Members Net of Terminated	11,779	13,060	12,347	568	4.82%	13,183	123	0.94%
4	Number of Members in Item #1 that have been Classified as Unreachable	2,491	3,054	3,001	510	20.47%	3,281	227	7.43%
5	New Members Net of Terminated and Unreachable	9,288	10,006	9,346	58	0.62%	9,902	-104	-1.04%
6	Number of Members in Item #1 that were Screened Within their First 90 Days of Enrollment	9,288	9,977	8,857	-431	-4.64%	9,721	-256	-2.57%
7	Performance Measure #1: Pct Screened Within 90 Days (all except Terminated)	79%	76%	72%	-7%	-9.0%	74%	-3%	-3.5%
8	Performance Measure #2: Pct Screened Within 90 Days (excluding Terminated and Unreachable)	100%	100%	95%	-5%	-5.2%	98%	-2%	-1.5%

MCE Name: MDwise Healthy Indiana Plan
Performance Measure: QR-HS1 New Member Health Screening Report

Validation Component	Audit Element	Yes	No	N/A	Comments
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources and programming logic.	X			
Denominator	Data sources used to calculate the denominator were complete and accurate.	X			
	Calculations of the performance measure adhered to the specifications for all components of the denominator of the performance measure.	X			
Numerator	Data sources used to calculate the numerator are complete and accurate.	X			
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measures.	X			
	If medical record abstraction was used, documentation/tools were adequate.			X	
	If hybrid method was used, the integration of administrative and medical record data was adequate.			X	
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			X	
Sampling	Sample was unbiased.			X	
	Sample treated all measures independently.			X	
	Sample size and replacement methodologies met specifications.			X	
Reporting	State specifications for reporting performance measures were followed.	X			

MCE Name: MDwise Healthy Indiana Plan
Performance Measure: QR-HS1 New Member Health Screening Report

Methodology for calculating measure: (Check One)
Administrative: X Medical Record Review:

Audit Elements	Audit Specification	Met	Not Met	N/A	Comments
1. New Member Totals	The number of new members enrolled with the MCE during the reporting period that require a screening to be completed.	X			
2. Terminated Members	The number of new members enrolled with the MCE durin gthe reporting period that have since terminated within their first 90 days of enrollment.	X			Slight variation can be attributed to retro eligibility available at the time data was pulled for the EQRO that was not available at the time of reporting to the state as well as NOPs that were deemed appropriate at time of orignal reporting.
3. New Members Net of Terminated	Calculation of total members identified in Item #1 minus total members identified in Item #2.			X	Field is auto-calculated by template provide by state to the MCEs.
4. Unreachable Members	The number of new members enrolled with the MCE during the reporting period that are determined to be unreachable. "Unreachable" is defined as a minimum of three outreach calls using the information provided to the MCE by OMPP but for which there is no response from the member.	X			
5. New Members Net of Terminated and Unreachable	Calculation of total members identified in Item #3 minus total members identified in Item #4.			X	Field is auto-calculated by template provide by state to the MCEs.
6. Total Screened	Indicate the number of new members identified in Item #1 that were screened within their first 90 days of enrollment.	X			
7. Percent Screened (all except Terminated)	Calculation of the percentage of newly enrolled MCE members, net of terminated members that have had a health screening assessment completed within 90 days. Calculation is number in Item #6 divided by number in Item #3.			X	Field is auto-calculated by template provide by state to the MCEs.
8. Percent Screened (excluding Terminated and Unreachable)	Calculation of the percentage of newly enrolled MCE members, net of terminated and unreachable members that have had a health screening assessment completed within 90 days. Calculation is number in Item #6 divided by number in Item #5.			X	Field is auto-calculated by template provide by state to the MCEs.

Validation Findings

V = Validated - Measure was compliant with State Specifications
NV = Not Validated - Measure was not compliant with State Specification
NR = Not Reported - MCE rate was materially biased or the MCE was not required to report.

Audit Designation:	**V**

QR-HS1 - New Member Health Screening Report
MDwise: Healthy Indiana Plan

Part 1		Part 2		Part 3					
		As reported by MCE to the OMPP		As calculated by B&A with files submitted for EQR					
	Experience Period >>	Q3 2013	Q4 2013	Verified Q3 2013			Verified Q4 2013		
Item No.	**Data Description**	**Count**	**Count**	**Count**	**Difference**	**Percent Difference**	**Count**	**Difference**	**Percent Difference**
1	Number of New Members Enrolled During the Reporting Period	480	401	480	0	0.00%	401	0	0.00%
2	Number of Members in Item #1 that Terminated Within their First 90 Days of Enrollment	9	10	9	0	0.00%	10	0	0.00%
3	New Members Net of Terminated	471	391	471	0	0.00%	391	0	0.00%
4	Number of Members in Item #1 that have been Classified as Unreachable	85	62	84	-1	-1.18%	61	-1	-1.61%
5	New Members Net of Terminated and Unreachable	386	329	387	1	0.26%	330	1	0.30%
6	Number of Members in Item #1 that were Screened Within their First 90 Days of Enrollment	386	329	353	-33	-8.55%	330	1	0.30%
7	Performance Measure #1: Pct Screened Within 90 Days (all except Terminated)	82%	84%	75%	-7%	-8.5%	84%	0%	0.3%
8	Performance Measure #2: Pct Screened Within 90 Days (excluding Terminated and Unreachable)	100%	100%	91%	-9%	-8.8%	100%	0%	0.0%

APPENDIX C

REVISED QUALITY IMPROVEMENT PROJECT WORKSHEET TEMPLATE

Quality Improvement Project Report

Quality Improvement Project Name

MCE **Date this Report Completed**

Person Responsible for Completion of this Form
Responsible Party's Email Address

Explain the **Rationale for QIP** (use quantifiable data where possible)

Is this QIP Related to an OMPP P4O? (place an X) Yes No

Which programs does the QIP cover? (place an X in one or both) HHW HIP

Calendar Year QIP began

If multiple years, state the reason(s) why this has continued

Will this QIP continue in the next year? Yes No
(Optional) State the reason(s) for continuing or discontinuing the QIP in the next year.

(Optional) Provide any relevant background or history related to this QIP.

QIP Name	**0**
MCE	

Measure Definitions

Measure #1:					
Numerator (describe):					
Denominator (describe):					
Place an X if this measure covers the entire population... for HHW		…for HIP			
HEDIS measure? Yes or No		If No, place an X if ...entire population		...or a sample	
If this measure is focused on specific subpopulation(s), state here					

Measure #2:					
Numerator (describe):					
Denominator (describe):					
Place an X if this measure covers the entire population... for HHW		…for HIP			
HEDIS measure? Yes or No		If No, place an X if ...entire population		...or a sample	
If this measure is focused on specific subpopulation(s), state here					

Measure #3:					
Numerator (describe):					
Denominator (describe):					
Place an X if this measure covers the entire population... for HHW		…for HIP			
HEDIS measure? Yes or No		If No, place an X if ...entire population		...or a sample	
If this measure is focused on specific subpopulation(s), state here					

Measure #4:					
Numerator (describe):					
Denominator (describe):					
Place an X if this measure covers the entire population... for HHW		…for HIP			
HEDIS measure? Yes or No		If No, place an X if ...entire population		...or a sample	
If this measure is focused on specific subpopulation(s), state here					

Data Sources (place an X in all that apply)

	Claims/ Encounters	Medical Records	Other	If Other, briefly describe in the space below
For Measure #1				
For Measure #2				
For Measure #3				
For Measure #4				

Reporting Periodicity (place an X in only one)

	Annually	Semi-Annually	Quarterly	Monthly	Other	If Other, describe
For Measure #1						
For Measure #2						
For Measure #3						
For Measure #4						

Other Methodological Considerations

Has the data source(s) changed for any measure since you began computing each measure? [Enter Yes or No]

If Yes, state which measure number, then what has changed.

If you use sampling on any measure, has the sampling method changed since you began? [Enter Yes or No]

If Yes, state which measure number, then what has changed.

QIP Name	**0**
MCE	

Measure Results

Complete the table for each measure you are tracking in the QIP year. Use this form to continually add more current data if the QIP is mult-year.
If the goal or benchmark has changed for any measure over the course of this PIP, state the reason for the change in the space below the table.
Example: If the measure is HEDIS and the benchmark changed from national 75 percentile value to 90th, state why it changed (such as, "we met the 75t
If the only change is year-to-year HEDIS value change at the 75th percentile itself, do not state that here.

