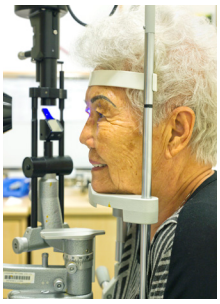
Hoosier CARE CONNECT

Hoosier Healthwise Health Care Program

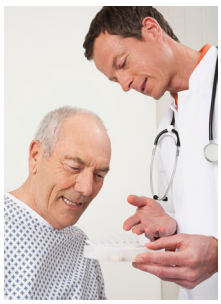
HIP HEALTHY INDIANA PLAN









External Quality Review of Indiana's Health Coverage Programs: Healthy Indiana Plan 2.0, Hoosier Healthwise and Hoosier Care Connect

Review Year Calendar 2019

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FINAL REPORT
2020 External Quality Review of Indiana's Health Coverage Programs:
Hoosier Healthwise, Hoosier Care Connect and Healthy Indiana Plan

ACKNOWLEDGMENTS

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Burns & Associates, Inc. would like to thank the staff at Anthem, CareSource, Managed Health Services and MDwise for their assistance in providing documentation and assistance in planning for the onsite portion of this review. We would also like to thank Susan Beecher and Meredith Edwards at the Office of Medicaid Policy and Planning for their assistance during the course of this study.

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TABLE OF CONTENTS

FINAL REPORT
2020 External Quality Review of Indiana's Health Coverage Programs:
Hoosier Healthwise, Hoosier Care Connect and Healthy Indiana Plan

Section VIII: Focus Study on Claims Adjudication and Encounter Submissions

ABBREVIATIONS LIST

Abbrev	Meaning
AAP	Adult Access to Preventive/Ambulatory Health Svc
ADV	Annual Dental Visit
AHRQ	Agency for Healthcare Research and Quality
AMM	Asthma Medication Management
AOD	Alcohol or Other Drug Dependence
APRN	Advanced Practice Registered Nurse
B&A	Burns & Associates, Inc.
BH	Behavioral Health
CHAT	Completion of Comprehensive Health Assessment Tool
CHIP	Children's Health Insurance Program
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CPT	Current Procedural Terminology
CY	Calendar Year
DXC	DXC Technology (OMPP's fiscal agent)
E&M	Evaluation and Management
ED	Emergency Department
EDW	Enterprise Data Warehouse
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FEIN	Federal Employer Identification Number
FFS	Fee-For-Service
FPC	Frequency of Postpartum Care Visit
FPL	Federal Poverty Level
FSSA	Family and Social Services Administration
FUH	Follow-Up Visit After Inpatient Psychiatric Hospitaliz.
HEDIS	Healthcare Effectiveness Data and Information Set
HCC	Hoosier Care Connect

Abbrev	Meaning
HHW	Hoosier Healthwise
HIP	Healthy Indiana Plan 2.0
HMO	Health Maintenance Organization
HNS	Health Needs Screening
IHCP	Indiana Health Coverage Programs
ISDH	Indiana State Department of Health
JOB	Job Connect Program
LSC	Lead Screening in Children
MCE	Managed Care Entity
MCO	Managed Care Organization
MHS	Managed Health Services
MMA	Medication Management for People with Asthma
MMR	Measles, Mumps, Rubella
NCQA	National Committee for Quality Assurance
NEMT	Non-emergency Medical Transportation
NPI	National Provider Identifier
OB-GYN	Obstetrics and Gynecology
OMPP	Office of Medicaid Policy and Planning
P4O	Pay For Outcomes
PIPs	Performance Improvement Projects
PMP	Primary Medical Provider
POWER	Personal Wellness and Responsibility Account
PPC	Prenatal and Postpartum Care
PQI	Prevention Quality Indicator
QIP	Quality Improvement Project
SAS	Statistical Analysis System
SED/SMI	Serious Emotional Disturbance/Serious Mental Illness
SUD	Substance Use Disorder
W15	Well Care Child Visit, First 15 Months of Life
W34	Well Care Child Visit, Third through Sixth Years of Life

FINAL REPORT
2020 External Quality Review of Indiana's Health Coverage Programs:
Hoosier Healthwise, Hoosier Care Connect and Healthy Indiana Plan

EXECUTIVE SUMMARY

The Indiana Family and Social Services Administration's (FSSA's) Office of Medicaid Policy and Planning (OMPP) has responsibility for the administration and oversight of Indiana's Medicaid program under waiver and state plan authorities. There are three risk-based managed care programs in place and each serves a targeted population—Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC).

The **Hoosier Healthwise (HHW)** program started as a voluntary program where, beginning in 1996, Medicaid members could enroll with a managed care entity (MCE)[1]. By 2005, enrollment with an MCE was mandatory for select populations—namely, low income families, pregnant women, and children including those enrolled in Indiana's Children's Health Insurance Program (CHIP). The HHW program is authorized by a 1932(a) state plan amendment.

The **Healthy Indiana Plan (HIP)** was first created in January 2008 under a separate Section 1115 waiver authority. This program covered uninsured custodial parents and caretakers of Medicaid and CHIP children as well as noncustodial adults ages 19 through 64 who were not otherwise eligible for Medicaid or Medicare. The State received a new Section 1115 demonstration waiver authority from the Centers for Medicare & Medicaid Services (CMS) to change the design of HIP (the original version now referred to as HIP 1.0) to a non-traditional Medicaid model (the new version called HIP 2.0) that terminated HIP 1.0 on January 31, 2015. The HIP 2.0 model began February 1, 2015 as a health insurance program for uninsured adults with incomes under 138 percent of the Federal Poverty Level (FPL) between the ages of 19 and 64. In addition to the existing HIP 1.0 enrollees, adults from the HHW program (with some exceptions) were transitioned into HIP 2.0. Additionally, individuals in the federal marketplace under 138 percent FPL were allowed to join HIP 2.0 at this time.

The **Hoosier Care Connect (HCC)** program was implemented April 1, 2015 under Section 1915(b) waiver authority. Enabling state legislation tasked the FSSA with considering a managed care model for the aged, blind and disabled Medicaid enrollees. HCC is a risk-based program that contracts with MCEs to administer and to deliver services to members. The HCC replaced a predecessor program that was not full-risk (Care Select) which ended June 30, 2015.

There were four MCEs that contracted with the OMPP to administer services to its managed care programs in CY 2019, which is the focus of this External Quality Review (EQR):

- Anthem Insurance Companies, Inc. (Anthem) has been under contract with Indiana Medicaid since 2007. Anthem serves members in HHW, HIP and HCC.
- Coordinated Care Corporation, Inc. d/b/a Managed Health Services (MHS) is a subsidiary of the Centene Corporation and has been under contract with Indiana Medicaid since the inception of HHW in 1994. MHS also serves members in HHW, HIP and HCC.
- MDwise, a McLaren company, has been participating in Indiana's managed care delivery system since the inception of HHW. MDwise serves members in HHW and HIP.
- The newest MCE, CareSource, began contracting with the State in January 2017. CareSource serves members in HHW and HIP.

[1] 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.

Net enrollment in Indiana Medicaid's program increased 1.9 percent overall from December 2018 to December 2019, but enrollment in managed care was flat during this time.[2] During 2019, the enrollment in HCC remained constant (90,594 members in December 2019). Enrollment in HHW saw a modest increase (600,164 members in December 2019) while enrollment in HIP saw a modest decrease (389,307 members in December 2019).

As of December 2019, the overall managed care enrollment for Indiana Medicaid was 74.9 percent of a total of 1.44 million Medicaid enrollees. Considering all three managed care programs together, Anthem had 42 percent of total managed care enrollment; CareSource had 8 percent; MDwise had 27 percent; and MHS had 23 percent.

EQRO Activities in CY 2020

Burns & Associates (B&A) has served as the External Quality Review Organization (EQRO) and has conducted annual EQRs for the OMPP each year since 2007. B&A has relied on the EQR protocols defined by CMS to conduct its reviews. B&A utilized the protocols released by CMS in October 2019 to serve as the basis for the format of the EQR this year.

The focus of the CY 2020 EQR is MCE activities that occurred in CY 2019. Topics include:

- Validation of Performance Measures
- Validation of MCE Performance Improvement Projects
- Examination of Provider Network Adequacy at Each MCE
- Optional EQR Activity: Focus Study on Lead Testing
- Optional EQR Activity: Focus Study on the Utilization and Delivery of Non-Emergency Medical Transportation (NEMT)
- Optional EQR Activity: Focus Study on Claims Adjudication and Encounter Submissions

All of the tasks in this year's EQR were conducted during May through August, 2020. Due to the pandemic, meetings that have customarily been conducted in person with each MCE were conducted via video webinar. Specific meetings were set up one-on-one with each MCE to cover the topics in the focus studies as well as the validation of performance measures. The meetings were conducted to review B&A's initial findings from each focus study so that the MCEs had an opportunity to provide feedback before this report was finalized. In total, five webinars were held with each MCE during the EQR.

Validation of Performance Measures

In the CY 2020 EQR, B&A validated four measures reported by the MCEs as required on a report in the OMPP's MCE Reporting Manual. The specific report is Report 0403: Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicator (PQI) Measures. These measures are required to be reported for the HIP and HCC programs. The four PQI measures relate to inpatient discharges for diabetes, chronic obstructive pulmonary disease (COPD), heart failure and asthma.

B&A conducted an intake of the four quarterly 0403 reports submitted by each MCE and compared quarter-by-quarter results for face validity. We then compared and contrasted the results from each MCE to assess similarities and variances in the results. Using the encounters and enrollment data received from the State's Enterprise Data Warehouse (EDW) through May 31, 2020, B&A prepared a dataset for this

[2] Source: OMPP Enterprise Data Warehouse as of August 2020.

study. Using the technical specifications released by the AHRQ, B&A computed its own results for each MCE/program for each of the four quarters in CY 2019 and then compared our results to those reported by each MCE. Summary tables showing the side-by-side comparison of each measure were prepared for the 1:1 meeting with each MCE. The MCEs were given the opportunity to request additional data from B&A to conduct their own analyses when initial variances were found.

In the end, B&A found only two occurrences out of 96 in total where there was significant variance between what B&A computed for the measure and what the MCE reported. There were 64 measures compared in the HIP program (4 MCEs * 4 measures * 4 quarters) and 32 measures compared in the HCC program (2 MCEs * 4 measures * 4 quarters).

Validation of Performance Improvement Projects

The OMPP uses the term "Quality Improvement Project" (QIP) to describe the projects in this review. B&A reviewed 18 QIPs in this year's EQR as follows:

Inventory of the Quality Improvement Programs Reviewed in the 2020 EQR

	Anthem			Caresource		MDwise		MHS		
QIP Topic (red X means new in 2019)	**HHW**	**HCC**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HCC**	**HIP**
AOD Treatment								X	X	X
Adult Preventive Care Visit		X	X							
Annual Dental Visit	X									
Asthma Medication Management						X				
Behavioral Health Utilization								X	X	X
ED Utilization		X	X	X	X					
Follow-up Psychiatric Hospitalization	X	X	X				X			
Health Needs Screening	X	X	X	X	X	X	X	X	X	X
Job Connect Program					X					
Lead Testing				X		X				
Prenatal and Postpartum Care						X	X			
Well Child Visits (Age 3-6)				X						

Throughout this report, references to "QIPs" means the same thing as "PIPs" in CMS's EQR Protocol 1. The MCEs are required to submit to the OMPP quarterly updates on their QIPs as well as an annual report after the study year (which is defined as CY 2019).

The B&A EQR team members reviewed each of the QIP annual reports as well as the interim quarterly reports as part of a desk review. It was observed that most of the QIPs in place in CY 2019 were continuations of QIPs put in place in previous years. Because of the review team's familiarity with the QIPs and due to the pandemic, B&A supplemented its desk review with follow-up questions for each MCE to respond to in written format in lieu of an onsite review.

In Section IV of this report, B&A offers its assessment of the measures selected by each MCE for its QIPs, the definition of interventions, and the effectiveness of results from the interventions conducted. A one-page summary is also offered that highlights information on the QIPs from each MCE. One recommendation by B&A for all MCEs relates to interventions. Many of the interventions as defined were found to be more passive in nature and have carried across multiple years with limited success. As the MCEs begin new QIPs, it is recommended that more robust interventions be considered.

Examination of Provider Network Adequacy

In the CY 2019 EQR, B&A conducted a study of network adequacy by focusing on nine provider specialty categories. This included five categories with a high volume of services used by members (primary care, dental, prenatal/postpartum care, substance use disorder treatment, and behavioral health services). Four acute care specialties were also selected. B&A used utilization from the CY 2018 (3.8 million Medicaid member trips in total) to compute the driving distance between the member's home and the provider's location. The average driving distance was computed by provider category, by county, and by OMPP program for each MCE. These values were compared to OMPP's contract requirements for distance standards. B&A recognizes that this is a stricter measure of provider availability than what could be considered because members may choose to obtain services from a provider that they prefer that is further from their home from another provider. Nonetheless, B&A believes that the average driving distance is a truer representation of provider availability.

B&A repeated the same study for the five high-volume services that was conducted in CY 2019 during this CY 2020 EQR, but this time CY 2019 utilization was used. In addition to this, B&A added an additional validation. B&A followed the same methodology discussed above but expanded the provider categories to include all 41 categories defined in a report that was introduced by the OMPP in 2019 MCEs must not submit annually. Because the OMPP report uses criteria that differs from what B&A had used in its previous study, for some provider categories, the information was tabulated using both filters. By running the average distance test on all 41 provider categories on the OMPP report, B&A was able to validate the results reported by each MCE in its first submission under this new specification.

B&A also reviewed a second network adequacy report that was introduced by the OMPP in CY 2019. This report asks each MCE to report the count of enrolled providers across the same 41 categories at a point in time during the year. B&A examined the results submitted by each MCE across its multiple programs (HHW, HIP and HCC) as well as the results for a provider category across MCEs.

In the review of Report 0902, Count of Enrolled Providers, B&A found a high degree of variability reported across the MCEs for most categories. Each MCE has the option to build its own network, but every MCE is limited to those providers also enrolled in the OMPP's fee-for-service program. Anthem reported a significantly higher number of providers than their peers in a majority of categories while CareSource usually reported significantly fewer providers than their peers. Both MDwise and MHS reported some categories with provider counts that were significantly higher and others significantly lower than their peers. Specific findings are reported in Section V. B&A recommends that the OMPP ensure that the method used to count providers is clearly stated to ensure consistent reporting.

In the review of Report 0903, Member Access to Providers, every MCE reported few issues with member access against the OMPP distance standards when measuring potential accessibility to the nearest provider in their network for the 41 categories. The notable exceptions were hematologists (two MCEs), oral surgeons (two MCEs) and orthodontists (three MCEs) where access was more limited. When B&A validated these results, we found considerably greater access issues in some provider categories when considering only those members that had a service from a provider in the category in CY 2019. The largest variances observed between what the MCE reported (all members considered and closest available provider on record) to what B&A reported (considering only those that used the service in CY 2019) were for inpatient psychiatric services (all MCEs), primary medical providers (predominantly Anthem) and behavioral health providers (all MCEs).

When B&A conducted a root cause on these variances, it was observed that it may be due to the attribution of coordinates for distance travelled between a provider's home office and satellite offices

(e.g., a community mental health center) or between billing provider and rendering provider locations. Therefore, the variances reported by B&A may be overstated. B&A offers recommendations to the OMPP to enhance the report specifications to strengthen the integrity of these findings.

In the review of network adequacy comparing the average distance travelled for five high-volume services, improvement was found in most areas between CY 2018 and CY 2019. In particular:

Service Category	Average Distance Computed by MCE/Program		# Counties (out of 92) with Access Issues in CY18	Status of Distance Travelled in these Counties in CY19 Compared to CY18		
	From	To	Total	Improved	No Change	Worse
Primary Care	10.7	17.6	11	11	0	0
Dental	10.5	14.8	12	7	5	0
Prenatal/Postpartum	13.6	17.9	12	4	7	1
Substance Use Disorder	11.5	17.4	17	6	6	5
Behavioral Health	15.2	18.8	19	4	9	6

Focus Study on Lead Testing

In this year's EQR, B&A repeated a study originally conducted in the CY 2017 EQR which was updated in CY 2018 in order to assess if the rate of lead testing among Medicaid-enrolled children has improved. To do this, B&A independently tracked the rate of lead testing among children in the OMPP's managed care programs. Specifically, B&A reviewed the lead test rates at a point-in-time age (up to age six), the rate of lead testing for children continuously enrolled in Medicaid up to age six, the lead test rates in 2019 for Medicaid children in each of Indiana's 92 counties, the percentage of tests found with elevated lead levels (when the results are known), and the locations in the state where elevated lead test levels were found. A new item in this year's study was B&A's validation of results reported by each MCE in a new report required by the OMPP on a quarterly basis related to lead tests.

To conduct this study, B&A utilized data from the Indiana State Department of Health (ISDH) STELLAR database as well as paid claims for lead tests from each of the MCEs.

Overall, the rate of lead tests has been improving. The percentage of children age 1 with a test found (through claims or ISDH) increased from 37.1% in CY 2016 to 47.6% in CY 2019. The percentage of children age 2 with a test found increased from 25.6% in CY 2016 to 34.1% in CY 2019. The rates improved for each of the four MCEs between CY 2018 and CY 2019 as well.

When comparing the testing rates for 1- and 2-year-olds in CY 2017 and CY 2019 by county, the number of counties statewide with a test rate of 30% or better increased from 54 in CY 2017 to 66 in CY 2019. By MCE, the number of counties with 30% or better test rate for children age 1 and 2 was between 59 counties (CareSource) and 71 counties (Anthem).

For those children continuously enrolled in Medicaid, 31% to 33% of children had no evidence of a lead test by age six. This has remained constant in the last four study years. In the most recent years, however, more children are receiving this test at age one or two than what was reported in earlier periods.

In CY 2019, the percentage of Medicaid children with a lead test result above 5 micrograms per deciliter (the current standard to define elevated test level) was 0.8% of all tests conducted. There are five predominant counties where these children reside. Among 321 children with an elevated lead test level in CY 2018, 96% of the children were found to have evidence that a follow-up test was conducted.

Focus Study on the Utilization and Delivery of Non-Emergency Medical Transportation

B&A initially conducted a focus study of NEMT in Indiana's managed care programs in the CY 2014 EQR. One of the key findings of this study was that there was not always evidence that the NEMT trips that were delivered were provided to an eligible Medicaid member to a contracted Medicaid provider for a covered Medicaid service. The finding from the CY 2014 EQR indicated that there were opportunities to strengthen the oversight of this benefit, either through better oversight of NEMT trips and/or improved reporting of medical encounters to conduct this match.

There has been significant work in both of these areas in recent years, so B&A re-examined this as a focus study in the CY 2020 EQR. The purpose of this focus study was to examine utilization trends and provider availability for transportation services, MCE policies and procedures for transportation services, and MCE delegation oversight of its NEMT brokers.

B&A requested four files from each of the MCE's NEMT brokers related to trip requests in CY 2019, claims paid to transportation providers in CY 2019, the contracted transportation provider roster in CY 2019, and the authorized driver roster in CY 2019. Once received, B&A initiated an intake and validation process of all files received from the NEMT brokers. Some follow-up clarification was completed to ensure the correct interpretation of the data.

Based on trip requests in CY 2019, as a percentage of December 2019 enrollment, only 1.6% of HHW members requested NEMT compared to 5.2% of HIP members and 14.9% of HCC members. The proportion of members requesting and the number of trips requested was proportional across regions of the state within each program. Among those requesting trips, 7.3% were deemed "super users" (more than 100 trip requests in CY 2019; for HCC, 6.8% were super users; HHW had almost no super users.

Almost all trips requested in each of the OMPP's managed care programs (97.7%) are for ambulatory vehicles as opposed to wheelchair vehicles, public transportation, or mileage reimbursement to a friend or family member. The average distance for a one-way trip was between 15.2 and 19.3 miles across the three OMPP programs. These statistics were similar for each MCE. Some regions of the state do have members requesting longer distances than others, however.