Measure #1:	**0**											
Measure-ment Period (e.g. Baseline, MY1,MY2)	Time Period Measurement Covers (e.g., enter CY or HEDIS Rate Year)	Num-erator	Denom-inator	Rate (enter a numeric value)	Difference in Rate: Current Period & Baseline	Goal (enter a numeric value)	Benchmark (enter a numeric value)	If Benchmark is HEDIS, what percentile?	Difference Between Rate and Goal	Difference between Rate and Benchmark	Statist. Signif. Change from Prior Period?	Statistical Test Used and Result
Baseline												

Reason for Goal/Benchmark Change:

Measure #2:	**0**											
Measure-ment Period (e.g. Baseline, MY1,MY2)	Time Period Measurement Covers (e.g., enter CY or HEDIS Rate Year)	Num-erator	Denom-inator	Rate (enter a numeric value)	Difference in Rate: Current Period & Baseline	Goal (enter a numeric value)	Benchmark (enter a numeric value)	If Benchmark is HEDIS, what percentile?	Difference Between Rate and Goal	Difference between Rate and Benchmark	Statist. Signif. Change from Prior Period?	Statistical Test Used and Result
Baseline												

Reason for Goal/Benchmark Change:

Measure #3:	**0**											
Measure-ment Period (e.g. Baseline, MY1,MY2)	Time Period Measurement Covers (e.g., enter CY or HEDIS Rate Year)	Num-erator	Denom-inator	Rate (enter a numeric value)	Difference in Rate: Current Period & Baseline	Goal (enter a numeric value)	Benchmark (enter a numeric value)	If Benchmark is HEDIS, what percentile?	Difference Between Rate and Goal	Difference between Rate and Benchmark	Statist. Signif. Change from Prior Period?	Statistical Test Used and Result
Baseline												

Reason for Goal/Benchmark Change:

Measure #4:	**0**											
Measure-ment Period (e.g. Baseline, MY1,MY2)	Time Period Measurement Covers (e.g., enter CY or HEDIS Rate Year)	Num-erator	Denom-inator	Rate (enter a numeric value)	Difference in Rate: Current Period & Baseline	Goal (enter a numeric value)	Benchmark (enter a numeric value)	If Benchmark is HEDIS, what percentile?	Difference Between Rate and Goal	Difference between Rate and Benchmark	Statist. Signif. Change from Prior Period?	Statistical Test Used and Result
Baseline												

Reason for Goal/Benchmark Change:

QIP Name	**0**
MCE	

Intervention Definitions

Name of Intervention #1:								
Study Question- What/who is the intervention specifically trying to address? If for subpopulations, for example, state here.								
Enter Date Implemented:		Place X if Ongoing			Place X if Retiring			
Place X if Intervention is intended for:	Member		Provider		MCE			
Place X for the population that the Intervention is targeted for:			Entire Pop		Targeted Population			
Place X if data is being collected to assess this intervention			Yes		No			
If yes, enter the date that data started to be collected								

Name of Intervention #2:								
Study Question- What/who is the intervention specifically trying to address? If for subpopulations, for example, state here.								
Enter Date Implemented:		Place X if Ongoing			Place X if Retiring			
Place X if Intervention is intended for:	Member		Provider		MCE			
Place X for the population that the Intervention is targeted for:			Entire Pop		Targeted Population			
Place X if data is being collected to assess this intervention			Yes		No			
If yes, enter the date that data started to be collected								

Name of Intervention #3:								
Study Question- What/who is the intervention specifically trying to address? If for subpopulations, for example, state here.								
Enter Date Implemented:		Place X if Ongoing			Place X if Retiring			
Place X if Intervention is intended for:	Member		Provider		MCE			
Place X for the population that the Intervention is targeted for:			Entire Pop		Targeted Population			
Place X if data is being collected to assess this intervention			Yes		No			
If yes, enter the date that data started to be collected								

Name of Intervention #4:								
Study Question- What/who is the intervention specifically trying to address? If for subpopulations, for example, state here.								
Enter Date Implemented:		Place X if Ongoing			Place X if Retiring			
Place X if Intervention is intended for:	Member		Provider		MCE			
Place X for the population that the Intervention is targeted for:			Entire Pop		Targeted Population			
Place X if data is being collected to assess this intervention			Yes		No			
If yes, enter the date that data started to be collected								

Name of Intervention #5:								
Study Question- What/who is the intervention specifically trying to address? If for subpopulations, for example, state here.								
Enter Date Implemented:		Place X if Ongoing			Place X if Retiring			
Place X if Intervention is intended for:	Member		Provider		MCE			
Place X for the population that the Intervention is targeted for:			Entire Pop		Targeted Population			
Place X if data is being collected to assess this intervention			Yes		No			
If yes, enter the date that data started to be collected								

Quality Improvement Project Report

QIP Name	**0**
MCE	

Intervention Results

Intervention #1:	**0**

What is the data used to measure the effectiveness of the intervention?

Time Period Intervention was Measured (enter from and to dates)	Numerator	Denominator	Result	Intervention Status (place X in one)			If this intervention has continued from a prior period and trend data is available, comment on any change seen in the intervention over time.
				Continue w/o Changes	Continue w/ Changes	Discontinued	

Based on the results above, how would you assess the effectiveness of the intervention?

Intervention #2:	**0**

What is the data used to measure the effectiveness of the intervention?

Time Period Intervention was Measured (enter from and to dates)	Numerator	Denominator	Result	Intervention Status (place X in one)			If this intervention has continued from a prior period and trend data is available, comment on any change seen in the intervention over time.
				Continue w/o Changes	Continue w/ Changes	Discontinued	

Based on the results above, how would you assess the effectiveness of the intervention?

Intervention #3:	**0**

What is the data used to measure the effectiveness of the intervention?

Time Period Intervention was Measured (enter from and to dates)	Numerator	Denominator	Result	Intervention Status (place X in one)			If this intervention has continued from a prior period and trend data is available, comment on any change seen in the intervention over time.
				Continue w/o Changes	Continue w/ Changes	Discontinued	

Based on the results above, how would you assess the effectiveness of the intervention?

Intervention #4:	**0**

What is the data used to measure the effectiveness of the intervention?

Time Period Intervention was Measured (enter from and to dates)	Numerator	Denominator	Result	Intervention Status (place X in one)			If this intervention has continued from a prior period and trend data is available, comment on any change seen in the intervention over time.
				Continue w/o Changes	Continue w/ Changes	Discontinued	

Based on the results above, how would you assess the effectiveness of the intervention?

Intervention #5:	**0**

What is the data used to measure the effectiveness of the intervention?

Time Period Intervention was Measured (enter from and to dates)	Numerator	Denominator	Result	Intervention Status (place X in one)			If this intervention has continued from a prior period and trend data is available, comment on any change seen in the intervention over time.
				Continue w/o Changes	Continue w/ Changes	Discontinued	

Based on the results above, how would you assess the effectiveness of the intervention?

QIP Name	**0**
MCE	

Qualitative Assessment

The MCE may have conducted other activities in support of this QIP that may not be interventions per se. Rather, they are part of a larger strategy to promote quality improvement related to the measures defined. "Activities" differ from "interventions" in that activities are not targeted to a specific population and are often not measurable to assess their effectiveness. Examples may be promotion of health services at health fairs, notifications in member newsletters, etc. Please describe any activities the MCE conducted in support of this QIP in the space below.

Explain any challenges/barriers that the MCE encountered in implementing interventions and what you did to alleviate these challenges. When describing, start the description by referencing the Intervention number from the prior page. Example: "For intervention #1, we had a challenge with…"

Explain any challenges/barriers that the MCE encountered in computing results from interventions that you conducted and what you did to alleviate these challenges. When describing, start the description by referencing the Intervention number from the prior page.

Explain any challenges/barriers that the MCE encountered in computing results for the measures you defined and what you did to alleviate these challenges. When describing, start the description by referencing the Measure number from the prior page. If there were no challenges in computing results, state this in the space below.

Provide an overall assessment of the Activity for the most recent reporting year: what was learned, any changes the MCE adapted to, successes to leverage, challenges to overcome.

APPENDIX D

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECT WORKSHEETS

Indiana External Quality Review for Review Year CY 2013

Validating Performance Improvement Projects

MCO	Anthem
Focus Period	1/1/13 - 12/31/13

Name of Performance Improvement Project (PIP)
Postpartum Care

HHW/HIP/Both	HHW Only

Is this a Recurring PIP? If yes, state # years	3

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No	N/A	*Is the PIP consistent with the demographics and epidemiology of the enrollees?*
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No		*Was the study question/objective of the PIP clearly stated and properly defined?*
X			-Do calls to mothers after delivery to remind them to make post partum visit have any impact on compliance rate -Do individual phone calls and assistance in making appointment have an impact on compliance rate

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No	N/A	*Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?*
X			HEDIS
			Did the indicators track performance over a specified period of time?
X			HEDIS 2012 and 2014 (CY 2011 and 2013)
			Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?
X			Anthem provided data on intervention results and outcomes in addition to HEDIS rates.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No	N/A	*Were the enrollees to whom the study question and indicators are relevant clearly defined?*
X			The programs and interventions applied to all pregnant women. The data was collected utilizing HEDIS methodology.
			If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?
X			The data was collected utilizing HEDIS methodology.
			In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?
	X		There are no subcategories of pregnant women

Step 5: REVIEW SAMPLING METHODS

Yes	No	N/A	*Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?*
X			MEASURE: Yes, the data was collected utilizing hybrid HEDIS methodology. INTERVENTION: Yes, no
			If not HEDIS: Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?
		X	MEASURE: N/A INTERVENTION: No
			If not HEDIS: Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:
		X	MEASURE: N/A INTERVENTION: It is not clear what the sampling technique is
			If not HEDIS: Did the sample contain a sufficient number of enrollees?
		X	MEASURE: N/A INTERVENTION: All calls made

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)			

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No	N/A	*Did the study design clearly specify the data to be collected?*
X			MEASURE: The data was collected utilizing HEDIS methodology. INTERVENTION: calls made and calls that are a success
			Did the study design clearly specify the source of data?
X	X		MEASURE: Claims and Medical Records INTERVENTION: The report did not identify where the call statistics were from
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
X			
			Were qualified staff and personnel used to collect the data?
	X		The report did not identify who was collecting the data.

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	*Were interventions developed to change behavior at the provider level? If yes, state below.*
	X		
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			-Calls to mothers after delivery reminding them to have a postpartum visit -Appointment assistance
			Were interventions developed to change behavior at the MCE level? If yes, state below.
	X		
			Are the interventions sufficient to be expected to improve outcomes?
X			The interventions seem to be working since Anthem has exceeded the 90th percentile for three years.
			Are the interventions culturally and linguistically appropriate?
	X		There was no evidence of cultural or linguistic considerations in the interventions.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	*Did the MCE conduct an analysis of the findings according to its data analysis plan?*
X			The intervention reduced care gaps
			Were numerical PIP results and findings accurately and clearly presented?
X			Table of rates
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
X			
			Did the analysis identify statistical significance?
X			
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
		X	Nothing changed in the methodology
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
X			Anthem presented the data results of its case manager intervention program.
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
X			

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	*Does the reported improvement in performance have "face" validity (Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence)?*
X			Anthem has stayed above the 90th percentile for the three years presented.
			Was there any documented, quantitative improvement in processes or outcomes of care?
X			Anthem has stayed above the 90th percentile for the three years presented.
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
X			Anthem has stayed above the 90th percentile for the three years presented.

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	*Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?*
X			MEASURE: Yes INTERVENTION: Not enough proof of improvement
			Was the same methodology as the baseline measurement used when measurement was repeated?
X			

ACTIVITY 2: Verifying Study Findings (Non completed - Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

High confidence in reported MCO PIP results	**X**
Confidence in reported MCO PIP results	
Low confidence in reported MCO PIP results	
Reported MCO PIP results not credible	

B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued.

Indiana External Quality Review for Review Year CY 2013

Validating Performance Improvement Projects

MCO	Anthem
Focus Period	1/1/13 - 12/31/13
HHW/HIP/Both	Both

Name of Performance Improvement Project (PIP)	
ER/ED Services	
Is this a Recurring PIP? If yes, state # years	2

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No	N/A	*Is the PIP consistent with the demographics and epidemiology of the enrollees?*
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No	N/A	*Was the study question/objective of the PIP clearly stated and properly defined?*
X			- To determine if contact with members that have 2 or more visits in 180 days has impact in future ER visits -To determine if education on the use of the Anthem Nurse Line will increase the utilization of the 24 Hour Nurse versus members going to the ER.

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No	N/A	*Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?*
X			Great subpopulation data by age and location (Evansville project)
			Did the indicators track performance over a specified period of time?
X			CY 2012-2013
			Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?
X			

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No	N/A	*Were the enrollees to whom the study question and indicators are relevant clearly defined?*
X			MEASURE: Adults 18 and over, children under 18, cities/zip codes and Deaconess Family Medicine in Evansville INTERVENTION: Adults 18 and over and children under 18.
			If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?
		X	
			In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?
X			-Anthem identified the Evansville area and zip code 47714 as an area to target as well as Adults 18 and over, and children under 18

Step 5: REVIEW SAMPLING METHODS

Yes	No	N/A	*Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?*
X			There were various sampling methods. None were HEDIS.
			If not HEDIS: Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?
	X		
			If not HEDIS: Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:
X			Anthem stated that they used all ED claims for each subpopulation
			If not HEDIS: Did the sample contain a sufficient number of enrollees?
X			

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)			

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No	N/A	*Did the study design clearly specify the data to be collected?*
X			
			Did the study design clearly specify the source of data?
X			Claims/encounters
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
X			a.) yes c.) yes b.) yes d.) no benchmarks
			Were qualified staff and personnel used to collect the data?
	X		The report did not identify who was collecting the data.

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	*Were interventions developed to change behavior at the provider level? If yes, state below.*
	X		
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			-ER Action Campaign - Contact with members 18 and over who have had 2 or more visits in 180days -Member Education on Nurse Line in the Evansville Area
			Were interventions developed to change behavior at the MCE level? If yes, state below.
	X		
			Are the interventions sufficient to be expected to improve outcomes?
X			The intervention interventions and activities should reduce ED use in Evansville.
			Are the interventions culturally and linguistically appropriate?
X			-There was no evidence of cultural or linguistic considerations in the interventions. However, Anthem did identify specific interactions toward Spanish-speaking members in its report on activities.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	*Did the MCE conduct an analysis of the findings according to its data analysis plan?*
X			
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
	X		No benchmarks provided
			Did the analysis identify statistical significance?
	X		No statistical significance provided
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
		X	Nothing changed in the methodology
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
	X		The data to determine the effectiveness of the ER Action program is not available.
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
X			They are discussing expanding the Evansville program to other parts of the State

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	*Does the reported improvement in performance have "face" validity (Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence)?*
		X	There is not enough data to assess this.
			Was there any documented, quantitative improvement in processes or outcomes of care?
X			There was a decrease in ED use between CY2012 and CY 2013.
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
	X		No statistical evidence

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	*Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?*
		X	There is not enough data to assess this.
			Was the same methodology as the baseline measurement used when measurement was repeated?
X			

ACTIVITY 2: Verifying Study Findings (Non completed - Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

High confidence in reported MCO PIP results	
Confidence in reported MCO PIP results	
Low confidence in reported MCO PIP results	**X**
Reported MCO PIP results not credible	

B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued. Additionally, Anthem should ensure they have specific goals and benchmarks documented. Since interventions were not active for one half of the measurement period, it is difficult to assess if the interventions had an impact on the measure.