Whereas the primary destination for trips in HHW and HCC is a physician's office, clinic or pharmacy, in HIP there are more trips requested to behavioral health or substance use disorder treatment providers.

Among all trips requested, the cancellation rate is 17% to 20% across programs. Few trip requests are denied. Most of the remainder are completed trips, but Anthem and MDwise had a high number of trips where the final disposition of the trip was unknown. B&A made a recommendation to these MCEs to ensure their broker tracks the final status of each trip. A recommendation is also made to all MCEs related to tracking the number of trips that were requested that could not be fulfilled due to the lack of provider availability. Although this appears to be low, this should be confirmed by each MCE.

The match rate between NEMT trips and medical claims improved significantly from the original NEMT study, but a wide range in the no match rate was found across MCEs from a low of under 1% for MHS to a high of 11% for MDwise (HHW and HIP) and Anthem (in HHW).

In our review of 25 contract components between the MCEs and their NEMT brokers, B&A found in almost all areas that the contract language was sufficient and appropriate. Each MCE has a set of reports that are reviewed for ongoing oversight, but there are opportunities to strengthen this. Three of the four MCEs were also found to have an in-depth annual audit of their NEMT broker.

Focus Study on Claims Adjudication and Encounter Submissions

A focus study on MCE claims adjudication processes was conducted in the CY 2017 EQR. This study was followed-up with an encounter validation focus study in the CY 2018 EQR. The encounter study focused on the *accuracy* of encounter submissions, the *timeliness* of encounter submissions, and the *completeness* of claims adjudicated and later submitted as encounters to the OMPP.

In CY 2020, the EQR focus study was on claims adjudication timeliness as well as encounter timeliness and completeness. Specifically, B&A validated the results submitted by the MCEs on a quarterly basis on two reports in the OMPP's MCE Reporting Manual—Report 0101, Claims Adjudication Summary and Report 0102, Encounters Summary. Information reviewed covered the period of CY 2019. B&A summarized the results as submitted in these reports by the MCEs against independent calculations completed by B&A using claim files submitted by each MCE to B&A specifically for this EQR study.

To track timeliness, B&A computed on a per claim basis the time from the date of receipt of the claim by the MCE to the date that they adjudicated the claim. Separately, B&A computed the time from the MCE adjudication date to the date that the OMPP acknowledged receipt of the claim as an encounter submission. In both studies, summary reports were tabulated by MCE for each OMPP program separately (HHW, HIP and HCC) and by claim type (institutional, professional, pharmacy and dental).

To track completeness, B&A compared the total encounters submitted by the MCEs in CY 2019 as shown on OMPP reports against the claims that they adjudicated in CY 2019. This analysis was also conducted for each MCE at the OMPP program level and claim type level as well.

With respect to encounter completeness, among 20.6 million non-pharmacy claims adjudicated by the MCEs in CY 2019, 7.0% did not appear on the OMPP's encounter reports by Jan 7, 2020. Among this 7.0%, however, B&A found that 46% of the claims were adjudicated in Dec 2019. Therefore, it is likely that these were submitted in early CY 2020 to OMPP. The remaining 54% (781,000 of 20.6 million) were adjudicated earlier than this, implying that these encounters were not submitted timely or ever.

With respect to timeliness, the turnaround time rates for claims adjudication and encounter submissions that are self-reported by each MCE on Reports 0101 and 0102. The OMPP has set a contractual target of 100% of claims adjudicated within 21 days from receipt for claims submitted electronically. A target of 98% of adjudicated claims must be submitted as encounters to OMPP within 21 days of adjudication.

B&A examined the number of quarters that each MCE did not meet a 98% target (B&A allowed for a 2% leeway from the 100% standard). The occurrences were tracked at the MCE, program and claim type level (excluding pharmacy). The results where each MCE did not meet this standard were: Anthem- 4 out of 36; CareSource- 0 out of 24; MDwise- 12 out of 24; and MHS- 0 out of 36.

A similar review was conducted to see how often the MCEs met the encounter submission target of 98% of adjudicated claims within 21 days. The results where each MCE did not meet this standard (pharmacy claim type included as well): Anthem- 14 out of 48; CareSource- 22 out of 32; MDwise- 15 out of 32; and MHS- 10 out of 48.

In B&A's validation of both of sets of measures, we found variances from what the MCEs reported. In some cases, B&A found more favorable results than what the MCEs reported and in other cases less favorable results. This appears to relate to the counting of reprocessed claims which B&A observed can be significant with some MCEs. B&A offers recommendations to both the MCEs and the OMPP on ways to continue to improve the accuracy of claims adjudication and encounter submission timeliness.

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

Introduction

The Family and Social Services Administration's (FSSA's) Office of Medicaid Policy and Planning (OMPP)[3] have responsibility for the administration and oversight of Indiana's Medicaid program under waiver and state plan authorities. There are three risk-based managed care programs in place and each serves a targeted population—Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC).

The **Hoosier Healthwise (HHW)** program began in 1994 with members having the option to enroll with a managed care entity (MCE)[4] in 1996. By 2005, enrollment with an MCE was mandatory for select populations, namely, low income families, pregnant women, and children. Enrollees in Indiana's Children's Health Insurance Program (CHIP), which covers children in families up to 250 percent of the Federal Poverty Level (FPL)[5], are also enrolled in HHW. This program is authorized by a 1932(a) state plan amendment.

The **Healthy Indiana Plan (HIP)** was first created in January 2008 under a separate Section 1115 waiver authority. This program covered two groups of adults with family income up to 200 percent of the FPL. The first group was uninsured custodial parents and caretaker relatives of children eligible for Medicaid or CHIP who were not otherwise eligible for Medicaid or Medicare. The second group was uninsured noncustodial parents and childless adults ages 19 through 64 who were not otherwise eligible for Medicaid or Medicare.

In January 2015, the State received a new Section 1115 demonstration waiver authority from the Centers for Medicare & Medicaid Services (CMS) to change the design of HIP (the original version now called HIP 1.0) to a non-traditional Medicaid model (the new version called HIP 2.0) that effectively terminated HIP 1.0 on January 31, 2015. The HIP 2.0 model is a health insurance program for uninsured adults between the ages of 19 and 64. The HIP 2.0 program began February 1, 2015. In addition to the existing HIP 1.0 enrollees, adults from the HHW program (with some exceptions) were transitioned into HIP 2.0. Additionally, the marketplace was open for new uninsured Hoosiers who met the enrollment criteria to join HIP 2.0 at this time.

HIP is a State-sponsored health insurance program where monthly contributions are required of each enrolled member. 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 was used in HIP 1.0 and continues to be used in the HIP 2.0 program. A $2,500 deductible is provided to each member annually.

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

[4] 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. Each MCE is a health maintenance organization (HMO) authorized by the Indiana Department of Insurance.

[5] CHIP children in families up to 150% FPL do not pay a premium. Children in families whose income is between 151% and 250% FPL pay a premium on a sliding scale.

Individuals eligible for HIP can opt to pay a modest POWER Account contribution in order to receive HIP Plus benefits. This includes enhanced benefits such as dental and vision. There are no co-payments. Contributions to the member's POWER Account may also come from the State (with federal matching dollars) and, in some cases, the member's employer. HIP members who do not choose this option will be placed in HIP Basic. Members enrolled here are charged co-payments and dental and vision benefits are not included. Members with certain medical conditions or criteria may be eligible for the HIP State Plan package which offers additional benefits.

The HHW and HIP were aligned in Calendar Year (CY) 2011 under a family-focused model such that the programs allow a seamless experience for Hoosier families and to establish a medical home model for continuity of care. The same MCEs were contracted to serve both the HHW and HIP populations.

The **Hoosier Care Connect (HCC)** program was implemented April 1, 2015 under 1915(b) waiver authority. Enabling state legislation in CY 2013 tasked the FSSA with managing the care for the aged, blind and disabled Medicaid enrollees. The HCC is a risk-based program that contracts with MCEs to administer and to deliver services to these members. The HCC replaced a predecessor program, Care Select, which ended June 30, 2015.

Traditional Medicaid is comprised of the remaining Medicaid enrollees who are not members of HHW, HIP or HCC. Specifically, the following populations are covered under Traditional Medicaid under a fee-for-service environment:

- Individuals dually enrolled receiving Medicare and Medicaid benefits;
- Individuals receiving home- and community-based waiver benefits;
- Individuals receiving care in a nursing facility or other State-operated facility;
- Individuals in specific aid categories (e.g., refugees); and
- Individuals awaiting an assignment to an MCE.

Applicants to HHW, HIP and HCC 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.

In CY 2019, which is the focus of this External Quality Review (EQR), there were four MCEs that contracted with the OMPP to administer services to its managed care programs. Anthem Insurance Companies, Inc. (Anthem) has been under contract with Indiana Medicaid since 2007. Coordinated Care Corporation, Inc. d/b/a Managed Health Services (MHS) is a subsidiary of the Centene Corporation and has been under contract with Indiana Medicaid since the inception of HHW in 1994. MDwise, a McLaren company, has also been participating in HHW since its inception. The newest MCE, CareSource, began contracting with the State in January 2017.

Anthem and MHS serve members in all three of the OMPP's managed care programs—HHW, HIP and HCC. CareSource and MDwise serve members in the HHW and HIP programs.

The latest contract between the OMPP and the MCEs began January 1, 2017 for the HHW and HIP programs. The latest contract for HCC began April 1, 2015. A new HCC contract is scheduled to take effect in 2021.

Enrollment at a Glance

As seen in Exhibit I.1 below, net enrollment in Indiana Medicaid's program increased 1.9 percent (27,000 members) December 2018 to December 2019. Enrollment in the three managed care programs was unchanged over this period, however, holding steady at 1,080,000 members. The increased enrollment in CY 2019 all occurred in the fee-for-service program.

Within each of the OMPP's managed care programs, the enrollment in HCC remained constant in CY 2019. Enrollment in HHW saw a very modest increase while enrollment in HIP saw a very modest decrease.

The overall managed care enrollment for Indiana Medicaid was 76.3 percent of total enrollment at the end of CY 2018. As of the end of CY 2019, it was 74.9 percent.

Exhibit I.1
Enrollment Across Indiana Medicaid's Programs, Year End 2016 - 2019

	Managed Care Programs				
	Hoosier Healthwise	**Healthy Indiana Plan**	**Hoosier Care Connect**	**Fee-for-Service**	**All Combined**
December 2016	602,768	404,151	94,438	349,737	1,451,094
	41.5%	27.9%	6.5%	24.1%	100.0%
	75.9%			24.1%	100.0%
December 2017	655,138	414,263	90,462	317,881	1,477,744
	44.3%	28.0%	6.1%	21.5%	100.0%
	78.5%			21.5%	100.0%
December 2018	597,615	392,018	90,488	334,676	1,414,797
	42.2%	27.7%	6.4%	23.7%	100.0%
	76.3%			23.7%	100.0%
December 2019	600,164	389,307	90,594	361,583	1,441,648
	41.6%	27.0%	6.3%	25.1%	100.0%
	74.9%			25.1%	100.0%

Source: OMPP Enterprise Data Warehouse as of August 2020.

From the data available in the OMPP Enterprise Data Warehouse (EDW), the profile of Indiana Medicaid's total enrollment by race/ethnicity at the end of CY 2019 was 60.7 percent Caucasian, 20.7 percent African-American, 9.4 percent Hispanic, and 3.0 percent other race/ethnicities combined. There is a limitation in that the race/ethnicity was not available for 6.2 percent of enrolled members. As seen in Exhibit I.2, the HHW program has a higher proportion of minorities, particularly Hispanic, than the other managed care programs. The HCC program has a higher proportion of African-Americans than other programs. The HIP program has a higher proportion of Caucasians.

Exhibit I.2
Enrollment in Indiana Medicaid's Programs by Race/Ethnicity
As of December 2019

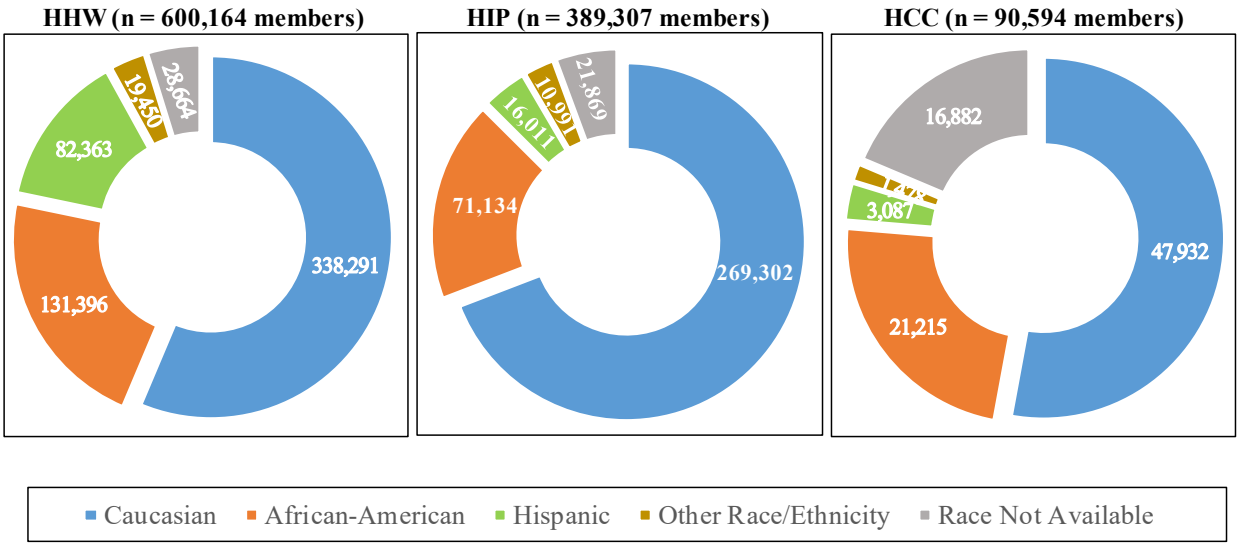


Exhibit I.3 shows the enrollment distribution within managed care by MCE. At the end of CY 2019, Anthem has 42 percent of all managed care enrollment (an increase from 40% at the end of CY 2018) and also has the greatest proportion of members in each of the three programs individually. MDwise has 27 percent of managed care enrollment (down from 28% at the end of CY 2018), MHS has 23 percent of managed care enrollment (unchanged from CY 2018) and CareSource had eight percent (down from 9% at the end of CY 2018).

Exhibit I.3
Managed Care Program Enrollment by MCE
As of December 2019

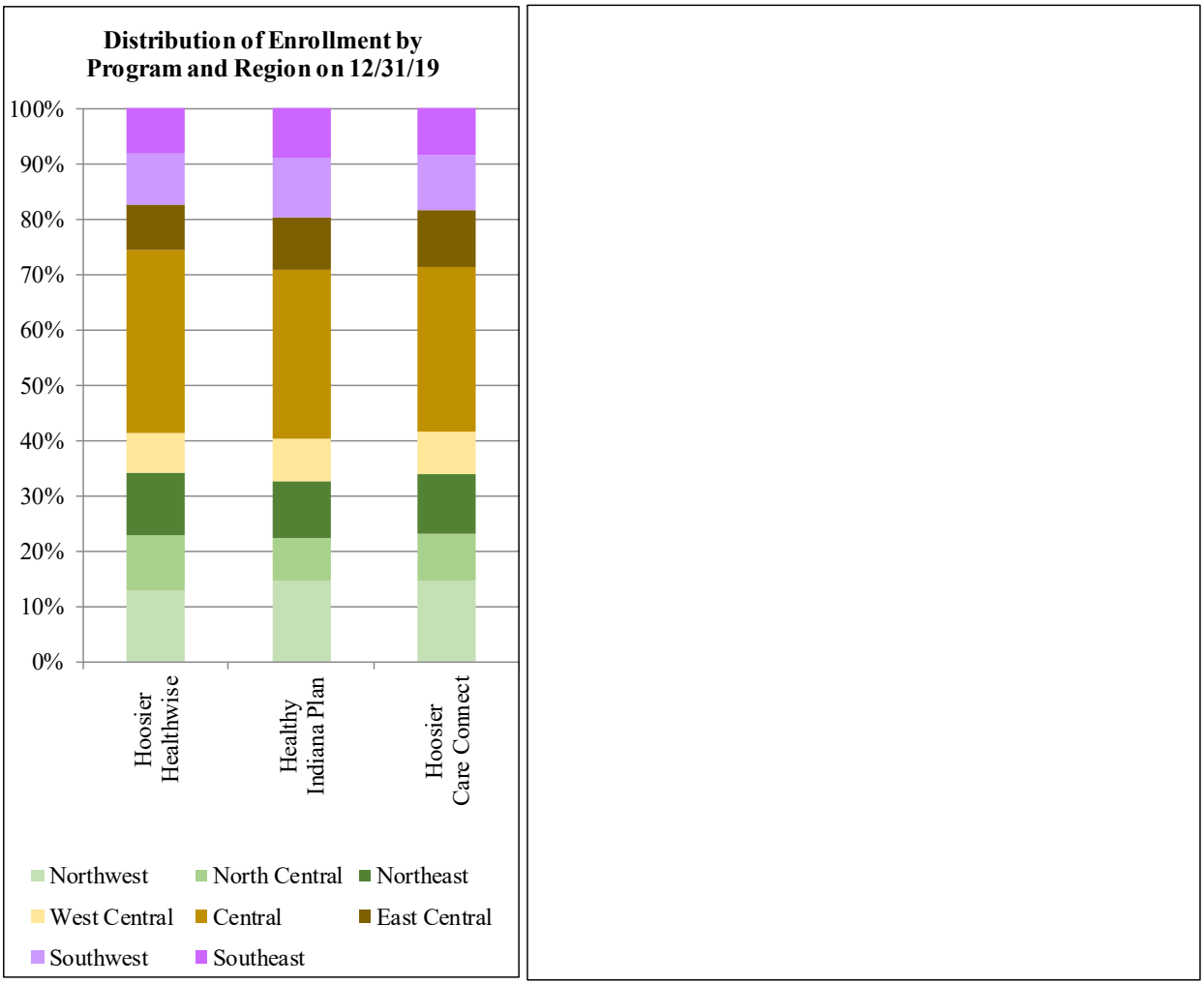
	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect	All Combined
Anthem	37%	46%	63%	42%
CareSource	9%	9%	0%	8%
MDwise	31%	26%	0%	27%
MHS	23%	18%	37%	23%

Source: OMPP Enterprise Data Warehouse as of August 2020.

Exhibit I.4 illustrates the enrollment patterns of the three managed care programs across the eight regions defined by the OMPP. Each of the 92 counties in Indiana has been mapped to one of eight MCE regions. The county-to-region mapping appears in Appendix A. There are three regions in the northern part of the state (shown in the green colors), three regions in the central part of the state (shown in the gold/brown colors), and two regions in the southern part of the state (shown in the purple colors).

In general, as seen in the left box of the exhibit, the distribution of the enrollment for HHW, HIP and HCC is consistent across the regions. In the right box of the exhibit, the enrollment is further distributed by both managed care program and MCE. When comparing the left box (statewide) against the right box (by MCE), there is some variation at the MCE level. MHS tends to have a higher percentage of the enrollment the northern regions, MDwise tends to have a higher percentage of the enrollment in the central regions, and Anthem tends to have a higher percentage of the enrollment in the southern regions. This is true for all programs that each of these MCEs is contracted under.