Indiana External Quality Review for Review Year CY 2013

Validating Performance Improvement Projects

MCO	Anthem
Focus Period	1/1/13 - 12/31/13

Name of Performance Improvement Project (PIP)
Tobacco Cessation

HHW/HIP/Both	Both

Is this a Recurring PIP? If yes, state # years	2

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No	N/A	*Is the PIP consistent with the demographics and epidemiology of the enrollees?*
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No	N/A	*Was the study question/objective of the PIP clearly stated and properly defined?*
X			-Do mailings to members who smoke and offering helpful tools to quit have an impact on members discussion with their provider. -To determine if those members who received Quit Kit found the material helpful and stopped smoking -To determine if prescribing NRT to Pregnant women has impact on rate of cessation

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No	N/A	*Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?*
X			
			Did the indicators track performance over a specified period of time?
X			CY 2012-2013 (CAHPS 2013-2014)
			Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?
X			Anthem developed several unique intermediate metrics that can provide information between CAHPS surveys on its impact on tobacco cessation: -Total number of Quit Kits requested vs number of mailings -Member outreach will be made to sample of members who received Quit kits to determine if they were helpful and smoking cessation -Number of NRT prescribed to Pregnant Women -Outreach to members who were prescribed NRT to determine if helpful and successful with smoking cessation

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No	N/A	*Were the enrollees to whom the study question and indicators are relevant clearly defined?*
X			
			If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?
		X	
			In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?
X			Pregnant women

Step 5: REVIEW SAMPLING METHODS

Yes	No	N/A	*Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?*
X			MEASURE: They used CAHPS sampling methodology and pharmacy claims querying. INTERVENTION: They intend to sample the number of members requesting Quit Kits
			If not HEDIS: Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?
	X		

			ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)
			If not HEDIS: Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:
X	X		MEASURE: They used CAHPS sampling methodology and pharmacy claims querying which seems to be the entire population of NRT rather than a sample. INTERVENTION: The sampling methodology is not specified
			If not HEDIS: Did the sample contain a sufficient number of enrollees?
X	X		MEASURE: They used CAHPS sampling methodology which has a defined sample size and pharmacy claims querying which seems to be the entire population of NRT rather than a sample. INTERVENTION: The sample size is not specified

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No	N/A	
			Did the study design clearly specify the data to be collected?
X	X		MEASURE: They used CAHPS data collection methods and pharmacy claims querying. INTERVENTION: Anthem does not define what the numerator and denominator for its measures will be in Interventions 2, 3, and 4.
			Did the study design clearly specify the source of data?
X	X		MEASURE: CAHPS data and pharmacy claims INTERVENTION: Anthem does not define what the numerator and denominator for its measures will be in Interventions 2, 3, and 4 and from where they will come.
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
X	X		a.) yes c.) yes b.) yes d.) no benchmarks
			Were qualified staff and personnel used to collect the data?
	X		The report did not identify who was collecting the data.

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	
	X		*Were interventions developed to change behavior at the provider level? If yes, state below.*
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			-Evaluation of mailings based on Quit Kit requests -Member outreach about Quit Kits and NRT
			Were interventions developed to change behavior at the MCE level? If yes, state below.
	X		
			Are the interventions sufficient to be expected to improve outcomes?
		X	Most of the interventions are proposed for the future
			Are the interventions culturally and linguistically appropriate?
	X		There was no evidence of cultural or linguistic considerations in the interventions.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	
			Did the MCE conduct an analysis of the findings according to its data analysis plan?
X			Anthem identified that the increase in the Quit Kit requests has not improved the CAHPS scores.
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
X			
			Did the analysis identify statistical significance?
	X		

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)			
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
		X	Nothing changed in the methodology
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
X			
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
X			

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	
			Does the reported improvement in performance have "face" validity (Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence)?
		X	There is too little data to evaluate improvement.
			Was there any documented, quantitative improvement in processes or outcomes of care?
	X		
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
	X		

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	
			Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?
		X	There is too little data to evaluate improvement.
			Was the same methodology as the baseline measurement used when measurement was repeated?
X			

ACTIVITY 2: Verifying Study Findings (Non completed - Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

High confidence in reported MCO PIP results	
Confidence in reported MCO PIP results	**X**
Low confidence in reported MCO PIP results	
Reported MCO PIP results not credible	

B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued. While B&A has confidence in the rates reported by Anthem since the rates are tied to the CAHPS survey, Anthem needs to be sure to include numerator and denominator information in their PIP documentation.

Indiana External Quality Review for Review Year CY 2013

Validating Performance Improvement Projects

MCO	MHS
Focus Period	1/1/13 - 12/31/13
HHW/HIP/Both	HHW Only

Name of Performance Improvement Project (PIP)	
Postpartum Care	
Is this a Recurring PIP? If yes, state # years	1

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No	N/A	*Is the PIP consistent with the demographics and epidemiology of the enrollees?*
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No	N/A	*Was the study question/objective of the PIP clearly stated and properly defined?*
X			-Are CentAccount rewards linked to postpartum visits effective in increasing postpartum visit rates? -Do Case Manager calls (to reinforce the importance of a postpartum visit and assist as needed with appointment scheduling/transportation) increase the rate of postpartum visits among recently-delivered MHS members? -Are Baby Shower events effective in increasing postpartum visit rates among MHS members? -Does a P4P incentive for the provision of timely postpartum care increase postpartum visit rates?

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No	N/A	*Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?*
X			MEASURE: HEDIS INTERVENTION: # of successful CM phone calls made at the 2 week postpartum dates, # of postpartum assessments completed and the # of deliveries, # of Baby Shower attendees who have made a postpartum visit within the recommended date range, # of CentAccount rewards earned by women having a postpartum visit within the appropriate date range
			Did the indicators track performance over a specified period of time?
X			Original documentation: 2013
			Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?
X			MHS has 4 measurable interventions that can impact the HEDIS measure.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No	N/A	*Were the enrollees to whom the study question and indicators are relevant clearly defined?*
X			Women with a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year
			If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?
X			MEASURE: HEDIS INTERVENTION: It appears that MHS captured the data.
			In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?
X			Baby shower attendees

Step 5: REVIEW SAMPLING METHODS

Yes	No	N/A	*Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?*
X			MEASURE: HEDIS INTERVENTION: MHS is reviewing the entire population that meets the specifications of the metric rather than just a sample.
			If not HEDIS: Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?
		X	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)			
			If not HEDIS: Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:
		X	
			If not HEDIS: Did the sample contain a sufficient number of enrollees?
		X	

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No	N/A	*Did the study design clearly specify the data to be collected?*
X			MEASURE: HEDIS
			Did the study design clearly specify the source of data?
X			Claims/Medical Record
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
X			a.) Yes b.) Yes c.) Compare to the prior period and the 2013 baseline d.) 90th HEDIS percentile, but none for the other metrics
			Were qualified staff and personnel used to collect the data?
X			Interview: The data goes from the data warehouse into HEDIS software. Parts of this process are in St. Louis and parts are done locally. The data is reviewed by the Quality Improvement Committee and Senior Executives.

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	*Were interventions developed to change behavior at the provider level? If yes, state below.*
X			- P4P payout for meeting the 75th percentile Quality Compass goal for timely postpartum visits for their assigned postpartum members
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			-Completing postpartum assessments -Case management phone calls two weeks after the birth -Baby Shower events -Cent Account rewards
			Were interventions developed to change behavior at the MCE level? If yes, state below.
	X		
			Are the interventions sufficient to be expected to improve outcomes?
		X	There is not enough data presented since MHS rebaselined all of its PIPs.
			Are the interventions culturally and linguistically appropriate?
	X		There was no evidence of cultural or linguistic considerations in the interventions.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	*Did the MCE conduct an analysis of the findings according to its data analysis plan?*
X			
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
		X	This is not available since MHS rebaseline its PIPs.
			Did the analysis identify statistical significance?
		X	This is not available since MHS rebaseline its PIPs.
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
		X	Nothing changed in the methodology
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
X			The Baby Shower proved very effective.

			ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
X			This is a baseline year. The Obestrics Case Management (OB CM) program was substantially revised in 2013. MHS decided to bring the program in house and not use a vendor. MHS has substantially increased the number of OB CMs. The rewards program was also enhanced. The 75th NCQA %tile was reached, falling short of goal. Challenges remain contacting women . MHS is attempting to improve contact rates.

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	*Does the reported improvement in performance have "face" validity (Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence)?*
		X	This is not available since MHS rebaselined its PIPs.
			Was there any documented, quantitative improvement in processes or outcomes of care?
		X	This is not available since MHS rebaselined its PIPs.
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
		X	This is not available since MHS rebaselined its PIPs.

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	*Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?*
	X		
			Was the same methodology as the baseline measurement used when measurement was repeated?
		X	This is not available since MHS rebaselined its PIPs.

ACTIVITY 2: Verifying Study Findings (Non completed - Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS:

High confidence in reported MCO PIP results	**X**
Confidence in reported MCO PIP results	
Low confidence in reported MCO PIP results	
Reported MCO PIP results not credible	

B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued.

MCO	MHS
Focus Period	1/1/13 - 12/31/13
HHW/HIP/Both	Both

Name of Performance Improvement Project (PIP)	
ER Utilization	
Is this a Recurring PIP? If yes, state # years	1

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No	N/A	*Is the PIP consistent with the demographics and epidemiology of the enrollees?*
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No	N/A	*Was the study question/objective of the PIP clearly stated and properly defined?*
X			-Is telephonic counseling effective in reducing ER utilization rates among members with ≥ 3 ER visits in a 6-month period? -Does RCP lock-in* result in decreased ER utilization among members whose use of ER services and narcotics exceeds the norm? [* Lock-in restricts RCP members to one hospital, one PMP and one pharmacy. RCP candidates are identified via comprehensive review of claims/clinical/other data and consultations as applicable.]