Exhibit I.4
Managed Care Program Enrollment by Region and MCE
As of December 2019



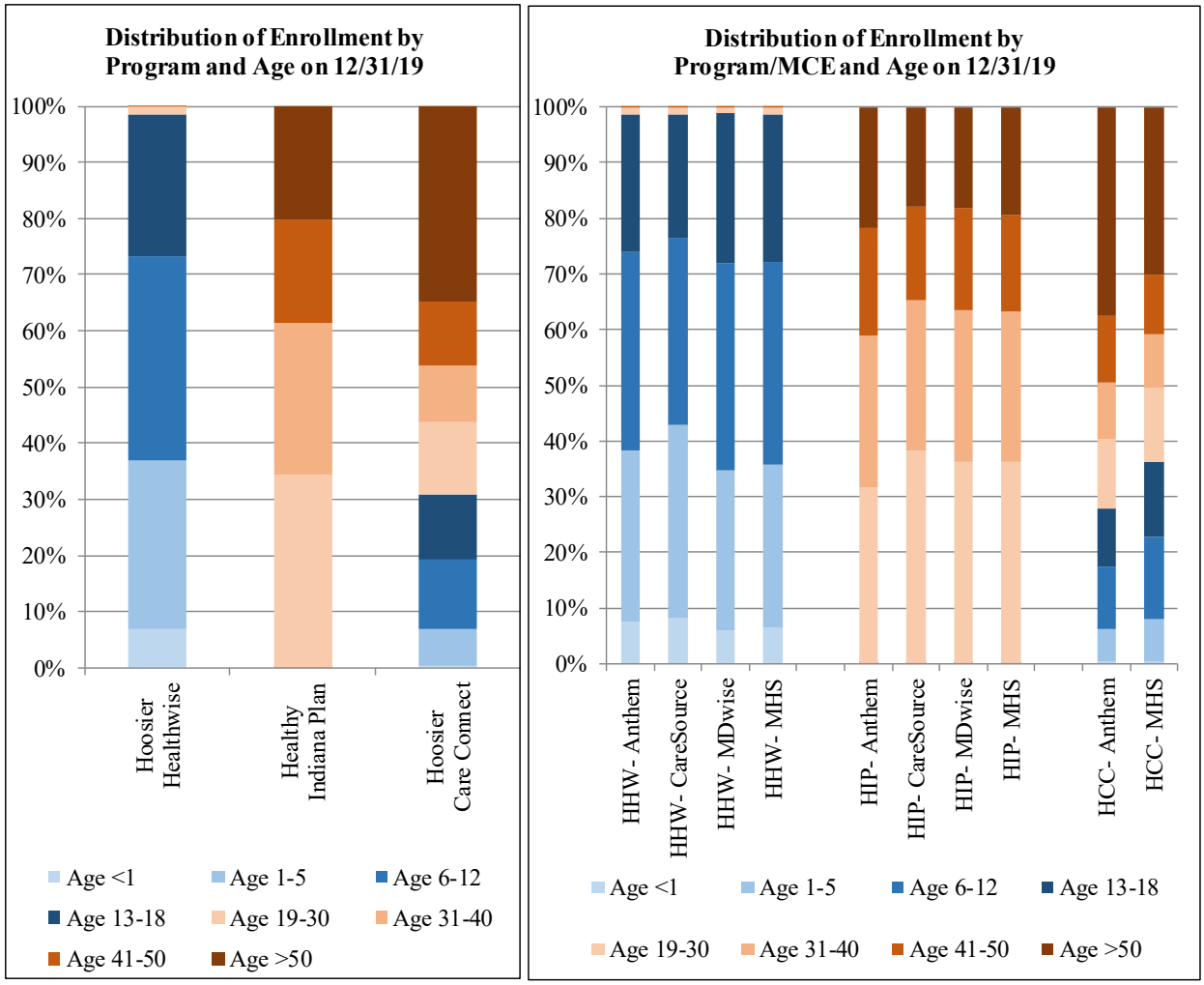
Source: OMPP Enterprise Data Warehouse as of August 2020.

The display for Exhibit I.5 is similar to what was shown in Exhibit I.4, but instead of distributing the enrollment by region, the enrollment is distributed by the age of the members. In this exhibit, the blue colors represent different age groups among children while the peach/brown colors represent different age groups among adults.

Exhibit I.5 illustrates the targeted populations of each of Indiana's managed care programs. As of December 2019, almost 99 percent of the HHW population is children. Conversely, all of the HIP population is adults. The HCC program is mixed with 31 percent children and 69 percent adults. Even within HCC, the children that are enrolled are mostly older children.

As shown in the box on the right, there are no significant differences in the distribution of the enrollment by age group across the MCEs in any of the three managed care programs.

Exhibit I.5
Managed Care Program Enrollment by Age and MCE
As of December 2019



Source: OMPP Enterprise Data Warehouse as of August 2020.

Indiana Medicaid's CY 2019 Quality Strategy Plan

The OMPP, like other State Medicaid Agencies, develops a Quality Strategy Plan. In its 2019 Plan, Indiana outlined specific initiatives for the HHW, HIP and HCC programs as well as the Traditional Medicaid program. The initiatives for the managed care programs are shown on the next page in Exhibit I.6. Most of the initiatives carried forward from the prior Quality Strategy Plan. One new initiative in CY 2019 relates to annual dental visits for children in HHW. The initiatives outlined stem from four global aims that the OMPP has identified that support the objectives for all of its programs. These are[6]:

1. Quality – Monitor quality improvement measures and strive to maintain high standards.
    a. Improve health outcomes
    b. Encourage quality, continuity and appropriateness of medical care

2. Prevention – Foster access to primary and preventive care services with a family focus.
    a. Promote primary and preventive care
    b. Foster personal responsibility and healthy lifestyles

3. Cost – Ensure medical coverage in a cost-effective manner.
    a. Deliver cost-effective coverage
    b. Ensure the appropriate use of health care services
    c. Ensure utilization management best practices

4. Coordination/Integration – Encourage the organization of patient activities to ensure appropriate care.
    a. Integrate physical and behavioral health services
    b. Emphasize communication and collaboration with network providers

The Quality Strategy Committee meets quarterly throughout the year. MCEs are involved with the Quality Strategy Committee in multiple ways. Most importantly, the MCEs are required to submit to OMPP quarterly updates to their quality improvement projects that were identified in their annual work plan. The Quality Strategy Committee is briefed on these updates by the MCEs.

[6] From the Indiana Medicaid Managed Care Quality Strategy Plan 2019, page 5. https://www.in.gov/fssa/ompp/5533.htm

Exhibit I.6
OMPP Quality Strategy Initiatives for 2019

Area of Focus	Goal	HHW	HIP	HCC
Improvements in Children and Adolescent Well-Care	Achieve at or above the 90th percentile for improvements in children and adolescent well-child visits (HEDIS).	✓		
Early Periodic Screening, Diagnosis and Treatment	Achieve at or above 80% participation rate in the EPSDT program.	✓		
Adult Preventive Care	Achieve at or above the 75th percentile for members age 19 years and older that had a preventive care visit (HEDIS).			✓
Improvement in Behavioral Health	Achieve at or above the 90th percentile (HHW, HIP) or 75th percentile (HCC members with Medicaid Rehab Option services) for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders (HEDIS).	✓	✓	✓
Emergency Room Visits	Achieve at or below the 10th percentile of Ambulatory Emergency Department Care Visits (HEDIS).	✓		
	Achieve at or below 80 visits per 1,000 member months.		✓	✓
Timeliness of Prenatal Care	Achieve at or above the 50th percentile for the timeliness of prenatal care (HEDIS).		✓	
Frequency of Postpartum Care	Achieve at or above the 75th percentile for required postpartum visits (HEDIS).		✓	
Pregnant Women Smoking Cessation	Achieve an increase in the percentage who are referred to and have one contact with the Indiana Tobacco Quitline.		✓	
Annual Dental Visit	Achieve at or above the 75th percentile for member annual dental visits (HEDIS).	✓		
Lead Screening in Children	Achieve at or above the 75th percentile for lead screening in children (HEDIS).	✓		
Medication Management for People with Asthma	Achieve at or above the 90th percentile for medication management for people with asthma (HEDIS).	✓		
Access to Care	90% of all HIP members shall have access to primary care within a minimum of 30 miles of a member's residence and at least two providers of each specialty type within 60 miles of their residence.		✓	
Access to Care	90% of all HIP members shall have access to dental care within a minimum of 30 miles of a member's residence and vision care within a maximum of 60 miles of a member's residence.		✓	
POWER Account Rollover	Achieve at or above the 75th percentile of NCQA 2019 Quality Compass of members who receive an annual preventive exam.		✓	
Completion of Health Needs Screen (HNS)	Achieve completion of a HNS for >= 60% (for HIP) or >= 70% (for HCC) of all new members within 90 days of enrollment with an MCE.		✓	✓
Completion of Comprehensive Health Assessment Tool (CHAT)	Achieve completion of a CHAT for >= 79% of all members within 150 days of enrollment.			✓

Source: Indiana Medicaid Managed Care Quality Strategy Plan 2019

The OMPP also had 15 different Pay for Outcome (P4O) measures in its contracts with the MCEs in CY 2019. Some P4O measures were consistent across OMPP programs while others are unique to specific programs given the population served in the program. Most measures are based on HEDIS measures, but three measures are defined by the OMPP.

The P4O measures in place during CY 2019 appear in Exhibit I.7 below.

Exhibit I.7
OMPP Pay for Outcomes Program in Effect for CY 2019

HEDIS Code	Description	HHW	HIP	HCC
AMB	ER Admissions per 1000 Member Months	✓	✓	✓
W15	Well-Child Visits in the First 15 Months of Life - Six or More Visits	✓		
W34	Well-Child Annual Visit in the Third, Fourth, Fifth and Sixth Years of Life	✓		
AWC	Adolescent Well-Child Visit	✓		
AAP	Adult Ambulatory and Preventive Care		✓	✓
FUH	Follow-up After Hospitalization for Mental Illness: 7-Day Follow-up	✓	✓	✓
FUH	Follow-up After Hospitalization for Mental Illness: 30-Day Follow-up			✓
ADV	Annual Dental Visit	✓		
LSC	Lead Screening for Children	✓		
MMA	Medication Management for People with Asthma	✓		
PPC	Timeliness of Prenatal Care		✓	
FPC	Frequency of Postpartum Care Visit		✓	
n/a	OMPP Measure: Health Needs Screen Completion		✓	✓
n/a	OMPP Measure: Comprehensive Health Assessment Tool Completion			✓
n/a	OMPP Measure: Referral to Quitline for Pregnant Members who Smoke		✓	

Source: Indiana Medicaid Managed Care Quality Strategy Plan 2019

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

Introduction

Burns & Associates (B&A) has served as the External Quality Review Organization (EQRO) and has conducted annual 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 Indiana Medicaid program.

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

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

All four of these activities were completed in the EQR conducted in Calendar Year (CY) 2018. For the EQR conducted in CY 2020, all but the first activity was completed.

In lieu of the review of MCE compliance with federal Medicaid managed care regulations completed last year, for the CY 2020 EQR, B&A worked with the OMPP to develop focus studies covering specific aspects of the Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC) programs. Since 2014, B&A has completed 24 focus studies as part of the annual EQR. The focus studies that have been completed in the last six years appears in Exhibit II.1 on the next page.

EQRO Activities in CY 2020

B&A met with the OMPP in early 2020 and developed the following topics for this year's EQR:

- Validation of four Performance Measures
- Validation of MCE Performance Improvement Projects (Quality Improvement Projects, QIPs)
- Examination of Provider Network Adequacy at Each MCE
- Optional EQR Activity: Focus Study on Lead Testing
- Optional EQR Activity: Focus Study on the Utilization and Delivery of Non-Emergency Medical Transportation (NEMT)
- Optional EQR Activity: Focus Study on Claims Adjudication and Encounter Submissions

The details pertaining to each aspect of this year's EQR were released to the MCEs in an EQR Guide on May 18, 2020. The EQR Guide appears in Appendix B 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.

All of the tasks in this year's EQR were conducted during May through August, 2020.

Exhibit II.1
EQR Focus Studies Conducted of MCE Operations in HHW, HIP and HCC, 2014 - 2019

Review Conducted	Review Year	HHW	HIP	HCC	Functional Area	Review Topic
CY 2014	CY 2013	x			Access to Care	Review of Non-Emergency Medical Transportation Services
CY 2014	CY 2013	x	x		Member Services	New Member Activities
CY 2014	CY 2013	x	x		Provider Relations	Review of MCE Provider Services Staff and Communication with Providers
CY 2014	CY 2013	x	x		Program Integrity	Review of Processes Related to Third Party Liability
CY 2015	CY 2014	x	x		Utilization Management	Review of Service Authorization Processes including sample review
CY 2015	CY 2014	x	x		Inpatient Hospital Readmissions	Assessment of Potentially Preventable Hospital Readmissions
CY 2015	CY 2014	x	x		Emergency Services	Assessment of Potentially Preventable Emergency Department Visits
CY 2016	CY 2015	x	x	x	Access to Care	Audit of MCE Provider Directories
CY 2016	CY 2015	x	x	x	Access to Care	Review of Beneficiary Access to Providers
CY 2016	CY 2015		x	x	Dental Care	Review of the Utilization and Access to Dental Services
CY 2016	CY 2015	x	x	x	Mental Health Utilization	Review of the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
CY 2016	CY 2015	x	x		Prenatal Care	Review of the Delivery of Prenatal Care
CY 2016	CY 2015	x		x	Well Child Visits and Primary Care	Review of the Delivery of Well Care and Primary Care to Children
CY 2017	CY 2015-CY 2016	x	x	x	Inpatient Hospital Readmissions	Assessment of Potentially Preventable Hospital Readmissions
CY 2017	CY 2016	x	x	x	Claims Processing	Review of Claims Adjudication and Pricing
CY 2017	CY 2016	x	x	x	Children's Health	Study of Lead Testing and Related Outreach
CY 2017	CY 2016	x	x	x	Pharmacy	Study of MCE Medication Adherence Programs
CY 2018	CY 2017	x	x	x	Encounters	Study of MCE Encounters Validation
CY 2018	CY 2017	x	x	x	Pharmacy	Study of MCE Pharmacy Management
CY 2019	CY 2018	x	x	x	Access to Care	Audit of MCE Provider Directories
CY 2019	CY 2018	x	x	x	Emergency Services	Assessment of Potentially Preventable Emergency Department Visits
CY 2019	CY 2018	x	x	x	Well Child Visits and Primary Care	Review of the Delivery of Well Care and Primary Care to Children and Adults
CY 2019	CY 2018	x	x		Prenatal Care	Review of the Delivery of Prenatal Care
CY 2019	CY 2018	x	x	x	Member Services	Examination of the Prevalence of Health Needs Screenings for New Members

In preparation for the study, B&A received data from the FSSA's Enterprise Data Warehouse (EDW) with the transfer of data facilitated by OMPP's EDW vendor, Optum. Under an agreement with the OMPP, B&A receives refreshed enrollment, provider and claims/encounters files at the start of each month that includes up-to-date information from the prior month. Both fee-for-service claims and encounter data is delivered to B&A for institutional services, professional services, dental services and pharmacy scripts.

When receiving data from the EDW, B&A leverages all data validation techniques used by Optum before the data is submitted to the EDW. For this EQR, B&A also requested data directly from each MCE. When this was done, B&A performed validation techniques on these data sources ourselves. The specific activities that were conducted are discussed in the methodology section of each focus study discussed in this report.

Sections III through VIII of this report describe in detail the methodology and findings of each of the EQR activities stated above. Because the MCEs that contract with the OMPP serve all three programs (HHW, HIP and HCC), the review of all three programs was conducted simultaneously. This report, therefore, serves as the EQR study for all three of Indiana's managed care programs for CY 2019. Throughout the report, where applicable, information is presented for each program individually. The focus studies that were conducted reviewed information on all four of OMPP's managed care programs.

Due to the pandemic, meetings that have customarily been conducted in person with each MCE were conducted via video webinar in this year's EQR. Specific meetings were set up 1:1 with each MCE to cover the topics in the focus studies as well as the validation of performance measures. The meetings were conducted to review B&A's initial findings from each focus study so that the MCEs had an opportunity to provide feedback before this report was finalized. In the same week that each set of MCE briefings was held, B&A also met with the OMPP Quality Team to give them a status on the findings from each focus study. Specific meetings conducted are as follows:

- June 2-3: Interviews with each MCE about NEMT oversight
- June 8: Meet with each MCE and their NEMT broker to review the data request to brokers
- June 23-24: A webinar was held with each MCE to review results of the network adequacy study
- July 28-29: A webinar was held with each MCE to review results of the claims and encounter study, the lead testing study, and the validation of performance measures
- August 11-12: A webinar was held with each MCE to review results of the NEMT analytics

The EQR Review Team

This year's review team included staff with many years of experience conducting EQR activities in Indiana as well as other studies that B&A has conducted for Indiana state agencies. The team included the following members:

- Mark Podrazik, Project Director, Burns & Associates, Inc. Mr. Podrazik provided project oversight and participated in all aspects of this year's EQR. He led the B&A team responsible for all analytics pertaining to this year's focus studies. He has worked with the OMPP in various capacities since 2000. Previously, Mr. Podrazik led the EQRs in CYs 2007-2019.

- Debbie Saxe, Project Manager, Burns & Associates, Inc. Debbie Saxe managed the team that conducted the focus study on network adequacy. While at B&A, she has also led projects for Indiana and two other states to provide technical assistance to states in the development and submission of their Access Monitoring Review Plan due to CMS once every three years. Ms. Saxe has previously worked on focus studies in three previous EQRs in Indiana.

- Shawn Stack, Project Manager, Burns & Associates, Inc. Shawn Stack managed the team that conducted the focus study on NEMT. Since joining B&A in 2019, he also contributed to an assessment of the delivery of NEMT in Indiana's fee-for-service program. As such, his familiarity with the Indiana landscape was leveraged in conducting this study in managed care.

- Dr. Linda Gunn, AGS Consulting, Inc. Dr. Gunn participated as a team member in the validation of quality improvement plans. She has participated in B&A's EQRs for Indiana programs in CYs 2009-2019.

- Kristy Lawrance, Lawrance Policy Consulting, LLC. Ms. Lawrence participated as a team member in the focus study on NEMT. She has participated in B&A's EQRs for Indiana programs in CYs 2013-2019.

- Jesse Eng, SAS Programmer, Burns & Associates, Inc. Mr. Eng conducted analytical support in SAS for the focus study related to claims adjudication and encounter submissions. He has conducted analytic support on B&A's engagements with the OMPP since 2009, in particular, the annual EQR and B&A's annual independent evaluation of Indiana's Children's Health Insurance Program.

- Akhilesh Pasupulati, SAS Programmer, Burns & Associates, Inc. Mr. Pasupulati completed the analytic support for this year's focus studies related to network adequacy, lead testing and NEMT. He served in this role in B&A's assessment of Indiana's fee-for-service NEMT program in 2019 as well. Previously, he has assisted in analytic support of EQR focus studies in Indiana in 2018 and 2019.

- Ryan Sandhaus, SAS Programmer, Burns & Associates, Inc. Mr. Sandhaus conducted analytical support in SAS for the validation of performance measures. He currently computes performance measures in Indiana in support of the evaluation of the State's substance use disorder waiver. He is also responsible for the intake and validation of the monthly files delivered to B&A from the State's EDW. Mr. Sandhaus has conducted analytic support on the validation of performance measures and specific focus studies for three prior EQRs in Indiana.

- Barry Smith, Analyst, Burns & Associates, Inc. Mr. Smith conducted analytical support related to the assessment of network adequacy, lead testing, NEMT and claims adjudication. He has previously worked on the analytics team for the EQRs conducted in CYs 2009-2019.

SECTION III: VALIDATION OF PERFORMANCE MEASURES

Introduction

In previous External Quality Reviews (EQRs), Burns & Associates (B&A) has selected performance measures to validate from among the various reports that the managed care entities (MCEs) submit to the Office of Medicaid Policy and Planning (OMPP) on a regular basis. The OMPP updated its MCE Reporting Manual that is used for each of the three managed care programs—Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC)—as part of the Calendar Year 2019 External Quality Review (EQR). The MCEs are required to submit results in pre-set reporting templates in Excel. Most reports must be submitted on a quarterly basis. In addition to the report template, the OMPP provides instructional guidance to the MCEs on how to complete each report.

In the CY 2020 EQR, B&A validated four measures reported on the OMPP's Report 0403: Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicator (PQI) Measures. These measures are required to be reported for the HIP and HCC programs. The four PQI measures relate to inpatient discharges for diabetes, chronic obstructive pulmonary disease (COPD), heart failure and asthma.

B&A referenced the elements for review suggested in the Centers for Medicare & Medicaid (CMS) External Quality Review (EQR) Protocol 2: *Validation of Performance Measures* (October 2019) to conduct our validation. Due to the ongoing pandemic, the planned onsite visit to each MCE could not be completed this year. The B&A team that conducted the validation did meet with staff responsible for computing the measures that were reviewed in a 1:1 webinar session. Preliminary results that were computed by B&A were shared with each MCE. Where differences were found between the B&A results and the MCE-reported results, a discussion occurred with each MCE about items to consider for a root cause analysis to explain the variation.

Methodology Related to the Validation Process

1. B&A conducted an intake of the four quarterly 0403 reports submitted by each MCE and compared quarter-by-quarter results for face validity.

2. B&A compared and contrasted the results from each MCE to assess similarities and variances in the results.

3. Using the encounters and enrollment data received from the State's Enterprise Data Warehouse (EDW) through May 31, 2020, B&A prepared an enrollment dataset for each MCE that was used to develop the denominators for each measure. B&A prepared a dataset of inpatient hospital discharges from the study time period that was used to determine the numerators for each measure.

4. B&A's programmer used the technical specifications released by the AHRQ to compute our own results for each of the four measures. Results were computed by MCE, by program (HIP or HCC) and by quarter.

5. B&A compared its results to those reported by each MCE. Variances were noted for each measure result individually (that is, by MCE, by program and by quarter). Summary tables showing the side-by-side comparison of each measure were prepared for the 1:1 meeting with

each MCE. B&A's computations showed the numerators and denominators as well to assist in the root cause analysis when variances were observed from the MCE's results.

6. Each MCE was given Excel files showing B&A's calculations after the meeting. The MCEs were given the opportunity to request additional data from B&A to conduct their own analyses.

7. When provided, B&A accepted the results of MCE investigations to assist in our final computations in the validation exercise.

Findings

Exhibits III.1 through III.4 appear on the next four pages. Each page contains an exhibit that shows the results for each measure. The first row shows what the MCE reported in each quarter. The second row shows what B&A computed for the MCE in the same quarter. The third row shows the difference.

The AHRQ measures reviewed require reporting on a per 100,000-member basis. These results are shown in the top portion of each exhibit. In an effort to use a more common convention for comparison purposes, B&A converted the data to a per 1,000-member basis by dividing each value by 1,000. These results are shown at the bottom of the exhibit. B&A then highlighted results where our computed value differed from what the MCE reported (higher or lower) by 0.05 per 1,000.

Using the thresholds described above, there were only two occurrences where larger variances were observed. One was with CareSource on the diabetes measure (refer to Exhibit III.1). This appears to be either a data entry or calculation error by CareSource since the quarter where the variance occurred had a result from CareSource much different than the other three quarters. The other variance was observed with MHS on the COPD measure (refer to Exhibit III.2). Although MHS reported a result higher than B&A in Quarter 1 of CY 2019, our results matched more closely in the other three quarters.

Findings from EQRs conducted in recent years showed that B&A was not always able to validate the results reported by MCEs in the Reporting Manual templates against encounter claims and enrollment information provided by the OMPP to B&A from the State's Enterprise Data Warehouse (EDW). A number of reasons have been identified as to why B&A may not match the results reported by the MCEs:

1. An MCE interpreted the instructions provided by the OMPP on how to compute a measure differently from how the OMPP intended.

2. An MCE did not update its internal programming for specification changes in the computation of a specific measure, particularly when the changes require mapping to specific diagnosis codes or procedure codes.

3. Claims submission lag may occur where utilization is still unknown at the point in time that the MCE is submitting its report to the OMPP. B&A, on the other hand, has the benefit of reviewing utilization after sufficient claims lag has occurred much after the initial reports were due.

4. Alternatively, incomplete encounters in the EDW means that B&A may not be using the same source database that was found internally at the MCE to compute numerators on measures.

5. There may be differences in the source used for enrollment data. B&A uses the enrollment file provided by the OMPP. At least one MCE mentioned that they use the capitation payment file that they receive each month to record active members with their MCE.

Exhibit III.1
Results of Validation of AHRQ Prevention Quality Indicator Measure
Discharges with Principal Diagnosis of Diabetes Short-term Complications
Per 100,000 Members Age 18 and Older

	HIP				HCC			
	Q1-2019	Q2-2019	Q3-2019	Q4-2019	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Anthem Results	28.9	29.2	26.2	23.9	32.3	32.5	32.4	35.2
B&A Results	26.8	25.2	23.1	21.5	27.1	26.9	26.0	28.8
Difference	2.2	4.0	3.1	2.4	5.2	5.6	6.5	6.4
CareSource Results	11.4	14.1	13.4	267.2	Not applicable. MCE not contracted in this program.			
B&A Results	12.5	13.4	13.8	12.5				
Difference	-1.1	0.7	-0.4	254.7				
MDwise Results	24.8	19.2	20.7	19.4	Not applicable. MCE not contracted in this program.			
B&A Results	25.7	25.7	23.3	22.3				
Difference	-1.0	-6.6	-2.6	-2.9				
MHS Results	16.2	16.9	15.5	17.8	30.6	25.3	26.2	25.3
B&A Results	19.5	18.8	16.9	17.7	16.8	22.8	23.2	22.4
Difference	-3.3	-1.9	-1.4	0.1	13.8	2.6	3.1	3.0

Values above converted to a per 1,000 Member Basis

	HIP				HCC			
	Q1-2019	Q2-2019	Q3-2019	Q4-2019	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Anthem Results	0.029	0.029	0.026	0.024	0.032	0.032	0.032	0.035
B&A Results	0.027	0.025	0.023	0.021	0.027	0.027	0.026	0.029
Difference	0.002	0.004	0.003	0.002	0.005	0.006	0.006	0.006
CareSource Results	0.011	0.014	0.013	0.267	Not applicable. MCE not contracted in this program.			
B&A Results	0.013	0.013	0.014	0.012				
Difference	-0.001	0.001	0.000	0.255				
MDwise Results	0.025	0.019	0.021	0.019	Not applicable. MCE not contracted in this program.			
B&A Results	0.026	0.026	0.023	0.022				
Difference	-0.001	-0.007	-0.003	-0.003				
MHS Results	0.016	0.017	0.016	0.018	0.031	0.025	0.026	0.025
B&A Results	0.020	0.019	0.017	0.018	0.017	0.023	0.023	0.022
Difference	-0.003	-0.002	-0.001	0.000	0.014	0.003	0.003	0.003

MCE is > 0.05 points below B&A's computed result when expressed on a per 1,000 basis

MCE is > 0.05 points above B&A's computed result when expressed on a per 1,000 basis

Exhibit III.2
Results of Validation of AHRQ Prevention Quality Indicator Measure
Discharges with Principal Diagnosis of COPD
Per 100,000 Members Age 40 and Older

	HIP				HCC			
	Q1-2019	Q2-2019	Q3-2019	Q4-2019	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Anthem Results	35.1	35.9	34.9	31.3	182.1	175.8	170.0	162.6
B&A Results	39.4	37.7	35.2	32.7	160.9	145.2	138.2	134.2
Difference	-4.3	-1.8	-0.4	-1.4	21.2	30.6	31.8	28.4
CareSource Results	43.3	43.0	37.4	33.8	Not applicable. MCE not contracted in this program.			
B&A Results	41.8	44.4	40.5	37.5				
Difference	1.5	-1.4	-3.1	-3.8				
MDwise Results	34.4	26.1	32.4	31.9	Not applicable. MCE not contracted in this program.			
B&A Results	41.2	41.3	40.3	41.4				
Difference	-6.7	-15.1	-7.9	-9.5				
MHS Results	28.9	33.2	34.4	32.7	181.2	156.8	161.6	149.5
B&A Results	31.9	35.0	36.7	34.9	100.4	123.0	124.8	124.2
Difference	-3.0	-1.9	-2.3	-2.2	80.8	33.8	36.8	25.3

Values above converted to a per 1,000 Member Basis

	HIP				HCC			
	Q1-2019	Q2-2019	Q3-2019	Q4-2019	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Anthem Results	0.035	0.036	0.035	0.031	0.182	0.176	0.170	0.163
B&A Results	0.039	0.038	0.035	0.033	0.161	0.145	0.138	0.134
Difference	-0.004	-0.002	0.000	-0.001	0.021	0.031	0.032	0.028
CareSource Results	0.043	0.043	0.037	0.034	Not applicable. MCE not contracted in this program.			
B&A Results	0.042	0.044	0.041	0.038				
Difference	0.002	-0.001	-0.003	-0.004				
MDwise Results	0.034	0.026	0.032	0.032	Not applicable. MCE not contracted in this program.			
B&A Results	0.041	0.041	0.040	0.041				
Difference	-0.007	-0.015	-0.008	-0.009				
MHS Results	0.029	0.033	0.034	0.033	0.181	0.157	0.162	0.149
B&A Results	0.032	0.035	0.037	0.035	0.100	0.123	0.125	0.124
Difference	-0.003	-0.002	-0.002	-0.002	0.081	0.034	0.037	0.025

MCE is > 0.05 points below B&A's computed result when expressed on a per 1,000 basis

MCE is > 0.05 points above B&A's computed result when expressed on a per 1,000 basis

Exhibit III.3
Results of Validation of AHRQ Prevention Quality Indicator Measure
Discharges with Principal Diagnosis of Heart Failure
Per 100,000 Members Age 18 and Older

	HIP				HCC			
	Q1-2019	Q2-2019	Q3-2019	Q4-2019	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Anthem Results	19.9	20.4	20.6	19.0	92.4	96.5	90.7	94.9
B&A Results	17.8	17.1	17.8	16.9	77.0	77.3	70.1	73.6
Difference	2.1	3.2	2.8	2.1	15.4	19.2	20.6	21.3
CareSource Results	12.0	12.4	11.6	13.9	Not applicable. MCE not contracted in this program.			
B&A Results	13.5	13.0	11.9	10.6				
Difference	-1.5	-0.6	-0.3	3.3				
MDwise Results	12.4	10.2	11.9	11.9	Not applicable. MCE not contracted in this program.			
B&A Results	14.5	14.3	14.9	14.0				
Difference	-2.1	-4.0	-3.0	-2.2				
MHS Results	13.0	15.4	15.3	15.9	82.3	78.5	76.9	74.1
B&A Results	14.5	16.2	15.8	17.1	48.3	59.8	60.5	62.5
Difference	-1.6	-0.9	-0.5	-1.2	34.0	18.7	16.4	11.6

Values above converted to a per 1,000 Member Basis

	HIP				HCC			
	Q1-2019	Q2-2019	Q3-2019	Q4-2019	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Anthem Results	0.020	0.020	0.021	0.019	0.092	0.096	0.091	0.095
B&A Results	0.018	0.017	0.018	0.017	0.077	0.077	0.070	0.074
Difference	0.002	0.003	0.003	0.002	0.015	0.019	0.021	0.021
CareSource Results	0.012	0.012	0.012	0.014	Not applicable. MCE not contracted in this program.			
B&A Results	0.013	0.013	0.012	0.011				
Difference	-0.002	-0.001	0.000	0.003				
MDwise Results	0.012	0.010	0.012	0.012	Not applicable. MCE not contracted in this program.			
B&A Results	0.015	0.014	0.015	0.014				
Difference	-0.002	-0.004	-0.003	-0.002				
MHS Results	0.013	0.015	0.015	0.016	0.082	0.079	0.077	0.074
B&A Results	0.015	0.016	0.016	0.017	0.048	0.060	0.061	0.063
Difference	-0.002	-0.001	-0.001	-0.001	0.034	0.019	0.016	0.012

MCE is > 0.05 points below B&A's computed result when expressed on a per 1,000 basis

MCE is > 0.05 points above B&A's computed result when expressed on a per 1,000 basis

Exhibit III.4
Results of Validation of AHRQ Prevention Quality Indicator Measure
Discharges with Principal Diagnosis of Asthma
Per 100,000 Members Age 18 to 39

	HIP				HCC			
	Q1-2019	Q2-2019	Q3-2019	Q4-2019	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Anthem Results	5.8	5.8	5.2	4.3	9.3	6.9	8.7	7.5
B&A Results	5.2	5.0	4.3	3.5	9.1	6.3	7.9	6.8
Difference	0.6	0.8	0.9	0.7	0.2	0.6	0.8	0.7
CareSource Results	4.5	4.8	6.4	4.5	Not applicable. MCE not contracted in this program.			
B&A Results	4.6	4.2	5.1	4.7				
Difference	0.0	0.6	1.3	-0.2				
MDwise Results	5.7	4.3	7.2	4.0	Not applicable. MCE not contracted in this program.			
B&A Results	5.7	4.8	4.6	4.3				
Difference	-0.1	-0.5	2.6	-0.3				
MHS Results	2.9	2.5	2.5	3.4	6.2	5.1	6.1	10.3
B&A Results	3.1	2.5	2.5	3.1	3.6	4.4	7.0	10.6
Difference	-0.2	0.0	0.0	0.3	2.6	0.7	-0.9	-0.3

Values above converted to a per 1,000 Member Basis

	HIP				HCC			
	Q1-2019	Q2-2019	Q3-2019	Q4-2019	Q1-2019	Q2-2019	Q3-2019	Q4-2019
Anthem Results	0.006	0.006	0.005	0.004	0.009	0.007	0.009	0.008
B&A Results	0.005	0.005	0.004	0.004	0.009	0.006	0.008	0.007
Difference	0.001	0.001	0.001	0.001	0.000	0.001	0.001	0.001
CareSource Results	0.005	0.005	0.006	0.005	Not applicable. MCE not contracted in this program.			
B&A Results	0.005	0.004	0.005	0.005				
Difference	0.000	0.001	0.001	0.000				
MDwise Results	0.006	0.004	0.007	0.004	Not applicable. MCE not contracted in this program.			
B&A Results	0.006	0.005	0.005	0.004				
Difference	0.000	0.000	0.003	0.000				
MHS Results	0.003	0.002	0.002	0.003	0.006	0.005	0.006	0.010
B&A Results	0.003	0.003	0.003	0.003	0.004	0.004	0.007	0.011
Difference	0.000	0.000	0.000	0.000	0.003	0.001	-0.001	0.000

MCE is > 0.05 points below B&A's computed result when expressed on a per 1,000 basis

MCE is > 0.05 points above B&A's computed result when expressed on a per 1,000 basis

Recommendations

Recommendation to OMPP

1. For the measures that were validated in this year's EQR, there was uncertainty on the interpretation of the specifications from the AHRQ (the measure stewards) on the enrollment criteria that defined the denominator in each measure as well as the inclusion or exclusion of denied claims that defined the numerator. The OMPP is encouraged to provide more specific language in its Reporting Manual instructions to ensure consistency in reporting across MCEs on these measures.

2. Additionally, given the AHRQ is the steward for the four measures reviewed, it may provide an annual update to each measure that occurs at some point during the calendar year instead of at the start of the year. The OMPP should provide guidance to the MCEs on when they should switch to the latest specification for measure computations if changes occur mid-year.

SECTION IV: VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

Introduction

The Office of Medicaid Policy and Planning (OMPP) uses the term Quality Improvement Plan, or QIP, to define the Performance Improvement Projects (PIPs) that it requires of its managed care entities (MCEs). Therefore, in this report, references to "QIPs" mean the same thing as "PIPs" as described in the Centers for Medicare & Medicaid (CMS) External Quality Review (EQR) Protocol 1: *Validation of Performance Improvement Projects* (October 2019). Burns & Associates (B&A) utilized the guidance for this CMS Protocol to complete this year's validation which includes the following steps:

Activity 1: Assess the Study Methodology

1. Review the selected PIP topic
2. Review the PIP AIM statement
3. Review the identified PIP population
4. Review sampling method
5. Review the selected PIP variables and performance measures
6. Review data collection procedures
7. Review data analysis and interpretation of PIP results
8. Assess the improvement strategies
9. Assess the likelihood that significant and sustained improvement occurred

Activity 2: Perform Overall Validation and Reporting of PIP Results

Activity 3: Verify Study Findings (an optional activity, was not completed as part of this year's EQR)

B&A considered components in the worksheets recommended for CMS Protocol 1 to better assess the specific QIPs at each MCE. In particular, more focus was spent on assessing improvement strategies (Worksheet 1.8 in the protocol) and assessing the likelihood of significant and sustained improvement (Worksheet 1.9 in the protocol).

The QIPs cover a calendar year period and the annual report on each QIP is due to the OMPP on August 1 of the following calendar year. As part of the validation of QIPs conducted in the CY 2020 EQR, the B&A EQR team members reviewed the submissions on the QIP Reporting Tool as well as ancillary information provided by the MCEs. In prior years of the EQR, onsite interviews were held with each MCE and the subject matter experts related to each QIP in addition to the desk review. In this year's EQR, because most of the QIPs were continuations from prior years, B&A supplemented its desk review with follow-up questions for each MCE to respond to in written format in lieu of an onsite review.

Methodology Related to the Validation Process

1. B&A verified with each MCE the QIPs in place for CY 2019 and the OMPP programs that each QIP pertained to.

2. B&A then selected QIPs from each MCE for inclusion in this year's validation.

3. The MCEs submitted the annual QIP reports to B&A for desk review that were due to the OMPP on August 1, 2020.

4. B&A team members Mark Podrazik and Linda Gunn conducted a desk review of each annual QIP report and the associated quarterly updates that had been submitted prior to the annual submission. Specific elements conducted as part of the desk review included examining:

    a. The study question;
    b. The definition of performance measures;
    c. The definition of interventions;
    d. The method in which numerators and denominators are defined as ways to assess the effectiveness of interventions;
    e. The methods in which the MCEs assess their interventions;
    f. The qualitative summary provided by the MCE in its annual QIP report; and
    g. Indications of how the MCE is continually improving upon its QIP.

5. The B&A team members developed customized follow-up questions after completing the desk review.

6. The MCEs responded to these follow-up questions and provided additional information as requested.

Quality Improvement Projects Reviewed

The MCEs are required to have QIPs for all three programs that it administers—Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC). The MCEs have the option to conduct the same QIP across programs. Although the MCEs select their own QIPs, it is often the case that the choice of QIPs reflects measures in the OMPP's Pay for Outcomes (P4O) program.

For this year's EQR, B&A validated the 12 QIPs shown Exhibit IV.1 on the next page. Anthem had five QIPs, CareSource had five QIPs, MDwise had five QIPs, and MHS had three QIPs. The middle section of the exhibit states if the MCE indicated if the QIP would continue in CY 2020 or not. If it is going to continue, the bottom section indicates if the MCE cited any improvements that are being made to the QIP in CY 2020.

Exhibit IV.1
Inventory of the Quality Improvement Programs Reviewed in the 2020 EQR

	Anthem			Caresource		MDwise		MHS		
QIP Topic (red X means new in 2019)	**HHW**	**HCC**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HCC**	**HIP**
AOD Treatment								X	X	X
Adult Preventive Care Visit		X	X							
Annual Dental Visit	X									
Asthma Medication Management						X				
Behavioral Health Utilization								X	X	X
ED Utilization		X	X	X	X					
Follow-up Psychiatric Hospitalization	X	X	X				X			
Health Needs Screening	X	X	X	X	X	X	X	X	X	X
Job Connect Program					X					
Lead Testing				X		X				
Prenatal and Postpartum Care						X	X			
Well Child Visits (Age 3-6)				X						
Will the QIP Continue in 2020?										
AOD Treatment								No	No	No
Adult Preventive Care Visit		No	No							
Annual Dental Visit	No									
Asthma Medication Management						No				
Behavioral Health Utilization								No	No	No
ED Utilization		No	No	No	No					
Follow-up Psychiatric Hospitalization	Yes	Yes	Yes				No			
Health Needs Screening	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Job Connect Program					No					
Lead Testing				Yes		No				
Prenatal and Postpartum Care						No	No			
Well Child Visits (Age 3-6)				Yes						
If Continuing, Were Improvements Cited to the QIP in the Coming Year?										
AOD Treatment								N/A	N/A	N/A
Adult Preventive Care Visit		N/A	N/A							
Annual Dental Visit	N/A									
Asthma Medication Management						N/A				
Behavioral Health Utilization								N/A	N/A	N/A
ED Utilization		N/A	N/A	N/A	N/A					
Follow-up Psychiatric Hospitalization	Yes	Yes	Yes				N/A			
Health Needs Screening	Yes	Yes	Yes	No	No	No	No	Yes	Yes	Yes
Job Connect Program					N/A					
Lead Testing				Yes		N/A				
Prenatal and Postpartum Care						N/A	N/A			
Well Child Visits (Age 3-6)				No						

Findings

In Exhibits IV.2 and IV.3 on the next two pages, summary tables are presented of B&A's assessment of the validation of measures identified in each MCE's QIP (Exhibit IV.2) and the validation of interventions identified in each MCE's QIP (Exhibit IV.3). After these exhibits, a brief description of each MCE's QIP is presented.