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No	N/A	*Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?*
X			MEASURE: HEDIS INTERVENTION: # of members identified as frequent ER utilizers who could be reached and educated by CM, # of potential candidates screened for RCP and the # of members actually entered into the program
			Did the indicators track performance over a specified period of time?
X			Original documentation: 2013
			Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?
X			MHS has 2 measurable interventions that can impact the HEDIS measure.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No	N/A	*Were the enrollees to whom the study question and indicators are relevant clearly defined?*
X			Members identified as frequent ER utilizers and candidates screened for RCP
			If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?
		X	
			In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?
X			Members identified as frequent ER utilizers and candidates screened for RCP. Previous data broke the utilization out by age and inappropriate versus appropriate visits.

Step 5: REVIEW SAMPLING METHODS

Yes	No	N/A	*Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?*
X			MEASURE: HEDIS INTERVENTION: MHS is reviewing the entire population that meets the specifications of the metric rather than just a sample.
			If not HEDIS: Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?
		X	
			If not HEDIS: Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:
		X	
			If not HEDIS: Did the sample contain a sufficient number of enrollees?
		X	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No	N/A	*Did the study design clearly specify the data to be collected?*
X			MEASURE: HEDIS INTERVENTION: # of members identified as frequent ER utilizers who could be reached and educated by CM, # of potential candidates screened for RCP and the # of members actually entered into the program
			Did the study design clearly specify the source of data?
X	X		MEASURE: claims INTERVENTION: not specified
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
X			a.) Yes b.) Yes c.) 2013 baseline d.) HEDIS 10th percentile benchmark rate but none for the interventions.
			Were qualified staff and personnel used to collect the data?
X			Interview: The data goes from the data warehouse into HEDIS software. Parts of this process are in St. Louis and parts are done locally. The data is reviewed by the Quality Improvement Committee and Senior Executives.

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	*Were interventions developed to change behavior at the provider level? If yes, state below.*
	X		
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			-ER diversion counseling -Enrollment into the Right Choices Program
			Were interventions developed to change behavior at the MCE level? If yes, state below.
	X		
			Are the interventions sufficient to be expected to improve outcomes?
		X	There is not enough data presented since MHS rebaselined all of its PIPs.
			Are the interventions culturally and linguistically appropriate?
	X		There was no evidence of cultural or linguistic considerations in the interventions.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	*Did the MCE conduct an analysis of the findings according to its data analysis plan?*
X			
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
		X	This is not available since MHS rebaselined its PIPs.
			Did the analysis identify statistical significance?
		X	This is not available since MHS rebaselined its PIPs.
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
		X	Nothing changed in the methodology
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
X			MHS analyzed the ER Diversion counseling program and found that the intervention is measurably effective in reaching members. It remains to be determined if the counseling results in decreasing ER utilization. Data query in progress..
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
X			

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	*Does the reported improvement in performance have "face" validity (Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence)?*
		X	This is not available since MHS rebaselined its PIPs.
			Was there any documented, quantitative improvement in processes or outcomes of care?
		X	This is not available since MHS rebaselined its PIPs.
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
		X	This is not available since MHS rebaselined its PIPs.

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	*Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?*
	X		
			Was the same methodology as the baseline measurement used when measurement was repeated?
		X	This is not available since MHS rebaselined its PIPs.

ACTIVITY 2: Verifying Study Findings (Non completed - Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS:

High confidence in reported MCO PIP results	**X**
Confidence in reported MCO PIP results	
Low confidence in reported MCO PIP results	
Reported MCO PIP results not credible	

B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued.

MCO	MHS	**Name of Performance Improvement Project (PIP)**	
Focus Period	1/1/13 - 12/31/13	Tobacco Cessation	
HHW/HIP/Both	Both	**Is this a Recurring PIP? If yes, state # years**	3

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No	N/A	*Is the PIP consistent with the demographics and epidemiology of the enrollees?*
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No	N/A	*Was the study question/objective of the PIP clearly stated and properly defined?*
X			-Does provision of smoking cessation education/referral information decrease the rate of smoking among pregnant MHS members? -Is Disease Management outreach (via the Puff-Free Pregnancy program) effective in decreasing smoking rates among pregnant members?

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No	N/A	*Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?*
X			MEASURE: CAHPS INTERVENTION: # of referrals made by CM to the Quit Line for pregnant women, Women referred to the Puff-Free Pregnancy program who stop smoking
			Did the indicators track performance over a specified period of time?
X			CY 2011-2013 (CAHPS 2012-2014)
			Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?
X			MHS has 2 measurable interventions that can impact the CAHPS measure.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No	N/A	*Were the enrollees to whom the study question and indicators are relevant clearly defined?*
X			MEASURE: MHS CAHPS survey respondents who indicated that they smoke cigarettes or use tobacco INTERVENTION: pregnant women who smoke
			If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?
		X	
			In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?
X			Pregnant women

Step 5: REVIEW SAMPLING METHODS

Yes	No	N/A	*Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?*
X			MEASURE: CAHPS INTERVENTION: MHS is reviewing the entire population that meets the specifications of the metric rather than just a sample.
			If not HEDIS: Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?
		X	
			If not HEDIS: Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:
		X	
			If not HEDIS: Did the sample contain a sufficient number of enrollees?
		X	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No	N/A	*Did the study design clearly specify the data to be collected?*
X			MEASURE: CAHPS survey results INTERVENTION: # of referrals made by CM to the Quit Line for pregnant women, Women referred to the Puff-Free Pregnancy program who stop smoking
			Did the study design clearly specify the source of data?
X			CAHPS and the TruCare system
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
X			Yes, with the exception of having multiple data comparison years. MHS rebaselined the data.
			Were qualified staff and personnel used to collect the data?
X			Interview: The data goes from the data warehouse into HEDIS software. Parts of this process are in St. Louis and parts are done locally. The data is reviewed by the Quality Improvement Committee and Senior Executives.

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	*Were interventions developed to change behavior at the provider level? If yes, state below.*
	X		
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			- Case managers make referrals to the Quit Line -Pregnant women are referred to the Puff-Free Pregnancy program
			Were interventions developed to change behavior at the MCE level? If yes, state below.
	X		
			Are the interventions sufficient to be expected to improve outcomes?
	X		It is difficult to determine if the interventions are successful since MHS has not been able to get outcome data from the Quit Line.
			Are the interventions culturally and linguistically appropriate?
	X		There was no evidence of cultural or linguistic considerations in the interventions.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	*Did the MCE conduct an analysis of the findings according to its data analysis plan?*
X			
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
		X	This is not available since MHS rebaselined its PIPs.
			Did the analysis identify statistical significance?
		X	This is not available since MHS rebaselined its PIPs.
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
X			Nothing changed in the methodology
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
X			For intervention #1, the measure requires ad hoc reporting drawn from the TruCare system. Presently, MHS only measure members referred from the CM pregnancy program. MHS will begin measuring referrals made from other components from the CM program such as cardiac, diabetes and respiratory disorders For intervention #2, MHS receives Quit Line reports which are only at the MCE level. They are waiting member specific reports since the plan level report does not differentiate between the entire membership and members who are pregnant. At this point in time, the only reliable numerator data is drawn from the Pregnancy Management Program.
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
X			

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	*Does the reported improvement in performance have "face" validity (Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence)?*
		X	No improvement
			Was there any documented, quantitative improvement in processes or outcomes of care?
	X		
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
		X	

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	*Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?*
	X		No improvement
			Was the same methodology as the baseline measurement used when measurement was repeated?
X			

ACTIVITY 2: Verifying Study Findings (Non completed - Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS:	
High confidence in reported MCO PIP results	
Confidence in reported MCO PIP results	**X**
Low confidence in reported MCO PIP results	
Reported MCO PIP results not credible	

B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued.

MCO	MDwise
Focus Period	1/1/13 - 12/31/13
HHW/HIP/Both	HHW Only

Name of Performance Improvement Project (PIP)	
Postpartum Care	
Is this a Recurring PIP? If yes, state # years	3

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No	N/A	*Is the PIP consistent with the demographics and epidemiology of the enrollees?*
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No	N/A	*Was the study question/objective of the PIP clearly stated and properly defined?*
X			-If an incentive is offered to pregnant women to get their postpartum exam, will it motivate them to get this exam?