The measures defined by each MCE for its QIPs were valid. This is because in the majority of situations, the MCE is using a HEDIS measure as the measure in its QIP as well. In Exhibit IV.2, if the measure(s) in a QIP are from the HEDIS set, the acronym commonly used for the measure is shown in the top exhibit. Note that, in some cases, an MCE is using more than one measure in its QIP.

In the majority of cases, the MCEs saw improvements in the measures defined within each of their QIPs compared to the prior year. However, when improvement was seen, it was not always statistically significant improvement. The measures that showed statistically significant improvement are indicated with an asterisk (*).

In the review of interventions, most interventions were well defined at the outset. That is, the intervention had a numerator and denominator defined to measure effectiveness. It was often observed that the MCE cited a control group to measure the effectiveness of the intervention.

Most interventions were carried out as planned in CY 2019. One finding by B&A in prior years is that not all interventions originally defined in the QIP were completed throughout the year. In some cases, the intervention was never even initiated. B&A saw improvement in the follow through of interventions in CY 2019. In the middle section of Exhibit IV.3, the total number of interventions completed (first number) are listed out of the total planned (second number).

When the interventions were implemented and could be measured for effectiveness, results were mixed as to whether the interventions were computed effectively. By the term effective, B&A means that in some cases it could easily be determined from the results used to measure the intervention that the intervention was effective. In other cases, this was less clear.

One recommendation by B&A for all MCEs related to interventions is that many of the interventions as defined were more passive in nature. Examples included sending follow-up texts to members either after a trigger event (e.g., an ED visit) or prior to the deadline of an event (e.g., recommended lead test or completion of a health needs screening). Although reminders such as these can certainly factor into improved outcomes, many of these interventions have carried across multiple years with limited success. With the advent of new QIP topics coming in CY 2020, there is an opportunity for the MCEs to initiate more active interventions with their members, even if these can only be conducted in a pilot region or subpopulation of members.

Exhibit IV.2
Summary of Findings Related to Validation of Measures in Each MCE's Quality Improvement Program

	Anthem			Caresource		MDwise		MHS		
	HHW	**HCC**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HCC**	**HIP**
Measure(s) Defined in the QIP	The acronym shown represents the commonly-used HEDIS acronym for the measure.									
AOD Treatment								IET- Init	IET- Init	IET- Init
								IET- Eng	IET- Eng	IET- Eng
								FUA-7	FUA-7	FUA-7
								FUA-30	FUA-30	FUA-30
Adult Preventive Care Visit		AAP	AAP							
Annual Dental Visit	ADV									
Asthma Medication Management						MMA				
Behavioral Health Utilization								1 custom	1 custom	1 custom
								FUH-7	FUH-7	FUH-7
								FUH-30	FUH-30	FUH-30
								FUM-7	FUM-7	FUM-7
								FUM-30	FUM-30	FUM-30
ED Utilization		AMB-ER	AMB-ER	AMB-ER	AMB-ER					
Follow-up Psychiatric Hospitalization	FUH-7	FUH-7	FUH-7				FUH-7			
Health Needs Screening	State-defined			State-defined		State-defined		State-defined		
Job Connect Program					3 custom					
Lead Testing				LSC		LSC				
Prenatal and Postpartum Care						PPC	PPC			
Well Child Visits (Age 3-6)				W34						
Was Improvement Found in the Results for the Measure(s) from the Previous Year?	* means the change is statistically significant									
AOD Treatment, IET Initiation								No	No	Yes*
AOD Treatment, IET Engagement								Yes	Yes	Yes*
AOD Treatment, FUA-7								No	Yes*	Yes*
AOD Treatment, FUA-30								No	Yes*	Yes*
Adult Preventive Care Visit		Yes	Yes							
Annual Dental Visit	Yes									
Asthma Medication Management						No				
Behavioral Health, Readmissions								Yes	No	No*
Behavioral Health, FUH-7								No	No	Yes
Behavioral Health, FUH-30								No	No*	Yes
Behavioral Health, FUM-7								Yes	Yes	Yes
Behavioral Health, FUM-30								Yes*	Yes*	Yes*
ED Utilization		No	No	No	Yes					
Follow-up Psychiatric Hospitalization	Yes*	Yes*	Yes*				No			
Health Needs Screening	Yes	Yes*	Yes*	Yes	Yes	unknown		Yes*	Yes*	Yes*
Job Connect Program					1 of 3					
Lead Testing				Yes		Yes				
Prenatal and Postpartum Care						Yes*	Yes*			
Well Child Visits (Age 3-6)				Yes						

Exhibit IV.3
Summary of Findings Related to Validation of Interventions in Each MCE's Quality Improvement Program

	Anthem			Caresource		MDwise		MHS		
	HHW	HCC	HIP	HHW	HIP	HHW	HIP	HHW	HCC	HIP
Were the Intervention(s) Well Defined in the QIP?										
AOD Treatment								Yes	Yes	Yes
Adult Preventive Care Visit		Yes	Yes							
Annual Dental Visit	Yes									
Asthma Medication Management						Yes				
Behavioral Health Utilization								Yes	Yes	Yes
ED Utilization		Yes	Yes	Yes	Yes					
Follow-up Psychiatric Hospitalization	Yes	Yes	Yes				Yes			
Health Needs Screening	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
Job Connect Program					Yes					
Lead Testing				Yes		Yes				
Prenatal and Postpartum Care						Yes	Yes			
Well Child Visits (Age 3-6)				Partial						
How Many of the Intervention(s) were Completed as Planned?										
AOD Treatment								2 of 2	2 of 2	2 of 2
Adult Preventive Care Visit		3 of 3	3 of 3							
Annual Dental Visit	3 of 3									
Asthma Medication Management						2 of 2				
Behavioral Health Utilization								3 of 4	3 of 4	3 of 4
ED Utilization		2 of 2	2 of 2	1 of 1	1 of 1					
Follow-up Psychiatric Hospitalization	3 of 3	3 of 3	3 of 3				2 of 2			
Health Needs Screening	3 of 3	3 of 3	3 of 3	2 of 2	2 of 2	1 of 2	1 of 2	2 of 2	2 of 2	2 of 2
Job Connect Program					1 of 1					
Lead Testing				1 of 1		2 of 2				
Prenatal and Postpartum Care						1 of 1	1 of 1			
Well Child Visits (Age 3-6)				1 of 1						
Were the Results from the Intervention(s) Computed Effectively?										
AOD Treatment								Yes	Yes	Yes
Adult Preventive Care Visit		Yes	Yes							
Annual Dental Visit	Yes									
Asthma Medication Management						Yes				
Behavioral Health Utilization								Yes	Yes	Yes
ED Utilization		some	some	Yes	Yes					
Follow-up Psychiatric Hospitalization	some	some	some				Yes			
Health Needs Screening	Yes	Yes	Yes	Yes	Yes	Yes	Yes	some	some	some
Job Connect Program					No					
Lead Testing				No		Yes				
Prenatal and Postpartum Care						No	No			
Well Child Visits (Age 3-6)				Partial						

Individual MCE Profiles and Assessments

In this section, B&A offers a brief description of the interventions used by each of the MCEs in their 2019 QIPs. Based on our assessment of each QIP, B&A offers some recommendations to each MCE for continuous quality improvement on those QIPs that are continuing in future years.

Anthem

QIPs Reviewed

- AAP: Adult Access to Preventive Care (HCC, HIP)
- ADV: Annual Dental Visit (HHW)
- ED: ED Utilization (HCC, HIP)
- FUH: Follow-up After Psychiatric Hospitalization (HHW, HCC, HIP)
- HNS: Health Needs Screening (HHW, HCC, HIP)

Types of interventions used

- Text message joined with live voice calls (AAP, ADV, ED)
- Provider incentive program (AAP)
- Phone outreach within 72 hours of discharge, text follow-up (FUH)
- Pursuant kiosks in Walmart, text campaign, dedicated member outreach team (HNS)

B&A's overall assessment of Anthem's QIPs

- Anthem has credible and usable data to show success or failure on most of its interventions.

- Anthem's QIPs have some type of internal dashboard that is used to track interventions and/or the measures in the QIP throughout the year. Anthem's internal tracking is sophisticated with respect to identifying areas of greatest opportunity for improving the measures of interest.

- The interventions for most of Anthem's QIPs have been in long-standing use and do not appear to be 'moving the needle' much if at all. There needs to be thought given on how to target the interventions better or develop new ones.

CareSource

QIPs Reviewed

- ED: ED Utilization (HHW, HIP)
- HNS: Health Needs Screening (HHW, HCC, HIP)
- JOB: Job Connect Program (HIP)
- LSC: Lead Testing (HHW)
- W34: Well Child Visits Age 3-6 (HHW)

Types of interventions used

- The Job Connect program itself (JOB)
- Pursuant kiosks in Walmart, dedicated member "contact tracer" team for outreach (HNS)
- Dedicated maternal child health coordinator team for provider education (LSC)
- In-home assessment for personalized member outreach (ED, W34)

B&A's overall assessment of CareSource's QIPs

- Although the Job Connect program itself is commendable, it is really more an intervention to other quality outcomes than a QIP itself. Further, the total population in this QIP is small.

- The in-home assessment outreach is certainly a "high touch" intervention. But the opportunity for extension of that outreach appears limited. CareSource may want to consider additional interventions beyond this for the ED and W34 QIPs such as one directed to providers to encourage follow-up members to complete well child visits and to avoid unnecessary ED visits.

- B&A saw some evidence of internal dashboards related to these QIPs, but they could be streamlined and enhanced for ongoing reporting to OMPP.

MDwise

QIPs Reviewed

- AMM: Asthma Medication Management (HHW)
- FUH: Follow-up After Psychiatric Hospitalization (HIP)
- HNS: Health Needs Screening (HHW, HIP)
- LSC: Lead Testing (HHW)
- PPC: Prenatal and Postpartum Care (HHW, HIP)

Types of interventions used

- Provider outreach (AMM, LSC, PPC)
- Automated calls to members (LSC)
- Case management (AMM)
- Targeted outreach to providers, member incentive (FUH)
- Internal process improvements on reporting (HNS)

B&A's overall assessment of MDwise's QIPs

- B&A saw evidence of internal dashboards related to some QIPs, but they could be streamlined and enhanced for ongoing reporting to OMPP.

- Although the provider education on prenatal/postpartum care and lead testing was commendable, there did not appear to be an effective method to retain provider engagement. B&A suggests more thought be directed to specific engagement such as identifying missed numerator opportunities for these measures or relaying best practices MDwise has observed with other provider practices on these measures.

- The interventions for most of MDwise's QIPs have been in long-standing use and do not appear to be 'moving the needle' much if at all. There needs to be thought given on how to target the interventions better or develop new ones.

MHS

QIPs Reviewed

- AOD: Alcohol and Other Drug Abuse Treatment (HHW, HCC, HIP)
- BH: Behavioral Health Utilization (HHW, HCC, HIP)
- HNS: Health Needs Screening (HHW, HCC, HIP)

Types of interventions used

- Case management, outreach from ED Diversion team (AOD, BH)
- Provider (Community Mental Health Centers) incentive (BH)
- Phone reminders, email campaigns, digital advertising (HNS)

B&A's overall assessment of MHS's QIPs

- The interventions for the AOD and BH QIPs have been in long-standing use and do not appear to be 'moving the needle' much if at all. There needs to be thought given on how to target the interventions better or develop new ones.

- The intervention proposed to work closely with Community Mental Health Centers had promise, but reporting of protected health information prohibited the intervention from moving forward. MHS is encouraged to find other methods to share useful information about its members with each CMHC even if this specific QIP is suspended.

- Whereas last year MHS reported on multiple types of interventions related to the HNS QIP, these were mostly absent this year.

SECTION V: EXAMINATION OF PROVIDER NETWORK ADEQUACY

Introduction

The Office of Medicaid Policy and Planning (OMPP) has contractual requirements that mandate that each managed care entity (MCE) maintain a provider network that ensures that members in the Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC) have access to an array of provider specialties to meet their medical needs.

Burns & Associates (B&A) conducted an assessment of provider network adequacy in the External Quality Review (EQR) conducted in CY 2018. For that assessment, B&A examined 16 provider specialties. In particular, we examined not just where members from each MCE had access to providers (as self-reported by the MCE), but also where members utilized providers within the MCE's network. B&A used claims experience from CY 2017 to compute the driving distance between the member's home and the provider's location. The average driving distance was computed by provider specialty and by county for each provider specialty within each OMPP program. These values were compared to OMPP's contract requirements. Recognizing that members have the choice to seek care from providers that are further from their home than other providers that may be available to them, B&A nonetheless believes that the average driving distance is a truer representation of provider availability.

In the CY 2019 EQR, B&A conducted a similar study for nine provider specialty categories. Many of the provider specialty categories are the same as those reviewed in CY 2020 since they represent the most common services utilized (e.g., primary care, dental). Other provider categories were added at the request of the OMPP (e.g., splitting behavioral health providers into two groups for behavioral health and substance use disorder). B&A used utilization from the CY 2018 time period to update the average driving distance calculations.

As a result of the CY 2019 EQR, the OMPP implemented two new reports for the MCEs to submit annually beginning in October 2019 as a way for it to strengthen the oversight of the MCE's provider networks. These reports were incorporated into the OMPP's MCE Reporting Manual.

Report 0902, *Count of Enrolled Providers*, requests a count of providers that the MCE contracts with across 41 different provider categories. The MCEs must report these counts separately for the HHW, HIP and HCC programs. The report instructions ask for the MCEs to count only those providers that can separately bill the OMPP or the MCEs. For example, emergency department doctors in a hospital setting are not counted. Counts of providers are distributed across Indiana's 92 counties. For facilities, the provider is counted in the county where they are physically located. For individuals, the provider is counted in the county where he/she primarily renders services.

Report 0903, *Member Access to Providers*, requests that the MCE report its total enrollment as of the month of September in the reporting year. Then, for 36 of the 41 provider categories as shown in Report 0902, the MCE is to report the count of members within each county that do not have access to each of the 36 provider categories where the OMPP has established a distance standard. This is an inverse to prior geoaccess reports that MCEs had previously submitted. In prior years, the MCEs reported the percent of members with access; in this new report, the MCEs report the number of members without access. The OMPP has set mileage standards for most of the 41 provider categories to define appropriate access. These standards appear in Exhibit V.1 on the next page.

Exhibit V.1
OMPP Standards for Network Adequacy by Provider Category

Acute Care Hospitals	30 mi urban, 60 mi rural
Inpatient Psychiatric Facilities	1 within 60 miles
Home Health Providers	1 within 60 miles
Clinic	no specific requirement
Pharmacy	2 within 30 miles
ESRD Clinic	1 within 60 miles

PMPs- Physicians	1 within 30 miles
PMPs- APRNs	no specific requirement
PMPs- Physician Assistants	no specific requirement
General Dentistry	1 within 30 miles
Dentists/ Oral Surgeons	2 within 60 miles
Behavioral Health Providers	30 mi urban, 45 mi rural

Addiction Services	no specific requirement
ABA Providers	no specific requirement
Anesthesiologists	2 within 60 miles
Cardiologists	2 within 60 miles
Cardiovascular Surgeons	1 within 90 miles
Dermatologists	1 within 90 miles
Endocrinologists	2 within 60 miles
Gastroenterologists	2 within 60 miles
Hematologists	2 within 60 miles
Infectious Disease Specialists	1 within 90 miles
Nephrologists	2 within 60 miles
Neurological Surgeons	1 within 90 miles
Neurologists	2 within 60 miles
OB/GYN	2 within 60 miles
Occupational Therapists	2 within 60 miles
Oncologists	2 within 60 miles
Ophthalmologists	2 within 60 miles
Optometrists	2 within 60 miles
Orthodontists	2 within 60 miles
Orthopedic Surgeons	2 within 60 miles
Otolaryngologists	2 within 60 miles
Pathologists	1 within 90 miles
Physical Therapists	2 within 60 miles
Psychiatrists	2 within 60 miles
Pulmonologists	2 within 60 miles
Radiologists	1 within 90 miles
Rheumatologists	1 within 90 miles
Speech Therapists	2 within 60 miles
Urologists	2 within 60 miles

The purpose of the CY 2020 EQR focus study on network adequacy is to:

- Assess changes in provider network adequacy from prior year studies; and
- Validate the results reported by the MCEs on Reports 0902 and 0903.

Methodology for Conducting the Study

Reports 0902 and 0903

For the review of the 0902 and 0903 reports, B&A built a side-by-side comparison of the results reported by each of the four MCEs. Since Report 0902 requests the count of unique providers, the results were reviewed from each MCE for face validity.

In Step 1, a review was conducted of the results reported by a single MCE *across OMPP programs* (HHW, HIP, HCC). Each MCE contracts with at least two programs. In total, 10 MCE/program combinations were reviewed for each unique provider category. The median value for each provider

category was determined across programs. B&A then compared the count for the provider category in each program individually. Provider categories were tagged if the MCE reported a count of providers in a specific OMPP program that was less than 90% or greater than 110% of the median value computed. This assesses if the provider network varies considerably for an MCE across the HHW, HIP and HCC programs.

In Step 2, the counts of providers within a category were reviewed *across MCEs*. The median value for each provider category was determined across MCEs. Provider categories were tagged if the MCE reported a count of providers that was less than 80% or greater than 120% of the statewide median value computed in a specific category.

In the desk review of Report 0903, 36 provider categories were reviewed across 10 MCE/program combinations. B&A captured the number of members in a given MCE/program who did not have sufficient access to the specific provider category. The members without "sufficient access" are those members who live further from the nearest MCE provider in the category using the mileage standards shown in Exhibit V.1. To control for variations in enrollment, B&A then computed these values into a no access rate per 1,000 members. B&A tagged MCE/programs where the network was not sufficient and noted the provider categories where this was most problematic.

To validate the results submitted by each MCE in Report 0903, B&A used a more conservative approach to assess network adequacy. B&A identified members enrolled in HHW, HIP and HCC in CY 2019 and compiled their utilization during this time period using encounter extracts from the OMPP's Enterprise Data Warehouse (EDW). The encounters were segmented by MCE and program (HHW, HIP or HCC) for analytical purposes.

When a provider enrolls in Indiana Health Coverage Programs (IHCP), the provider is identified by provider type and specialty. These are the usual variables that the OMPP assigns to each provider category when requesting information from the MCEs on Reports 0902 and 0903. Sometimes a taxonomy code is used as well. B&A followed the mapping logic of provider type and specialty to define the providers to analyze.

B&A computes the driving distance for each member-to-provider trip included in the study. Only one unique member-to-provider pairing was used in the study. For example, if a member saw the same behavioral health provider 20 times in CY 2019, only one trip of the 20 is included in the study. All trips were arrayed from shortest to longest driving distance. Using the mileage requirement shown in Exhibit V.1, B&A identified the percentage of trips in the provider category that exceeded the OMPP-defined distance standard.

It should be noted that B&A did report information for categories that the OMPP did not define a distance standard.

- For Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs), B&A used the same threshold set for Primary Medical Providers (PMP), namely, a standard of 30 miles. All three categories were then merged into a Primary Care category for reporting purposes.
- For Clinics, B&A also used a standard of 30 miles.
- For Addiction Services and ABA providers, B&A used a standard of 60 miles.

It is true that the MCEs are reporting on *all* members (including non-users) and their access to the *closest provider* on record. B&A reported on *users of the service only* and their access to their *chosen provider*. Some differences, therefore, between B&A's results and the MCE's results can be due to utilization

trends and member choice. The purpose of the validation was to determine where there may be significant variation not only between B&A's percentages and the MCE's percentages of members with no access, but also to review the percentage of members with no access in a particular provider category across MCEs or OMPP programs.

B&A did identify some MCE/provider categories with higher-than-usual percentages of members accessing providers above the distance standard for the provider category. A root cause analysis was conducted to confirm our original findings. The results of this analysis are reported in the Findings section.

Comparison to Prior Year Findings

The methodology used to compare results from CY 2019 to CY 2018 was identical, but this methodology differs from the provider mapping logic used to validate Report 0903.

Five high-volume service categories were examined to compare results across the two years. The five service categories include primary care, dental services, prenatal/postpartum care, substance use disorder (SUD) and serious emotional disturbance or serious mental illness (SED/SMI). Whereas the Report 0903 uses only the provider type, provider specialty or taxonomy to filter the providers for review, the service categories mentioned here use a variety of variables to define the service category, e.g., CPT, diagnosis codes or place of service codes.

In-state individuals enrolled in HHW, HIP and HCC were mapped to one of Indiana's 92 counties based on their home address in the enrollment file provided to B&A from the EDW. The latitude and longitude coordinates of each member's home address, as provided by the State, were plotted. Likewise, the latitude and longitude coordinates of every provider with a claim in the study database was plotted.

Utilization was obtained from the State's EDW for services delivered in CY 2019. The average distance travelled was computed by taking the average distance for all encounters within the specialty for members' utilization within a county. As mentioned previously, the data for this tabulation was limited to a single pairing of member-to-provider.

Geocoding software (either the Google Distance Matrix web service or BING Maps web service) was used to map the driving distance from the member's home to the provider's office[7]. Some exclusions were applied due to the fact that the latitude/longitude coordinates were missing or not valid for either the member's home or the provider's office. Non-valid coordinates were defined if the computed driving distance was either less than 0.2 miles or more than 100.0 miles between the member's home and provider's office. The final total number of trips in the CY 2019 study after exclusions were applied was 2,799,941—for HHW, there were 1,272,065; for HIP, there were 1,233,872; and for HCC, there were 294,004 trips.

For each of the five specialties, the average distance was computed for CY 2019 for each MCE/program combination. This value was compared to the CY 2018 result. Counties that were identified as potential access issues in CY 2018 were reviewed to determine if the CY 2019 results were better, worse or the same as CY 2018. The average distance was also computed for each county. B&A created a three-scale range to count the number of counties that had average driving distance of 20 miles or less, between 20 and 30 miles, and greater than 30 miles. Although this scale range is stricter than OMPP's contractual requirements, it was used to assess the relative variation in the average distance travelled by members

[7] Note that B&A computes the driving distance (turn by turn) as opposed to a crow flies' distance.

across the 92 counties in the state. Note that if a county had fewer than 10 member trips for a provider category in the entire year, the county was noted as low volume and not counted in the totals.

Average Distance Reports for Providers on Report 0903

A similar approach was used to compute the average distances for the provider categories on Report 0903. For this portion of the study, B&A used the definitions to categorize providers as defined in the report specification (i.e., provider type, provider specialty, and potentially taxonomy).

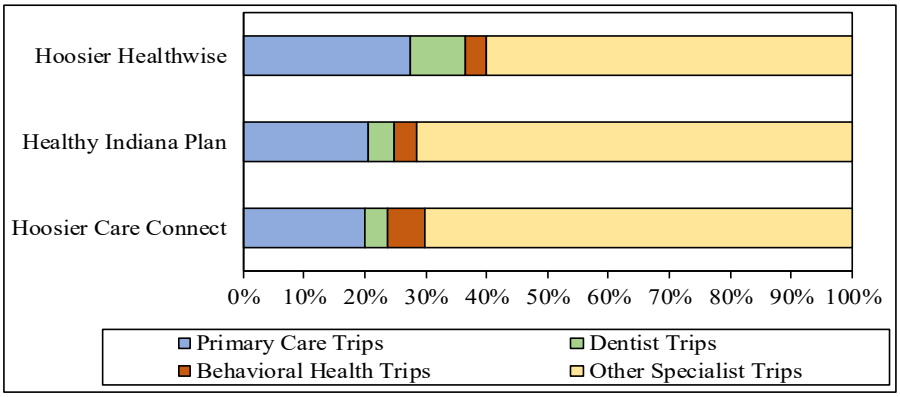
The CY 2019 utilization dataset used for the comparison to CY 2018 was also used in this portion of the study with the same members. After defining the provider categories, the process was the same as described above with respect to unique member-to-provider pairings, geocoding the driving distance, and excluding very low or very high mileage trips.

The average distance was computed for CY 2019 for each of the 36 provider categories reviewed by MCE/program combination. After the average distance was computed for each individual county, the counties were tallied across a three-scale range. The difference in this study is that the three-scale range can vary based upon the OMPP's maximum mileage limit (e.g., 30 miles, 60 miles or 90 miles). Counties with less than 10 trips in the entire year were once again removed from the tabulation.

An additional analysis conducted in this portion of the study is that B&A created histograms to compare the average driving distance across eight regions in the state so that results could be compared not only across regions but also across MCEs within the same region.

As shown in Exhibit V.2 below, the final total number of trips in this portion of the study after exclusions were applied was 6,961,447—for HHW, there were 3,055,090; for HIP, there were 3,107,503; and for HCC, there were 798,854 trips.

Exhibit V.2
Proportion of Trips in the Network Adequacy Study
by Program and Major Provider Type on Report 0903



	Primary Care Trips	Dentist Trips	Behavioral Health Trips	Other Specialist Trips	Total
Hoosier Healthwise	835,536	281,238	104,440	1,833,876	3,055,090
Healthy Indiana Plan	641,719	129,490	115,907	2,220,387	3,107,503
Hoosier Care Connect	160,360	29,069	48,203	561,222	798,854

Findings from the Review of Access to Services by Provider Specialty

Validation of Report 0902, Count of Enrolled Providers

Exhibit V.3 that appears on the next page shows the compilation of the results from this report from each MCE. When each MCE was reviewed for provider counts across the three OMPP programs (HHW, HIP, HCC), there was little variance found across programs. This indicates that the MCE's provider network is fairly constant across all of the OMPP programs.

There was variability found, however, in some provider categories across MCEs. The greatest variances on the high side are shown in green, meaning that the MCE reported provider counts more than 120% above the all-MCE median value. Cells in peach mean that the MCE reported counts much lower (less than 80%) of the all-MCE median value.

There is high variability among counts of providers by type across the MCEs with few exceptions. Out of 41 provider categories,

- Anthem is below 80% of the MCE median in one category and above 120% of the MCE median in 30 categories.
- CareSource is below 80% of the MCE median in 27 categories and above 120% of the MCE median in one category.
- MDwise is below 80% of the MCE median in 4 categories and above 120% of the MCE median in 10 categories.
- MHS is below 80% of the MCE median in 8 categories and above 120% of the MCE median in 4 categories.
- The greatest variation on the high side (green cells) was found with Pharmacy, Physicians, APRNs, Behavioral Health Providers, Hematologists, Orthodontists, Physical Therapists, Radiologists, and Speech Therapists.
- The greatest variation on the low side (peach cells) was found with Home Health Providers, Pharmacy, APRNs, General Dentistry, Oral Surgeons, Anesthesiologists, Cardiovascular Surgeons, Occupational Therapists, Physical Therapists, Psychiatrists, and Speech Therapists.

Exhibit V.3
Side-by-Side Comparison of MCE Submissions on OMPP Report 0902: Count of Enrolled Providers

	Anthem			CareSource		MDwise		MHS		
Provider Types	**HHW**	**HIP**	**HCC**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HCC**
Acute Care Hospitals	130	130	128	99	110	163	165	165	164	162
Inpatient Psychiatric Facilities	50	54	50	42	50	32	33	24	24	24
Home Health Providers	176	178	175	56	63	62	65	115	115	124
Clinic	158	159	158	155	200	1,943	1,950	206	203	204
Pharmacy	1,240	1,240	1,240	1,448	1,448	865	865	2,291	2,291	2,291
ESRD Clinic	166	166	166	43	43	47	47	155	155	157
ABA Providers	471	461	471	265	266	219	219	215	205	209
Behavioral Health Providers	2,911	3,171	2,910	534	560	614	614	692	685	690
Addiction Services	31	32	31	33	35	40	40	28	28	29
Anesthesiologists	1,738	1,690	1,739	125	138	1,240	1,263	1,038	1,037	1,012
Cardiologists	1,155	1,067	1,158	488	489	729	715	428	423	412
Cardiovascular Surgeons	94	93	94	51	51	178	180	126	122	118
Dentistry (General)	1,120	1,096	1,102	669	728	1,039	1,039	1,172	1,165	1,173
Dentistry (Oral Surgeons)	135	130	134	35	36	99	99	65	64	65
Dermatologists	126	129	127	72	72	125	120	111	111	99
Endocrinologists	145	146	144	90	92	137	134	111	98	104
Gastroenterologists	411	408	412	266	263	364	373	274	270	268
Hematologists	53	53	53	45	49	297	301	15	16	24
Infectious Disease Specialists	191	188	190	96	96	146	151	126	111	115
Nephrologists	314	309	315	154	155	243	251	200	200	200
Neurological Surgeons	174	172	174	52	52	118	122	123	124	125
Neurologists	450	440	451	221	224	398	400	333	333	329
OB/GYN	1,106	1,135	1,110	606	607	940	947	925	911	904
Occupational Therapists	855	735	860	49	50	336	333	347	343	346
Oncologists	279	242	279	269	268	420	415	291	289	288
Ophthalmologists	327	379	327	146	143	267	272	246	246	239
Optometrists	384	613	384	476	478	408	408	468	469	461
Orthodontists	13	13	13	5	4	20	20	137	137	137
Orthopedic Surgeons	682	622	684	321	322	524	521	566	555	545
Otolaryngologists	253	257	253	138	138	227	231	216	213	209
Pathologists	457	430	457	55	56	366	369	262	260	233
Physical Therapists	1,650	1,760	1,649	237	244	800	793	832	829	832
PMPs-Physicians	3,195	3,092	3,224	2,047	2,033	2,156	2,129	2,342	2,208	2,565
PMPs-APRNs	1,097	1,106	1,083	829	832	474	468	568	565	538
PMPs-Physician Assistants	83	89	87	41	41	44	44	41	41	41
Psychiatrists	903	896	903	411	416	619	619	674	663	664
Pulmonologists	466	432	465	248	239	388	383	232	231	229
Radiologists	2,401	2,458	2,400	176	183	1,230	1,281	951	949	947
Rheumatologists	113	115	113	76	76	111	116	81	78	75
Speech Therapists	528	365	527	58	58	211	209	209	204	208
Urologists	390	385	390	160	161	251	252	221	221	221

Above 120% of median of medians | *Below 80% of median of medians*

Validation of Report 0903, Member Access to Providers

B&A conducted a side-by-side analysis of the MCE submissions on this report as well. B&A then ran its own validation of the MCE's submission related to access issues. Both analyses were shared with each MCE in a 1:1 meeting. After allowing for time for their own review, some MCEs submitted updates to their original Report 0903 submissions.

When measuring potential accessibility to the nearest provider on file, every MCE reported few issues with member access against the OMPP distance standards. The notable exceptions where access was reported to be an issue in some portions of the state were in the following categories:

- Hematologists (two MCEs)
- Oral Surgeons (two MCEs)
- Orthodontists (three MCEs)

When B&A validated these results, we found considerably greater access issues in some provider categories when considering only those members that had a service from a provider in the category in CY 2019. Using claims experience, B&A computed the percentage of users who traveled beyond the mileage threshold within each of the provider categories. This was compared to the MCE's reporting of the percentage of members with access beyond the OMPP threshold.

Exhibit V.4 appears on the next two pages and displays this comparison. The first page of the exhibit shows facility-based providers and high-volume service providers in Medicaid. The second page of the exhibit shows individual specialists.

The vast majority of the provider categories demonstrated variance between the MCE-reported and B&A-computed member access beyond the OMPP threshold. The largest variances were observed for the following provider types shown on the first page of Exhibit V.4 (with the red border):

- Inpatient Psychiatric Facilities (*All MCEs*)
- PMPs – Physicians, APRNs, and Physician Assistants (*Anthem primarily*)
- Behavioral Health Providers (*All MCEs*)

As an example of how to read the exhibit, all MCEs reported zero access issues related to inpatient psychiatric facilities for their members, meaning that there is a provider within 60 miles of every member (the OMPP standard). When B&A computed the distances from the homes of the members who used inpatient psychiatric hospital services to the hospital that they went to, it was found that, at minimum, 12 percent of users travelled more than 60 miles for the service in every MCE and program. Similar findings were observed for behavioral health providers where a minimum of 17 percent of utilizers travelled more than 30 miles (in urban counties) or 45 miles (in rural counties) to seek this service.

Exhibit V.4
Comparing the Percent of Members with Access Beyond OMPP's Distance Threshold: MCE Reported Results and Burns & Associates Validation

MCE percentages reflect the percent of all members that the MCE indicated are outside of the OMPP-defined access range for the provider type.
B&A percentages reflect members that used the service in CY2019 and the percent that traveled beyond the OMPP-defined access range for the provider type.

Provider Types	Anthem						CareSource				MDwise				MHS					
	HHW		HIP		HCC		HHW		HIP		HHW		HIP		HHW		HIP		HCC	
	MCE	B&A	MCE	B&A	MCE	B&A	MCE	B&A	MCE	B&A	MCE	B&A	MCE	B&A	MCE	B&A	MCE	B&A	MCE	B&A
Facilities/Agency-Based																				
Acute Care Hospitals	0.0%	7.0%	0.0%	6.2%	0.0%	7.8%	0.0%	7.7%	0.0%	6.8%	0.0%	6.8%	0.0%	6.1%	0.0%	7.3%	0.0%	6.5%	0.0%	9.2%
Inpatient Psychiatric Facilities	0.0%	17.7%	0.0%	12.6%	0.0%	15.5%	0.0%	23.6%	0.0%	14.3%	0.0%	26.4%	0.0%	15.3%	0.0%	23.8%	0.0%	12.3%	0.0%	20.6%
Clinic*		14.8%		19.3%		20.0%		7.8%		9.9%		8.3%		10.9%		8.9%		11.1%		14.1%
Pharmacy	0.0%	2.9%	0.0%	5.3%	0.0%	5.8%	0.0%	2.9%	0.0%	4.9%	0.0%	2.6%	0.0%	5.3%	0.0%	2.8%	0.0%	5.0%	0.0%	6.3%
ESRD Clinic	0.0%	0.0%	0.0%	3.8%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.4%	0.0%	1.0%
High-Volume Services																				
Primary Medical Providers	0.1%	17.3%	0.2%	20.8%	0.1%	20.1%	0.0%	6.5%	0.0%	8.2%	0.0%	6.5%	0.0%	8.2%	0.0%	6.8%	0.0%	8.7%	0.0%	11.2%
General Dentistry	0.0%	7.5%	0.0%	5.8%	0.0%	8.7%	0.1%	10.2%	0.1%	9.1%	0.0%	7.7%	0.0%	5.9%	0.0%	9.5%	0.0%	10.4%	0.0%	12.8%
Dentists/ Oral Surgeons	0.0%	1.9%	0.0%	2.1%	0.0%	3.2%	4.2%	11.6%	4.3%	13.7%	0.0%	2.9%	0.0%	4.0%	2.0%	7.8%	2.8%	5.5%	2.6%	7.0%
Addiction Services*		1.6%		4.7%		3.6%		0.0%		8.0%		0.0%		5.3%		0.0%		6.8%		5.2%
Behavioral Health Providers	0.0%	17.7%	0.0%	21.3%	0.0%	19.7%	0.0%	21.5%	0.0%	19.2%	0.0%	17.9%	0.0%	19.2%	0.0%	21.1%	0.0%	20.4%	0.0%	20.6%

*For Clinic and Addiction Services, the MCEs were not required to report on the 0903.

indicates providers with greatest variation between MCE reporting and B&A validation

Exhibit V.4 (continued)

Comparing the Percent of Members with Access Beyond OMPP's Distance Threshold: MCE Reported Results and Burns & Associates Validation

MCE percentages reflect the percent of all members that the MCE indicated are outside of the OMPP-defined access range for the provider type.
B&A percentages reflect members that used the service in CY2019 and the percent that traveled beyond the OMPP-defined access range for the provider type.