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No	N/A	*Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?*
X			MEASURE: HEDIS INTERVENTION: Comparison of members redeeming rewards for a gift card and and having postpartum visits
			Did the indicators track performance over a specified period of time?
X			HEDIS 2012 and 2014 (CY 2011 and 2013)
			Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?
X			It is hard to evaluate the effects of not providing a reward since all members are eligible for it.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No	N/A	*Were the enrollees to whom the study question and indicators are relevant clearly defined?*
X			All recently delivered MDwise members
			If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?
X			Yes, MDwise used HEDIS definitions
			In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?
X			Those redeeming rewards for a gift card and those not redeeming.

Step 5: REVIEW SAMPLING METHODS

Yes	No	N/A	*Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?*
X			MEASURE: HEDIS INTERVENTION: MDwise compared members redeeming rewards for a gift card and and having postpartum visits with those not. They utilized the entire HEDIS sample.
			If not HEDIS: Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?
		X	
			If not HEDIS: Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:
		X	
			If not HEDIS: Did the sample contain a sufficient number of enrollees?
		X	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No	N/A	
			Did the study design clearly specify the data to be collected?
X			The HEDIS defined numerator and denominator were used and then compared to the list of members who redeemed gift cards.
			Did the study design clearly specify the source of data?
X			MEASURE: Claims, Medical Records INTERVENTION: Unknown
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
X	X		Yes to all for the measures. No benchmarks for the interventions.
			Were qualified staff and personnel used to collect the data?
	X		The report did not identify who was collecting the data.

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	
	X		*Were interventions developed to change behavior at the provider level? If yes, state below.*
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			-Incentive gift cards
			Were interventions developed to change behavior at the MCE level? If yes, state below.
	X		
			Are the interventions sufficient to be expected to improve outcomes?
		X	MDwise measured the results of its member incentive intervention in 2013 and 2014. 9-10% more members who redeemed points for a gift card got a postpartum care exam than those that did not get a gift card. However, all members are eligible for the incentive program. To measure the program's impact, MDwise would need to compare results before and after the program.
			Are the interventions culturally and linguistically appropriate?
	X		There was no evidence of cultural or linguistic considerations in the interventions.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	
X			*Did the MCE conduct an analysis of the findings according to its data analysis plan?*
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
X			MEASURE: Yes
			Did the analysis identify statistical significance?
X			MEASURE: Yes
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
		X	Nothing changed in the methodology
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
	X		MDwise believes that its intervention was a success, but the HEDIS rate did not change.
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
X			Additional drill down with the postpartum members related to the REWARDS program.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	*Does the reported improvement in performance have "face" validity (Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence)?*
	X		There was no improvement in the HEDIS rate.
			Was there any documented, quantitative improvement in processes or outcomes of care?
	X		There was no improvement in the HEDIS rate.
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
	X		There was no improvement in the HEDIS rate.

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	*Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?*
	X		There was no improvement in the HEDIS rate.
			Was the same methodology as the baseline measurement used when measurement was repeated?
X			

ACTIVITY 2: Verifying Study Findings (Non completed - Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

High confidence in reported MCO PIP results	**X**
Confidence in reported MCO PIP results	
Low confidence in reported MCO PIP results	
Reported MCO PIP results not credible	

B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued.

Indiana External Quality Review for Review Year CY 2013

Validating Performance Improvement Projects

MCO	MDwise
Focus Period	1/1/13 - 12/31/13
HHW/HIP/Both	Both

Name of Performance Improvement Project (PIP)	
ER Utilization	
Is this a Recurring PIP? If yes, state # years	3

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No	N/A	*Is the PIP consistent with the demographics and epidemiology of the enrollees?*
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No	N/A	*Was the study question/objective of the PIP clearly stated and properly defined?*
X			-Will a timely educational call following an inappropriate ER visit influence subsequent ER behaviors? -Will direct outreach and intervention by a case manager with non-RCP high utilizer members impact subsequent ER behavior? -Does restricting members to one doctor, one hospital and one pharmacy have any impact on ER behavior?

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No	N/A	*Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?*
X			-HEDIS AMB-A ER Visits per 1,000 -Inappropriate (MDwise defined) ER Visits (paid and denied) during the measurement year -ER visits per 1,000 for high utilizers (4+ visits/year)
			Did the indicators track performance over a specified period of time?
X			HEDIS 2012 and 2014 (CY 2011 and 2013)
			Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?
X			The three proposed measures each look at different aspects of utilization: total population, inappropriate visits, and high utilizers

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No	N/A	*Were the enrollees to whom the study question and indicators are relevant clearly defined?*
X	X		MDwise clearly defined some study groups: All enrollees with an ER visit, utilizers with 4+ visits per year, Right Choices Program enrollees. It did not clearly define "inappropriate" ER visits.
			If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?
		X	
			In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?
X			Utilizers with 4+ visits per year, Right Choices Program enrollees, individuals with "inappropriate" ER visits.

Step 5: REVIEW SAMPLING METHODS

Yes	No	N/A	*Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?*
X	X		MDwise is using both HEDIS sampling logic and self-defined measures.
			If not HEDIS: Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?
		X	For non-HEDIS measures there was 100% sample size.
			If not HEDIS: Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:
		X	
			If not HEDIS: Did the sample contain a sufficient number of enrollees?
X			

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)			

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No	N/A	*Did the study design clearly specify the data to be collected?*
X			-HEDIS AMB-A ER Visits per 1,000 -Inappropriate (MDwise defined) ER Visits (paid and denied) during the measurement year -ER visits per 1,000 for high utilizers (4+ visits/year) -ER claims 6 months prior and 6 months post intervention for automated call, case management, or RCP
			Did the study design clearly specify the source of data?
X			ER claims data, enrollment data, call data
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
X			a.) Yes b.) Yes c.) Yes d.) There are benchmarks for the HEDIS metrics but not the other measures.
			Were qualified staff and personnel used to collect the data?
	X		The report did not identify who was collecting the data.

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	*Were interventions developed to change behavior at the provider level? If yes, state below.*
	X		
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			-Automated call intervention -Case manager contacts the member -Right Choices Program enrollment
			Were interventions developed to change behavior at the MCE level? If yes, state below.
	X		
			Are the interventions sufficient to be expected to improve outcomes?
X			
			Are the interventions culturally and linguistically appropriate?
	X		There was no evidence of cultural or linguistic considerations in the interventions.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	*Did the MCE conduct an analysis of the findings according to its data analysis plan?*
X			MDwise found that the automated phone calls seem to have some impact influencing post call visits to the ER.
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
X			The study includes both multi-year measurements and new measures.
			Did the analysis identify statistical significance?
X			For the HEDIS measure
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
		X	Nothing changed in the methodology
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
X			MDwise found that the automated phone calls seem to have some impact influencing post call visits to the ER.
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
X			For the automated call intervention, MDwise has evidence that it can be impactful and is a low cost intervention. The other two interventions are ones that MDwise has just established baselines for and looks forward to analyzing results.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)			

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	*Does the reported improvement in performance have "face" validity (Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence)?*
	X		There was no improvement in the HEDIS rate.
			Was there any documented, quantitative improvement in processes or outcomes of care?
	X		There was no improvement in the HEDIS rate.
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
	X		There was no improvement in the HEDIS rate.

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	*Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?*
	X		There was no improvement in the HEDIS rate.
			Was the same methodology as the baseline measurement used when measurement was repeated?
X			

ACTIVITY 2: Verifying Study Findings (Non completed - Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS:		
	High confidence in reported MCO PIP results	**X**
	Confidence in reported MCO PIP results	
	Low confidence in reported MCO PIP results	
	Reported MCO PIP results not credible	

B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued. Additionally, MDwise needs to ensure they develop goal and benchmark rates for all measures.

Indiana External Quality Review for Review Year CY 2013

Validating Performance Improvement Projects

MCO	MDwise
Focus Period	1/1/13 - 12/31/13
HHW/HIP/Both	Both

Name of Performance Improvement Project (PIP)	
Tobacco Cessation	
Is this a Recurring PIP? If yes, state # years	3

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No	N/A	*Is the PIP consistent with the demographics and epidemiology of the enrollees?*
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No	N/A	*Was the study question/objective of the PIP clearly stated and properly defined?*
X			-Will an IVR call reminding members that their providers can help them with tobacco cessation impact their recollection of provider conversations on this topic? -Will a large format, colorful postcard reminding members that their providers can help them with tobacco cessation impact their recollection of provider conversations on this topic?