Provider Types	Anthem						CareSource				MDwise				MHS					
	HHW		HIP		HCC		HHW		HIP		HHW		HIP		HHW		HIP		HCC	
	MCE	B&A	MCE	B&A	MCE	B&A	MCE	B&A	MCE	B&A	MCE	B&A	MCE	B&A	MCE	B&A	MCE	B&A	MCE	B&A
Other Specialities																				
ABA Providers*		5.6%		3.1%		6.5%		2.2%		0.0%		3.3%		0.0%		1.9%		0.0%		7.6%
Anesthesiologists	0.0%	6.3%	0.0%	6.2%	0.0%	7.3%	0.0%	7.1%	0.0%	4.4%	0.0%	9.2%	0.0%	5.1%	0.0%	5.9%	0.0%	4.2%	0.0%	7.1%
Cardiologists	0.0%	12.3%	0.0%	7.0%	0.0%	7.2%	0.0%	5.7%	0.0%	4.3%	0.0%	5.0%	0.0%	4.2%	0.0%	5.3%	0.0%	3.5%	0.0%	4.8%
Cardiovascular Surgeons	0.0%	1.0%	0.0%	4.2%	0.0%	4.3%	0.0%	0.0%	0.0%	1.3%	0.0%	3.2%	0.0%	1.9%	0.0%	0.0%	0.0%	1.3%	0.0%	1.4%
Dermatologists	0.0%	1.3%	0.0%	1.0%	0.0%	1.2%	0.0%	0.9%	0.0%	1.6%	0.1%	1.3%	0.1%	1.0%	0.0%	0.7%	0.0%	0.8%	0.0%	0.8%
Endocrinologists	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.6%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.5%	0.0%	0.3%	0.0%
Gastroenterologists	0.0%	9.4%	0.0%	3.5%	0.0%	4.9%	0.0%	11.8%	0.0%	5.0%	0.0%	14.5%	0.0%	9.5%	0.0%	11.8%	0.0%	2.6%	0.0%	7.2%
Hematologists	1.3%	0.0%	1.9%	0.0%	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	52.4%	0.0%	37.3%	0.0%	27.0%	0.0%
Infectious Disease Specialists	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
Nephrologists	0.0%	15.2%	0.0%	10.5%	0.0%	8.8%	0.0%	5.8%	0.0%	9.1%	0.0%	16.5%	0.0%	3.7%	0.0%	12.8%	0.0%	7.6%	0.0%	7.4%
Neurological Surgeons	0.0%	0.0%	0.0%	0.6%	0.0%	0.2%	0.0%	2.1%	0.0%	0.9%	0.0%	1.7%	0.0%	1.0%	0.0%	1.8%	0.1%	0.7%	0.0%	0.4%
Neurologists	0.0%	21.0%	0.0%	7.3%	0.0%	12.3%	0.0%	22.0%	0.0%	7.8%	0.0%	24.4%	0.0%	6.7%	0.0%	19.3%	0.0%	6.0%	0.0%	15.1%
OB/GYN	0.0%	6.2%	0.0%	5.0%	0.1%	8.6%	0.0%	2.0%	0.0%	3.2%	0.0%	2.8%	0.0%	3.6%	0.0%	1.7%	0.0%	2.5%	0.0%	4.5%
Occupational Therapists	0.0%	4.9%	0.0%	2.9%	0.0%	7.0%	0.0%	1.8%	0.0%	9.1%	0.0%	3.0%	0.0%	3.1%	0.0%	1.9%	0.0%	8.6%	0.0%	1.5%
Oncologists	0.0%	2.3%	0.0%	5.7%	0.0%	6.3%	0.0%	15.2%	0.0%	5.3%	0.0%	18.0%	0.0%	5.6%	0.0%	11.9%	0.0%	3.4%	0.0%	5.5%
Ophthalmologists	0.0%	6.2%	0.0%	5.0%	0.0%	6.7%	0.0%	9.3%	0.0%	6.6%	0.0%	6.5%	0.0%	5.6%	0.0%	5.5%	0.0%	5.4%	0.0%	7.6%
Optometrists	0.0%	0.9%	0.0%	1.5%	0.0%	2.1%	0.0%	0.8%	0.0%	1.0%	0.0%	0.7%	0.0%	1.1%	0.0%	7.9%	0.0%	9.0%	0.0%	9.5%
Orthodontists	32.7%	4.2%	32.1%	0.0%	33.8%	10.7%	37.7%	4.4%	36.4%	7.2%	29.3%	5.9%	28.7%	0.0%	0.2%	10.6%	0.3%	0.0%	0.3%	19.9%
Orthopedic Surgeons	0.0%	11.7%	0.0%	6.0%	0.0%	8.3%	0.0%	10.0%	0.0%	2.0%	0.0%	13.7%	0.0%	2.1%	0.0%	7.5%	0.0%	2.4%	0.0%	5.2%
Otolaryngologists	0.0%	6.9%	0.0%	6.4%	0.0%	9.5%	0.0%	7.7%	0.0%	5.9%	0.0%	13.3%	0.0%	9.5%	0.0%	6.5%	0.0%	5.2%	0.0%	10.0%
Pathologists	0.0%	0.5%	0.0%	0.6%	0.0%	0.7%	0.0%	0.1%	0.0%	1.0%	0.0%	0.8%	0.0%	0.9%	0.0%	0.4%	0.0%	0.9%	0.0%	1.1%
Physical Therapists	0.0%	6.4%	0.0%	4.6%	0.0%	6.9%	0.0%	0.8%	0.0%	1.2%	0.0%	4.1%	0.0%	1.4%	0.0%	0.9%	0.0%	1.0%	0.0%	1.7%
Psychiatrists	0.0%	6.8%	0.2%	5.5%	0.0%	6.9%	0.0%	13.6%	0.0%	6.1%	0.0%	12.7%	0.0%	8.4%	0.0%	14.0%	0.0%	8.0%	0.0%	12.1%
Pulmonologists	0.0%	5.3%	0.0%	5.0%	0.0%	5.3%	0.0%	6.3%	0.0%	3.8%	0.0%	3.8%	0.0%	4.1%	0.0%	2.1%	0.0%	3.4%	0.0%	5.1%
Radiologists	0.0%	0.9%	0.0%	0.9%	0.0%	1.3%	0.0%	0.7%	0.0%	0.6%	0.0%	0.6%	0.0%	0.7%	0.0%	0.8%	0.0%	0.9%	0.0%	0.9%
Rheumatologists	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
Speech Therapists	0.0%	8.4%	0.0%	7.7%	0.0%	12.5%	0.0%	0.5%	0.0%	0.0%	0.0%	1.7%	0.0%	0.0%	0.0%	1.2%	0.0%	0.0%	0.0%	3.7%
Urologists	0.0%	12.2%	0.0%	5.6%	0.0%	7.9%	0.0%	16.2%	0.0%	2.7%	0.0%	13.1%	0.0%	2.8%	0.0%	16.7%	0.0%	1.5%	0.0%	9.6%

*For ABA providers, the MCEs were not required to report on the 0903.

Root Cause Analysis When High Variances Observed

Due to the high degree of variation between what B&A found for member access and what the MCEs reported, B&A conducted a root cause analysis to better understand what was causing the variation. Our focus was on primary medical providers and behavioral health providers.

Based on the initial findings and discussion with the MCEs, it was determined that the MCEs are not receiving state assigned latitude and longitude coordinates on member and provider files from OMPP. Instead, the MCEs are using software to geocode member and provider records to assign a latitude and longitude for the purposes of determining the number of members traveling outside the established provider type mile threshold for Report 0903. However, B&A used the assigned latitude and longitude values in member and provider files provided to us by the OMPP for our analysis. B&A, therefore, analyzed the integrity of the latitude and longitude values we used to determine if this may explain the variation from what the MCEs reported. B&A independently obtained latitude and longitude values using the member home addresses and the provider office addresses.

The focus of this targeted review was primary medical providers, or PMPs. The member-to-PMP trips were arrayed from shortest to longest distance using the state-assigned latitude and longitude coordinates. After review, 11,486 members who traveled more than 65 miles to receive PMP services were selected for validation of the state-assigned coordinates. B&A independently obtained the member and provider coordinates using geocoding software. The driving distance was recomputed using the updated coordinate values. A comparison was then made between the driving distance obtained using the state-assigned coordinates and the B&A-assigned coordinates.

Differences in assigned coordinates among the sample unique member-to-provider pairings resulted in slight differences in driving distance for a majority of members. This was true statewide and for each MCE in particular. However, 76% of the sample showed a difference of five miles or less between the state-assigned coordinates and the B&A-assigned coordinates. Since B&A used the threshold of 65 miles or greater to determine the sample, even a five-mile reduction down to 60 miles using alternate coordinates would still show access concerns for most of the sample of trips where this was identified.

Exhibit V.5
Results of Root Cause Analysis on the Validity of
Latitude and Longitude Coordinates Used in Access Measures

All MCEs - 11,486 Included Records			
Mileage Differences	**Count**	**%**	**Cum %**
Within 1.0 miles	5,491	48%	48%
Within 1.1 - 5 miles	3,187	28%	76%
Within 5.1 - 10 miles	1,006	9%	84%
Within 10.1 - 15 miles	398	3%	88%
Within 15.1 - 20 miles	253	2%	90%
Over 20 miles	1,151	10%	100%

At the individual MCE level, the percentage of trips found to be within five miles using both sets of coordinates was 76% for Anthem, 73% for CareSource, 78% for MDwise and 68% for MHS.

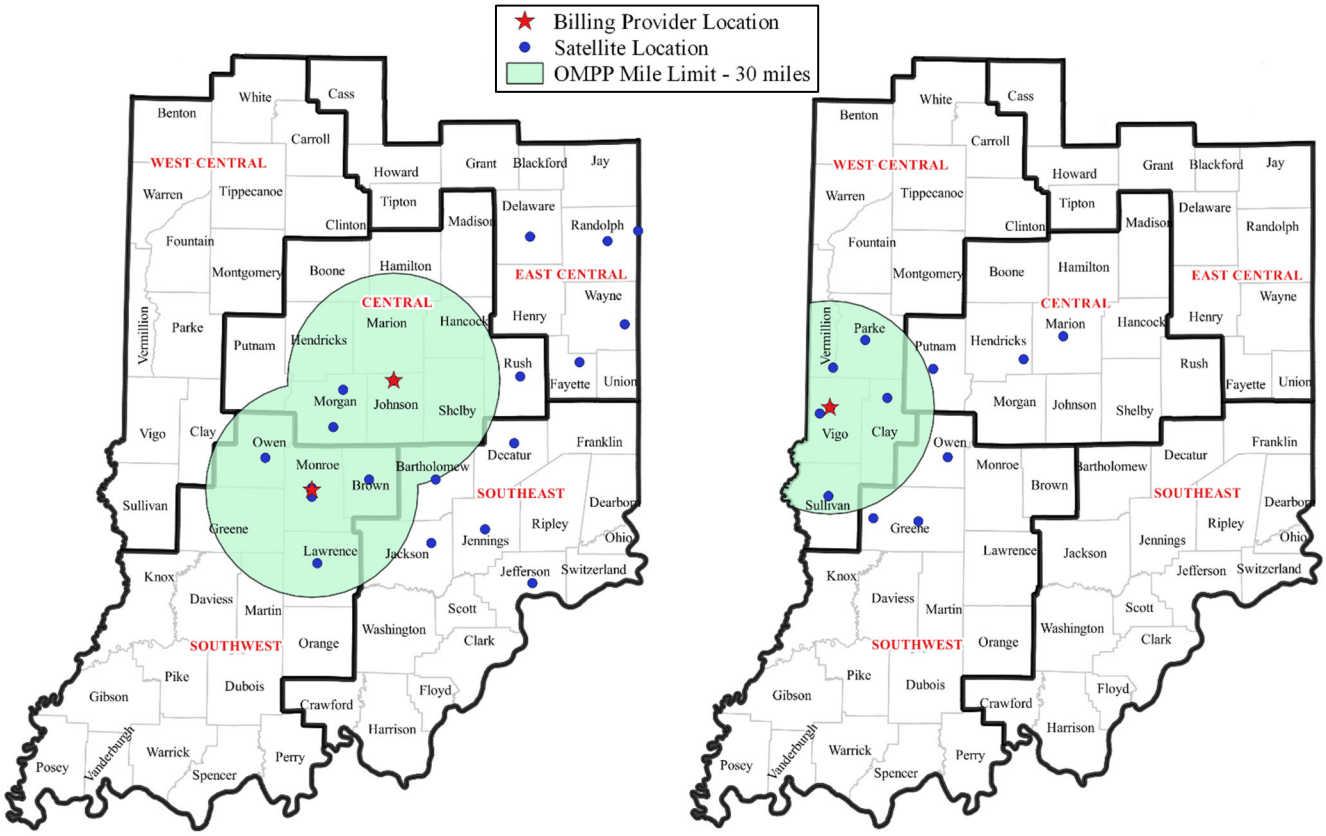
B&A conducted a second root cause analysis with a focus on behavioral health providers since this was the other provider category where high variation was seen between B&A and MCE results on access.

B&A created a sample of behavioral health providers that had at least 100 member trips attached to them in CY 2019. From this list, the sample was further filtered to investigate those providers where at least 20% of the trips were found to be above the mile threshold established by OMPP (30 miles for urban counties and 45 miles for rural counties). In total, 44 providers (3% of all behavioral health providers) were included in this study. These providers, however, represented 63% of all trips found to be above the OMPP mileage thresholds.

To assist with the investigation, provider locations were compiled using the provider billing address and geocoordinates associated with each selected rendering provider. An internet search by billing and rendering provider name and location was performed to identify additional locations. This was completed because B&A noted that, in the files provided by the OMPP, all rendering provider latitude and longitude coordinates were the same for a specific provider, implying that the coordinates are tied to the provider's central (billing) location even if the rendering provider delivers services in a satellite location.

From this review, B&A determined the following:

- Across all MCEs, 39 of the 44 rendering providers have more than one practice location.
- From the study of high-distance trips, 13% of the trips were instances where the provider had a location in the member's home county. The member may have obtained services in the location closer to home; therefore, the distances are overstated due to incorrect provider coordinates.
- To illustrate this, B&A plotted two providers where members may be seeking services in satellite locations in blue that, as shown, sit outside the 30-mile radius of the billing location (red star).



Comparison to Prior Year Findings on Average Distance

The key components for the comparison of average distances between what was found in CY 2019 service utilization compared to CY 2018 utilization was to assess if the average distance travelled improved across the two years. A statistic was tracked to count the number of MCE/program/county combinations out of a total 920 (92 counties * 10 MCE/program combinations) where B&A found access was above the OMPP threshold (county combinations with low sample were excluded). Additionally, B&A identified specific counties in the CY 2018 study that had access challenges –namely, that the average distance that members living in that county travelled to obtain the service exceeded the OMPP maximum threshold. B&A investigated to determine if access in these counties improved, worsened or was the same in CY 2019.

Detailed information on the five provider categories examined appear as dashboard reports in Appendix C. A summary of key findings is discussed below and appears in Exhibit V.6 on page V-15.

- Primary Care
  - Range in average miles travelled across MCE/programs in CY2019: 10.7 - 17.6 miles
  - MCE/program/county combinations with average > 30 miles: 44
  - Counties in CY 2019 with challenges for most MCEs:
    - In the Northern Region: Fulton, Jasper, Newton, Pulaski
    - In the Central Region: Blackford, Benton, Fountain, Montgomery, Warren
    - In the Southern Region: Brown
  - Counties with challenges identified in CY 2018: 11, of which 11 improved

- Dental Services
  - Range in average miles travelled across MCE/programs in CY2019: 10.5 - 14.8 miles
  - MCE/program/county combinations with average > 30 miles: 84
  - Counties in CY 2019 with challenges for most MCEs:
    - In the Northern Region: Newton, Pulaski
    - In the Central Region: Benton, Fountain, Warren, White, Union
    - In the Southern Region: Crawford, Ripley, Switzerland
  - Counties with challenges in CY 2018: 12, of which 5 improved and others had no change

- Prenatal/Postpartum Care
  - Range in average miles across MCE/programs in CY2019: 13.6 - 17.9 miles
  - MCE/program/county combinations with average > 30 miles: 146
  - Counties in CY 2019 with challenges for most MCEs:
    - In the Northern Region: Fulton, Jasper, Kosciusko, LaGrange, Miami, Newton, Pulaski, Starke, Wabash
    - In the Central Region: Benton, Fountain, Jay, Parke, Putnam, Sullivan, Warren, White
    - In the Southern Region: Brown, Crawford, Martin, Orange, Owen, Perry, Switzerland, Washington
  - Counties with challenges in CY 2018: 12, of which 4 improved, 7 remained the same, 1 got worse

- Substance Use Disorder
  - Range in average miles across MCE/programs in CY2019: 11.5 - 17.4 miles
  - MCE/program/county combinations with average > 30 miles: 130
  - Counties in CY 2019 with challenges for most MCEs:
    - In the Northern Region: Jasper, Newton, Pulaski, LaGrange, Wabash
    - In the Central Region: Benton, Fountain, Rush
    - In the Southern Region: Crawford, Decatur, Greene, Jefferson, Jennings, Martin, Ripley, Switzerland
  - Counties with challenges in CY 2018: 17, of which 6 improved, 6 remained the same, 5 got worse

- Serious Emotional Disturbance/Serious Mental Illness
  - Range in average miles across MCE/programs in CY2019: 15.2 - 18.8 miles
  - MCE/program/county combinations with average > 30 miles: 195
  - Counties in CY 2019 with challenges for most MCEs:
    - In the Northern Region: Jasper, Newton, LaGrange, Steuben
    - In the Central Region: Benton, Fountain, Warren, Rush, Shelby, Union
    - In the Southern Region: Crawford, Decatur, Franklin, Greene, Jackson, Jefferson, Jennings, Martin, Owen, Pike, Ripley, Switzerland
  - Counties with challenges in CY 2018: 19, of which 4 improved, 9 remained the same, 6 got worse

The following are areas where specific MCEs differed from the trends found statewide:

- Anthem has more individual counties with average distance travelled >30 miles for primary care than the other MCEs. This true for all three OMPP programs.

- Anthem also has the most counties with average distance travelled > 30 miles for prenatal and post-partum services among the MCEs.

- CareSource has more individual counties with average distance travelled >30 miles in HHW and HIP than other MCEs for dental services.

- MDwise and MHS have fewer individual counties with average distance travelled >30 miles in HHW and HIP than Anthem and CareSource for primary care services.

- MDwise also has fewer counties with average distance travelled > 30 miles for dental services.

- MHS has lower average distances travelled for SUD and SED/SMI services than the averages reported statewide.

Exhibit V.6

Comparison of Network Adequacy Using Average Driving Distance Measures in CY 2019 and CY 2018 EQR Study

	Hoosier Healthwise				Healthy Indiana Plan				Hoosier Care Connect	
	Anthem	CareSource	MDwise	MHS	Anthem	CareSource	MDwise	MHS	Anthem	MHS
	CY 2019 value > 1.0 shorter than CY 2018				CY 2019 value > 1.0 longer than CY 2018				within 1.0 miles	
Primary Care										
CY 2019 Average	15.3	10.6	11.0	10.7	17.4	11.7	12.1	11.7	17.6	13.2
CY 2018 Average	17.9	17.0	14.4	12.8	18.7	17.7	16.6	17.2	20.1	16.3
Dental										
CY 2019 Average	10.9	13.9	11.1	12.3	10.5	12.7	10.6	13.4	11.8	14.8
CY 2018 Average	13.2	16.8	12.8	13.7	13.4	15.8	12.8	15.5	14.1	16.2
Prenatal/Postpartum Care										
CY 2019 Average	17.9	15.0	15.0	14.2	17.8	15.4	15.6	15.1	16.4	13.6
CY 2018 Average	19.0	18.8	16.4	14.9	17.5	17.6	16.3	16.5	17.2	14.1
Substance Use Disorder										
CY 2019 Average	12.2	11.5	12.7	12.6	17.2	17.4	17.2	17.3	14.2	14.7
CY 2018 Average	15.1	16.4	13.7	14.7	18.8	19.3	18.6	18.6	16.3	15.0
SED/SMI Services										
CY 2019 Average	17.6	18.8	17.8	18.6	15.7	15.8	15.2	15.2	16.2	17.4
CY 2018 Average	17.6	18.2	16.7	18.7	15.7	16.1	15.1	15.7	16.6	17.8

Status of Average Distance Computed in CY 2019 for CY 2018 Counties Identified with Access Challenges

	Primary Care	Dental	Prenatal	SUD/SED/SMI
Benton	Better		Better	Same
Crawford	Better		Worse	Better
Decatur				Worse
Fountain	Better	Same	Same	Worse
Franklin		Better		
Greene		Better		Worse
Howard			Better	
Jackson				Same
Jasper	Better		Same	Same
Jefferson		Better		Worse
Jennings				Same
Kosciusko			Same	
LaGrange	Better		Same	Same
Lawrence	Better		Better	
Martin				Worse

	Primary Care	Dental	Prenatal	SUD/SED/SMI
Newton	Better	Same	Same	Worse
Orange	Better			
Pulaski		Same		Same
Ripley		Same		Better
Rush				Same
Scott		Better		Better
Starke		Better		
Steuben				Same
Switzerland		Same		Same
Union		Same		
Wabash	Better		Same	Better
Warren	Better			
Washington	Better		Same	
White		Same	Better	

Average Distance Reports for Providers on Report 0903

Exhibit V.4 showed the percentage of members who sought services in CY 2019 from each provider category listed in the OMPP Report 0903 who travelled beyond the OMPP mileage standard. Additional information was tabulated for each provider category including the average distanced travelled by OMPP program/MCE at the statewide level and across eight regions of the state. Additionally, the count of counties with an average distance that exceeds the OMPP standard were tracked by OMPP program and by MCE. All of this information is shown for each of the provider categories on single-page dashboard reports that appear in Appendix D.

Exhibit V.7 which appears on pages V-17 and V-18 displays the average miles travelled by members in CY 2019 for each provider category by OMPP program (HHW, HIP, HCC) and by MCE. As described in the Methodology section, B&A created a three-scale range that varies based upon the OMPP's maximum mileage limit (e.g., 30 miles, 60 miles or 90 miles). Each cell in Exhibit V.7 is color coded as follows:

- Cells in green represent instances where the average distance is in the lowest of the three-scale range defined (i.e., best access)
- Cells in blue represent instances where the average distance is still below the OMPP target, but access is not as great as the lowest-tier in the scale (i.e., sufficient access)
- Cells in red represent instances where the average distance exceeds the OMPP target (i.e., potential access issues)
- Cells in gray represent instances where there were less than 10 trips in the sample reviewed, so an assessment cannot be made

Key Findings:

- On a *statewide average* basis, there are no instances where potential access issues were identified
- On a statewide average basis, there were some instances where the OMPP target was met, but access may be more challenging. In particular, for inpatient psychiatric facilities in HHW, behavioral health providers in rural counties (Anthem, all programs), and neurologists in HHW.