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No	N/A	*Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?*
	X		Because MDwise chose to measure only the change in the CAHPS rate, it is difficult for them to determine if their interventions work since the sample of members surveyed is not available.
			Did the indicators track performance over a specified period of time?
X			CY 2011-2013 (CAHPS 2012-2014)
			Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?
X			The interventions address the CAHPS question, but it is not clear that they affect the smoking cessation rate.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No	N/A	*Were the enrollees to whom the study question and indicators are relevant clearly defined?*
	X		It is not clear who gets the calls and who gets the postcards.
			If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?
		X	
			In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?
	X		

Step 5: REVIEW SAMPLING METHODS

Yes	No	N/A	*Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?*
X			MEASURE: They used CAHPS sampling methodology. INTERVENTION: It is not clear how members were selected for a call or a postcard.
			If not HEDIS: Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?
	X		
			If not HEDIS: Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:
	X		
			If not HEDIS: Did the sample contain a sufficient number of enrollees?
X			

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No	N/A	
			Did the study design clearly specify the data to be collected?
	X		MEASURE: They used CAHPS sampling methodology. INTERVENTION: It is not clear how members were selected for a call or a postcard.
			Did the study design clearly specify the source of data?
X			MEASURE: CAHPS Survey INTERVENTION: Automated call system and mailing reports
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
X	X		a.) Yes b.) Not clear if this a sample of the Hoosier Healthwise population or the entire population of smokers c.) Yes d.) Yes, there are benchmarks for CAHPS
			Were qualified staff and personnel used to collect the data?
	X		The report did not identify who was collecting the data.

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	
	X		*Were interventions developed to change behavior at the provider level? If yes, state below.*
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			-Postcard -Automated call
			Were interventions developed to change behavior at the MCE level? If yes, state below.
	X		
			Are the interventions sufficient to be expected to improve outcomes?
		X	Since the CAHPS measure is non member-specific, there is no way to directly tie a specific intervention to a positive
			Are the interventions culturally and linguistically appropriate?
	X		There was no evidence of cultural or linguistic considerations in the interventions.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	
X			*Did the MCE conduct an analysis of the findings according to its data analysis plan?*
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
X			
			Did the analysis identify statistical significance?
X			MDwise measured statistical significance in the CAHPS rates.
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
		X	Nothing changed in the methodology
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
X			
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
X			MDwise noted that the rates increased and deduced that the interventions worked.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	*Does the reported improvement in performance have "face" validity (Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence)?*
	X		There is no way to connect the CAHPS cohort to the interventions.
			Was there any documented, quantitative improvement in processes or outcomes of care?
	X		The measures only show that the survey results increased. This does not prove that the interventions helped the member stop smoking.
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
X			The rate increased 6.4% from the baseline.

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	*Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?*
X			
			Was the same methodology as the baseline measurement used when measurement was repeated?
X			

ACTIVITY 2: Verifying Study Findings (Non completed - Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

High confidence in reported MCO PIP results	
Confidence in reported MCO PIP results	**X**
Low confidence in reported MCO PIP results	
Reported MCO PIP results not credible	

B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued.

APPENDIX E

CALCULATION OF NON-EMERGENCY MEDICAL TRANSPORTATION BY DEFINED COHORTS

Indiana External Quality Review for Review Year 2013
Appendix E

Calculation of Non-Emergency Medical Transportation for Defined Cohorts per MCE, by County
(Bold text in calculation indicates at or above the statewide 90th percentile for the defined cohort)

County	Anthem			MHS			MDwise		
	Transports per 1,000 Member Months	Providers per 1,000 Member Months	Average Distance Per Trip	Transports per 1,000 Member Months	Providers per 1,000 Member Months	Average Distance Per Trip	Transports per 1,000 Member Months	Providers per 1,000 Member Months	Average Distance Per Trip
Adams	6	0.57	14	8	0.28	20	14	0.11	37
Allen	15	**0.03**	7	13	0.06	10	**29**	**0.02**	12
Bartholomew	**37**	0.27	21	15	0.07	21	**29**	**0.04**	37
Benton	14	2.63	37	11	1.18	35	5	0.16	50
Blackford	8	0.48	25	14	0.75	21	23	0.10	34
Boone	11	0.44	14	5	0.13	8	4	0.26	23
Brown	1	0.38	0	15	0.23	6	7	0.46	34
Carroll	**31**	1.72	8	4	1.27	26	6	0.10	38
Cass	24	0.77	19	5	0.54	31	14	0.07	51
Clark	15	0.10	3	6	0.07	5	20	0.11	12
Clay	9	0.24	23	3	0.90	19	15	0.07	35
Clinton	5	0.81	14	13	0.56	22	1	**0.03**	**69**
Crawford	12	0.32	28	**30**	0.27	33	2	1.50	**121**
Daviess	17	0.06	27	15	0.16	26	**32**	0.18	40
Dearborn	5	0.14	13	16	0.22	19	11	0.05	26
Decatur	16	0.34	32	11	0.76	12	12	0.15	40
Dekalb	2	0.27	18	2	0.45	29	3	0.08	35
Delaware	18	0.11	31	10	0.06	27	10	**0.04**	33
Dubois	10	0.58	24	9	0.14	32	12	1.17	**74**
Elkhart	10	0.06	14	9	**0.01**	31	10	0.13	32
Fayette	8	0.14	35	8	0.47	32	9	**0.04**	50
Floyd	20	0.06	3	23	0.21	6	**46**	0.21	8
Fountain	4	0.64	43	10	0.78	40	20	0.06	39
Franklin	4	0.20	44	5	0.44	18	2	0.19	**354**
Fulton	10	0.41	15	3	0.13	**64**	18	0.26	34
Gibson	12	0.09	30	**29**	0.68	10	18	0.12	35
Grant	16	0.14	27	12	0.06	23	16	0.09	34
Greene	20	0.11	37	20	0.57	16	**31**	0.09	39
Hamilton	6	0.10	8	4	0.05	3	5	0.10	18
Hancock	8	0.07	13	4	0.56	31	5	0.53	31
Harrison	9	0.06	18	3	0.41	25	19	0.37	27
Hendricks	9	0.13	7	2	0.07	8	8	**0.04**	19

Calculation of Non-Emergency Medical Transportation for Defined Cohorts per MCE, by County

(Bold text in calculation indicates at or above the statewide 90th percentile for the defined cohort)

County	Anthem			MHS			MDwise		
	Transports per 1,000 Member Months	Providers per 1,000 Member Months	Average Distance Per Trip	Transports per 1,000 Member Months	Providers per 1,000 Member Months	Average Distance Per Trip	Transports per 1,000 Member Months	Providers per 1,000 Member Months	Average Distance Per Trip
Henry	18	0.19	22	11	0.37	12	25	**0.04**	36
Howard	18	0.16	**68**	26	0.11	**66**	17	0.05	44
Huntington	5	0.61	6	7	0.42	13	10	0.08	24
Jackson	27	0.34	25	19	0.21	29	26	0.14	25
Jasper	3	0.52	19	3	0.31	35	1	0.07	**131**
Jay	2	0.28	40	10	0.38	20	2	0.10	**88**
Jefferson	**29**	1.18	29	8	0.13	45	20	0.51	25
Jennings	19	0.50	20	13	0.30	17	**42**	**0.04**	41
Johnson	8	**0.04**	11	7	0.07	7	26	0.12	13
Knox	**40**	0.19	37	19	0.06	34	**36**	0.46	41
Kosciusko	4	0.25	6	3	0.07	26	6	0.06	56
Lagrange	3	0.53	**120**	3	0.23	**88**	1	0.16	**203**
Lake	**30**	**0.03**	7	**29**	**0.03**	12	21	**0.02**	20
Laporte	9	0.09	29	10	0.13	34	15	0.08	**57**
Lawrence	8	0.13	20	9	0.34	14	9	0.11	52
Madison	10	**0.03**	16	10	**0.04**	12	11	0.26	31
Marion	19	**0.01**	3	18	**0.02**	4	**40**	**0.01**	9
Marshall	8	0.28	15	9	0.13	23	8	0.06	34
Martin	9	0.49	30	13	0.36	41	11	0.47	**98**
Miami	5	0.44	14	9	0.45	26	6	0.06	30
Monroe	12	0.05	27	22	0.11	19	18	0.48	30
Montgomery	19	0.22	20	**31**	0.14	26	**31**	0.10	30
Morgan	22	0.11	22	21	0.11	11	11	0.08	17
Newton	8	1.29	24	18	0.65	46	8	0.13	**64**
Noble	2	0.29	6	8	0.18	6	3	**0.03**	48
Ohio	0	4.20	0	0	6.10	0	7	0.24	47
Orange	7	0.74	23	18	0.26	21	**38**	0.36	43
Owen	8	0.20	21	21	0.27	16	21	0.26	29
Parke	**32**	0.27	9	5	0.64	18	8	0.06	37
Perry	6	0.08	24	2	0.29	29	28	0.51	**57**
Pike	16	0.31	35	5	0.36	23	**29**	0.65	37
Porter	11	0.07	19	9	0.11	25	4	0.05	54

Calculation of Non-Emergency Medical Transportation for Defined Cohorts per MCE, by County

(Bold text in calculation indicates at or above the statewide 90th percentile for the defined cohort)

County	Anthem			MHS			MDwise		
	Transports per 1,000 Member Months	Providers per 1,000 Member Months	Average Distance Per Trip	Transports per 1,000 Member Months	Providers per 1,000 Member Months	Average Distance Per Trip	Transports per 1,000 Member Months	Providers per 1,000 Member Months	Average Distance Per Trip
Posey	20	0.11	18	12	0.19	29	**31**	0.25	33
Pulaski	3	1.15	**119**	4	0.37	52	8	0.19	56
Putnam	11	0.05	28	13	0.08	17	17	0.24	**69**
Randolph	5	1.17	28	3	0.87	24	11	**0.03**	48
Ripley	4	0.28	11	3	0.70	27	16	0.06	36
Rush	5	0.16	27	21	0.50	14	21	0.28	28
St. Joseph	12	**0.03**	16	10	**0.01**	13	15	0.10	20
Scott	20	0.51	25	28	0.48	29	**43**	0.11	29
Shelby	8	0.16	11	10	0.05	13	14	0.39	38
Spencer	10	0.13	39	13	0.14	**58**	5	0.34	**80**
Starke	12	0.22	38	9	0.23	47	4	0.05	**87**
Steuben	4	0.61	31	3	0.16	32	3	0.17	**64**
Sullivan	25	0.23	16	17	1.73	8	**29**	0.11	33
Switzerland	**49**	1.40	**59**	8	0.32	24	15	0.17	55
Tippecanoe	10	0.06	12	17	0.05	15	1	**0.05**	**85**
Tipton	4	0.55	43	2	0.26	23	5	0.53	49
Union	6	1.25	14	4	1.80	11	10	0.19	42
Vanderburgh	**30**	**0.01**	9	16	0.09	24	**44**	0.12	16
Vermillion	24	0.28	35	2	1.06	25	8	0.06	**68**
Vigo	21	0.09	12	13	0.36	22	18	**0.02**	28
Wabash	2	0.63	10	1	0.35	28	4	0.09	44
Warren	0	2.66	0	6	3.14	30	14	0.30	50
Warrick	9	**0.03**	20	14	0.20	35	**35**	0.22	34
Washington	21	0.10	28	12	0.25	33	23	0.11	29
Wayne	20	0.55	20	21	0.08	25	21	0.05	26
Wells	1	0.49	15	0	1.03	0	4	0.08	27
White	2	1.36	**69**	16	0.33	15	2	0.22	**67**
Whitley	2	1.26	25	11	2.45	16	1	**0.05**	**75**

APPENDIX F

PROVIDER INTERVIEW PROTOCOL

Indiana External Quality Review for Review Year 2013
Appendix F: Provider Interview Protocol

CY 2014 HHW/HIP EQR
Provider Telephone Interview Questions

Date:	
Provider Type:	Primary Care / FQHC / RHC / CMHC / Specialist
Provider Name:	
Person Interviewed:	

1) Which MCE is interview regarding?	Anthem	Yes	No
	MDwise	Yes	No
	MHS	Yes	No

2) Do you know who your provider representative is?		Yes	No

								Notes/Comments
3) How helpful are the visits from your provider representative, with 1 being not helpful and 5 being very helpful?	Anthem	1	2	3	4	5	N/A	
	MDwise	1	2	3	4	5	N/A	
	MHS	1	2	3	4	5	N/A	
4) How knowledgeable is your provider representative, with 1 being not knowledgeable and 5 being very knowledgeable?	Anthem	1	2	3	4	5	N/A	
	MDwise	1	2	3	4	5	N/A	
	MHS	1	2	3	4	5	N/A	
5) How easy is it to reach your provider representative, with 1 being very difficult to reach and 5 being very easy to reach?	Anthem	1	2	3	4	5	N/A	
	MDwise	1	2	3	4	5	N/A	
	MHS	1	2	3	4	5	N/A	
6) How well does your provider representative follow-up with you, with 1 being does not follow-up and 5 being always follows-up promptly?	Anthem	1	2	3	4	5	N/A	
	MDwise	1	2	3	4	5	N/A	
	MHS	1	2	3	4	5	N/A	
7) Do you find that your provider representative is available to visit your office if you request a visit, with 1 being never available and 5 being always available?	Anthem	1	2	3	4	5	N/A	
	MDwise	1	2	3	4	5	N/A	
	MHS	1	2	3	4	5	N/A	
8) How accommodating to your needs or requests is your provider representative, with 1 being not accommodating and 5 being very accommodating?	Anthem	1	2	3	4	5	N/A	
	MDwise	1	2	3	4	5	N/A	
	MHS	1	2	3	4	5	N/A	
9) How often does your provider representative provide you with correct information, with 1 being never provide correct information and 5 being always provides correct information?	Anthem	1	2	3	4	5	N/A	
	MDwise	1	2	3	4	5	N/A	
	MHS	1	2	3	4	5	N/A	
10) Does your provider representative keep you informed about new products,	Anthem	1	2	3	4	5	N/A	

services, policies, and forms, with 1 being does not keep you informed and 5 being always keeps you informed?	MDwise	1	2	3	4	5	N/A	
	MHS	1	2	3	4	5	N/A	

11) Are the materials provided to you by your provider representative useful, with 1 being materials are not useful and 5 being materials are very useful?	Anthem	1	2	3	4	5	N/A	
	MDwise	1	2	3	4	5	N/A	
	MHS	1	2	3	4	5	N/A	

12) Does your provider representative assist you with referring members to specialists, with 1 being will not assist and 5 being always will assist?	Anthem	1	2	3	4	5	N/A	
	MDwise	1	2	3	4	5	N/A	
	MHS	1	2	3	4	5	N/A	

13) Do you find that the toll-free provider helpline is helpful, with 1 being not helpful and 5 being very helpful?	Anthem	1	2	3	4	5	N/A	
	MDwise	1	2	3	4	5	N/A	
	MHS	1	2	3	4	5	N/A	

14) Do you find that the toll-free provider helpline provides you with accurate information, with 1 being information is never accurate and 5 being information is always accurate?	Anthem	1	2	3	4	5	N/A	
	MDwise	1	2	3	4	5	N/A	
	MHS	1	2	3	4	5	N/A	

15) Do you find that the toll-free provider helpline staff are polite and courteous, with 1 being never polite or courteous and 5 being always polite and courteous?	Anthem	1	2	3	4	5	N/A	
	MDwise	1	2	3	4	5	N/A	
	MHS	1	2	3	4	5	N/A	

16) Do the toll-free provider helpline staff assist your with referring members to specialists, with 1 being will not assist and 5 being always will assist?	Anthem	1	2	3	4	5	N/A	
	MDwise	1	2	3	4	5	N/A	
	MHS	1	2	3	4	5	N/A	

17) Which do you find more helpful: your provider representative, the provider helpline, both or neither?	Anthem	Provider Representative	Provider Helpline	Both	Neither	
	MDwise	Provider Representative	Provider Helpline	Both	Neither	
	MHS	Provider Representative	Provider Helpline	Both	Neither	

18) What can your provider representative do to be more helpful?	Anthem	
	MDwise	
	MHS	

19) Is there anything else you would like to share about your provider representative or the provider helpline?	Anthem	
	MDwise	
	MHS	

3. With the increased managed care enrollment of adults and people with disabilities in 2015 due to Hoosier Care Connect and HIP 2.0, Indiana Medicaid should enhance its MCE and provider guidance on Medicare disenrollment practices. These instructions should include when to recover payments made to providers, when to stop paying for Medicare eligible members, what to do in cases of retroactive Medicare eligibility, and impact to capitation payments (i.e., how will the capitation be recovered).

4. Indiana Medicaid should consider defining timely filing standards for claims with TPL to create consistency. Currently each MCE has its own timeline (90 from claim vs. 90 from EOB vs. 360 from EOB.