Exhibit V.8 which appears on pages V-19 and V-20 displays the count of individual counties (out of 92) where the average distance was determined, through CY 2019 utilization, to be above the OMPP standard. This is a more granular view of Exhibit V.7. Cells highlighted in red are indicators where the MCE/program had a count of counties that exceeded the statewide average of counties with potential access problems by more than five counties.

Key Findings:

- Provider categories with more than 10 counties with potential access issues for at least some MCEs:
    - Clinic
    - Primary Medical Providers – Physicians, Advanced Practice Registered Nurses and Physician Assistants
    - General Dentistry
    - Behavioral Health – Urban counties
    - Gastroenterologists
    - Neurologists
    - Urologists

Exhibit V.7
Average Driving Distances in CY 2019 by Provider Category and OMPP Program/MCE

Legend

- At or below lower bound for Provider Category
- Exceeds upper bound for Provider Category
- Between lower and upper bound for Provider Category
- Low sample (for MCEs, individual counties excluded if <10 trips in sample; for Program-wide columns, if <50 trips in sample overall)

Provider Category	Mile Threshold	HHW Statewide	HHW Anthem	HHW CareSource	HHW MDwise	HHW MHS	HIP Statewide	HIP Anthem	HIP CareSource	HIP MDwise	HIP MHS	HCC Statewide	HCC Anthem	HCC MHS
Facilities/Agency-Based														
Acute Care Hospital- Urban	30	11.6	11.5	12.0	11.6	11.5	11.5	11.4	12.0	11.6	11.5	12.1	11.8	12.4
Acute Care Hospital- Rural	60	18.5	19.4	19.2	18.1	17.6	18.6	19.2	18.8	18.0	18.0	21.2	21.3	21.0
Inpatient Psychiatric Facility	60	25.7	29.4	15.3	33.5	36.3	23.7	26.7	24.6	27.7	24.6	23.5	24.5	27.0
Clinic	30	12.6	14.8	11.0	11.6	11.4	14.8	17.2	12.1	13.0	12.8	16.4	17.6	14.3
Pharmacy	30	6.5	6.5	6.5	6.6	6.4	8.3	8.4	7.9	8.6	8.1	8.6	8.5	8.7
ESRD Clinic	60						6.8	9.7	4.2		9.1	6.9	6.6	6.6
High-Volume Services														
PMPs-Physicians	30	12.5	15.9	10.3	10.6	10.4	14.6	18.0	11.0	11.5	11.2	15.7	17.4	12.4
PMPs-APRNs	30	12.7	16.8	10.7	10.9	10.9	14.3	17.9	11.9	11.8	11.6	16.1	18.1	13.3
PMPs-Physician Assistants	30	10.9	16.8	9.5	9.6	10.9	14.6	20.9	12.5	13.1	14.1	13.8	17.5	13.6
General Dentistry	30	11.6	11.3	12.9	11.4	12.0	10.9	10.2	12.4	10.2	12.8	12.4	11.7	14.0
Dentists/ Oral Surgeons	60	13.8	14.3	10.3	15.4	20.5	15.4	15.3	20.1	17.2	19.8	9.6	12.4	16.8
Behavioral Health - Urban	30	17.5	17.0	19.2	17.0	18.4	17.7	18.0	17.6	17.2	17.5	17.2	17.1	17.5
Behavioral Health - Rural	45	29.6	31.4	29.9	29.3	28.0	29.0	31.4	27.1	27.5	27.1	29.8	30.5	29.0

Note that the mileage thresholds set for clinic and PMP- APRN and PMP- Physician Assistants shown here were set by B&A because OMPP does not have a published standard.

Exhibit V.7 (continued)
Average Driving Distances in CY 2019 by Provider Category and OMPP Program/MCE

Legend

- At or below lower bound for Provider Category
- Exceeds upper bound for Provider Category
- Between lower and upper bound for Provider Category
- Low sample (for MCEs, individual counties excluded if <10 trips in sample; for Program-wide columns, if <50 trips in sample overall)

Provider Category	Mile Threshold	HHW	HHW				HIP	HIP				HCC	HCC	
		Statewide	Anthem	CareSource	MDwise	MHS	Statewide	Anthem	CareSource	MDwise	MHS	Statewide	Anthem	MHS
Other Specialties														
ABA Providers	60	13.2	18.7	9.4	10.5	14.7	21.2	20.9				17.2	18.5	17.4
Addiction Services	60	5.4	11.1		6.0		17.0	17.8	15.5	18.0	19.5	7.7	11.1	15.0
Anesthesiologists	60	20.7	21.3	19.3	21.6	19.4	19.6	21.2	17.5	18.4	18.2	20.8	22.5	19.8
Cardiologists	60	20.8	27.5	15.3	16.0	18.2	19.0	22.5	16.4	16.9	16.0	18.6	21.5	16.2
Cardiovascular Surgeons	90	15.4	18.8	31.5	7.5	10.8	27.5	30.7	15.7	23.4	19.1	24.2	26.9	18.9
Dermatologists	90	17.8	20.1	15.1	19.9	18.0	18.7	21.2	17.4	18.7	17.9	15.0	20.7	15.3
Endocrinologists	60	13.3					18.0	13.9	8.3	20.8				
Gastroenterologists	60	21.2	18.4	17.4	24.2	20.6	17.5	16.1	13.9	21.9	12.5	11.9	14.6	14.8
Hematologists	60													
Infectious Disease Specialist	90						16.3			18.2				
Nephrologists	60	10.9	36.5	20.4	10.2	13.7	17.7	23.6	15.6	12.8	17.5	19.6	23.2	20.9
Neurological Surgeons	90	9.8	13.0	29.5	14.5	17.8	18.6	22.9	19.1	15.9	20.9	13.9	19.2	20.6
Neurologists	60	29.0	28.5	26.4	30.5	32.8	19.5	22.5	15.0	17.8	18.6	22.3	24.9	25.4
OB/GYN	60	21.0	25.4	15.8	20.0	16.0	18.4	20.3	16.6	17.6	16.4	21.7	24.9	18.6
Occupational Therapists	60	11.3	14.1	8.8	11.1	13.2	10.0	10.7	4.9	10.8	12.6	14.6	18.3	11.2
Oncologists	60	15.0	7.5	15.9	28.2	19.5	14.3	17.8	11.3	15.4	13.1	13.5	17.2	14.2
Ophthalmologists	60	18.2	19.1	18.8	18.1	19.4	17.0	18.5	16.0	17.1	16.7	17.1	19.7	17.8
Optometrists	60	11.9	8.7	10.1	9.7	20.0	11.8	9.6	10.3	10.5	20.4	13.1	9.9	19.9
Orthodontists	60	12.1	13.8	10.7	13.0	14.7	10.0	17.5	10.0			9.8	13.4	18.2
Orthopedic Surgeons	60	19.0	23.2	16.1	22.0	17.7	15.5	18.6	12.6	15.1	13.5	13.5	18.7	13.8
Otolaryngologists	60	23.9	25.2	20.4	25.9	22.6	19.5	22.7	13.0	19.5	17.3	18.0	22.6	21.4
Pathologists	90	18.7	19.6	14.5	21.9	19.7	21.8	21.2	19.8	22.7	22.9	17.9	20.4	22.0
Physical Therapists	60	12.1	16.5	8.2	11.8	10.3	12.6	16.4	8.2	9.0	8.9	13.7	16.8	10.1
Psychiatrists	60	15.6	20.3	11.1	22.0	23.7	18.4	20.6	11.8	19.4	16.2	13.7	18.5	18.8
Pulmonologists	60	8.4	12.1	5.7	9.8	6.8	15.9	20.0	11.6	14.4	12.7	12.4	16.7	10.9
Radiologists	90	22.8	23.3	21.5	22.0	23.3	23.0	23.5	21.5	21.9	23.8	24.0	24.6	23.5
Rheumatologists	90						25.3					18.8		
Speech Therapists	60	11.3	16.7	6.0	9.8	10.2	17.8	15.4		3.7	19.6	18.0	22.2	12.3
Urologists	60	18.7	27.0	21.7	19.5	25.9	13.2	21.3	12.7	11.7	12.8	16.8	19.6	16.6

Note that the mileage thresholds set for ABA and Addiction Services shown here were set by B&A because OMPP does not have a published standard.

Exhibit V.8
Count of Counties Where Average Driving Distances in CY 2019 Exceeds Upper Bound Established by OMPP

Legend — MCE count >5 counties above statewide average value; Low sample (for MCEs, individual counties excluded if <10 trips in sample; for Program-wide columns, if <50 trips in sample overall)

Provider Category	HHW Statewide	HHW				HIP Statewide	HIP				HCC Statewide	HCC	
		Anthem	CareSource	MDwise	MHS		Anthem	CareSource	MDwise	MHS		Anthem	MHS
Facilities/Agency-Based													
Acute Care Hospital- Urban	3	3	4	3	3	2	3	2	3	2	3	4	3
Acute Care Hospital- Rural	0	0	0	0	0	0	0	0	0	0	0	0	0
Inpatient Psychiatric Facility	1	3	0	4	3	1	5	0	3	1	0	0	1
Clinic	8	13	9	9	5	8	14	5	6	4	16	20	16
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0
ESRD Clinic						0	0	0		0	0	0	0
High-Volume Services													
PMPs-Physicians	3	14	3	3	1	5	19	1	1	2	11	19	2
PMPs-APRNs	1	11	0	1	2	1	9	2	1	2	5	13	4
PMPs-Physician Assistants	2	4	2	9	4	9	18	7	20	14	1	3	6
General Dentistry	6	8	14	6	10	0	1	9	0	6	3	3	8
Dentists/ Oral Surgeons	0	0	0	1	1	0	0	1	1	0	0	0	1
Behavioral Health - Urban	9	10	10	8	11	10	10	10	9	11	11	13	16
Behavioral Health - Rural	8	5	8	7	7	4	7	6	4	6	7	8	7

Note that the mileage thresholds set for clinic and PMP- APRN and PMP- Physician Assistants shown here were set by B&A because OMPP does not have a published standard.

Exhibit V.8 (continued)
Count of Counties Where Average Driving Distances in CY 2019 Exceeds Upper Bound Established by OMPP

Legend MCE count >5 counties above statewide average value; Low sample (for MCEs, individual counties excluded if <10 trips in sample; for Program-wide columns, if <50 trips in sample overall)

Provider Category	HHW Statewide	HHW				HIP Statewide	HIP				HCC Statewide	HCC	
		Anthem	CareSource	MDwise	MHS		Anthem	CareSource	MDwise	MHS		Anthem	MHS
Other Specialties													
ABA Providers	0	0	0	0	0	0	0				0	0	0
Addiction Services	0	0		0		0	0	0	0	0	0	0	0
Anesthesiologists	2	2	0	4	2	1	1	0	0	2	0	1	2
Cardiologists	2	10	0	1	5	0	7	0	0	0	0	5	0
Cardiovascular Surgeons	0	0	0	0	0	0	0	0	0	0	0	0	0
Dermatologists	0	1	0	0	0	0	0	0	0	0	0	0	0
Endocrinologists	0						0	0	0				
Gastroenterologists	12	7	5	24	12	3	5	1	10	1	1	2	0
Hematologists													
Infectious Disease Specialists									0				
Nephrologists	0	0	0	0	0	0	3	0	0	1	0	1	2
Neurological Surgeons	0	0	0	0	0	0	0	0	0	0	0	0	0
Neurologists	9	12	3	14	11	0	4	0	3	1	1	8	5
OB/GYN	2	7	0	2	0	1	4	1	2	1	0	4	1
Occupational Therapists	0	0	0	0	0	0	0	0	0	0	0	0	0
Oncologists	0	0	0	8	0	0	0	0	1	0	0	1	0
Ophthalmologists	1	8	1	4	7	0	7	1	3	1	0	5	3
Optometrists	0	0	0	0	1	0	0	0	0	0	0	0	0
Orthodontists	2	3	0	7	1	0	0	0			0	1	2
Orthopedic Surgeons	2	5	0	7	5	0	0	0	0	0	0	2	0
Otolaryngologists	3	10	2	10	3	1	6	0	4	0	1	4	3
Pathologists	0	0	0	0	0	0	0	0	0	0	0	0	0
Physical Therapists	0	0	0	0	0	0	1	0	0	0	0	0	0
Psychiatrists	0	2	0	2	0	2	4	0	2	2	0	1	2
Pulmonologists	0	1	0	0	0	0	10	0	1	1	0	4	0
Radiologists	0	0	0	0	0	0	0	0	0	0	0	0	0
Rheumatologists						0					0		
Speech Therapists	0	1	0	0	0	0	0		0	0	0	0	0
Urologists	0	3	1	11	3	0	0	0	1	0	0	0	0

Note that the mileage thresholds set for ABA and Addiction Services shown here were set by B&A because OMPP does not have a published standard.

Key Findings from Data Presented in Appendix D

- PMPs (combined Physicians, APRNs and Physician Assistants) – *refer to Appendices D.1 - D.3*
  - Overall average distances are below the established 30-mile threshold across all MCEs/programs.
  - Regions with challenges for most MCEs: West Central for the combined PMPs, West Central for Physicians specifically, North Central for Physician Assistants specifically

- General Dentistry, Oral Surgeons, Orthodontists – *refer to Appendices D.4 - D.6*
  - Overall average distances for Dentists, Oral Surgeons and Orthodontists are below the established 30 (Dentists) and 60 (Oral Surgeons/Orthodontists) mile threshold across most MCEs/programs.
  - The majority of the MCE/county/program combinations for Oral Surgeons (539 of 920) and Orthodontists (860 of 920) had 10 or fewer trips and were not counted in average distance calculations.
  - While there are no regional challenges for Dentists, there are counties with challenges for most MCEs: Newton, Pulaski, Ripley, Switzerland, Union, White

- OB/GYN –*refer to Appendix D.7*
  - Overall average distances for OB/GYNs are well below the established 60-mile threshold across all MCEs/programs.
  - Regions with challenges for most MCEs include: East Central, Northeast, and West Central
  - Counties with challenges for most MCEs include: Cass, Fulton, Jackson, Ripley, Switzerland

- Addiction Services – *refer to Appendix D.8*
  - Overall average distances for Addiction Services are below the B&A established 60-mile threshold across all MCEs/programs.
  - 747 out of 920 MCE/county/program combinations had 10 or fewer trips and were not counted in average distance calculations.
  - Counties with challenges for most MCEs include: Daviess, Dubois

- Behavioral Health Providers – *refer to Appendices D.9 and D.10*
  - Overall average distances for Behavioral Health are below the established 30 mile Urban and 45-mile Rural threshold across all MCEs/programs.
  - Regions with challenges for most MCEs include:
    - For Urban counties: East Central, Northeast, and Southeast
    - For Rural counties: Central, Southeast
  - Counties with challenges for most MCEs include: Decatur, Jasper, Jefferson, Jennings, Newton, Rush, Shelby

- Remaining Specialty Providers – *refer to Appendices D.11 through D.38*
  - Overall average distances are at or below established thresholds for most MCEs and programs.
  - Most specialties have sufficient volume to compute statewide and regional breakouts by MCE and program.

- Low Volume Specialty Providers – *refer to Appendix D.39*
  - Four provider categories had too few member trips statewide to compute meaningful results: Endocrinologists, Hematologists, Infectious Disease Specialists and Rheumatologists

Recommendations

Recommendations to All MCEs

1. There are many counties with an average distance above 60 miles for addiction services. This is particularly true for HIP as this is the OMPP program where most SUD services are delivered. As the State continues to expand its SUD network of providers, each MCE is encouraged to build relationships and incentives to contract with all of the SUD providers in the IHCP to reduce the distance that members must travel for addiction services.

2. Although the statewide average distance is under the OMPP standard of 30 miles for prenatal and postpartum services for all MCEs, there are opportunities to improve distances at the individual county level.

3. Although the statewide average distance is under the OMPP standard of 30 miles for general dentistry for all MCEs, there are opportunities for each of the MCEs to improve distances at the individual county level.

4. Although the statewide average distance travelled for behavioral health services meets the OMPP standard for all MCEs, there are opportunities to improve access in areas where challenges were found in the state. In particular,
    a. Some rural counties were identified in the Central Region (all OMPP programs) and the Southeast Region (all OMPP programs).
    b. Some urban counties were identified in the Northeast Region (HHW), the East Central Region (HIP) and the Southeast Region (HHW).

Recommendations to Specific MCEs

5. Specific to Anthem:
    a. In addition to the specific service categories recommended for all MCEs, Anthem is encouraged to bolster its network of PMPs to improve distances traveled by members in the West Central Region in the HIP and HCC programs.
    b. In addition to the locations mentioned for behavioral health for all MCEs, Anthem has an opportunity to improve its network in the Northeast Region for HIP and HCC.
    c. The count of behavioral health providers reported by Anthem to the OMPP is far above the count reported by each of the other MCEs. Given the high variation and the number of known entities contracted with the State, the reported values should be re-examined to confirm accuracy.
    d. The same finding of providers far above other MCEs was observed for therapists (occupational, physical and speech) and radiologists. The reported values should be re-examined to confirm accuracy.

6. Specific to CareSource:
    a. The count of some provider specialties reported by CareSource to the OMPP is far below the count reported by each of the other MCEs. These values should be re-examined to confirm accuracy. Specific categories identified include anesthesiologists, neurological surgeons, neurologists and therapists (occupational, physical and speech).

7. Specific to MDwise:
    a. The count of clinics reported by MDwise to the OMPP is far above the count reported by each of the other MCEs. Given the high variation and the number of known entities contracted with the State, the reported values should be re-examined.

Recommendations to OMPP

8. In discussions with the MCEs, it became apparent that there was no uniform basis used to count providers on the OMPP annual Report 0902. Methods reported by MCEs included counting providers based on NPI, FEIN or by IHCP (the Medicaid provider) number. Additionally, providers work in multiple locations that cross geographical boundaries which created difficulties with counting a provider only once (as stated in the report requirements) when, in reality, they are providing access at multiple locations. Finally, the provider specialties in Report 0902 may not always be discrete. One example of this is Hematology and Oncology. It is with these findings in mind that B&A is recommending that OMPP revise Report 0902 specifications as follows:
    a. Specify the basis and methodology for counting providers. This would include how providers are to be counted if they provide services in locations that cross geographical locations.
    b. Provide more specifications on the categorization of providers, e.g. to distinguish addiction services and behavioral health. The OMPP may want to consider specific evaluation and management (E&M) codes to define PMPs.
    c. Collapse related provider specialties, such as Hematology and Oncology, to reduce confusion about which category to place a provider in.
    d. Develop a dashboard tool similar to what was shown in Exhibit V.3 for the purpose of comparing, validating and monitoring the number of enrolled providers reported by each MCE by category.
    e. Consider benchmarking the count of providers reported by each MCE against the total available to each MCE for contracting (those providers enrolled in the IHCP).

9. The MCEs are running provider and member addresses through geocoding software to assign latitude and longitude coordinates because they do not receive this information in their enrollment files. OMPP separately assigns latitude and longitude coordinates to billing providers and members, but this data is not provided to the MCEs. OMPP assigns the same latitude and longitude coordinates to rendering providers associated with a billing provider. If the OMPP were to validate member travel distances using its data against MCE-reported data, this may yield discrepancies. In an effort to strengthen the validity of what is submitted on its Report 0903 and to allow for MCE comparisons, B&A recommends the following:
    a. Assign each Indiana county as urban or rural when reporting is required using this categorization.
    b. Provide provider and member assigned latitude and longitude coordinates to the MCEs so that there is one source of truth for geocoding and computing distance traveled.
    c. Assign actual latitude and longitude coordinates for rendering providers instead of the uniform default values. This will improve distance calculations and assessment of member access, in particular for behavioral health services as evidenced by the root cause analysis performed by B&A.
    d. Consider collapsing or eliminating distance traveled for low-volume service specialties, such as endocrinologists, hematologists, infectious disease specialists.
    e. The current report requests that the MCEs compute the number of members that do not have access within a specific driving distance to any contracted provider. It may not be

assumed that the closest provider to a member is available or that members choose to access that provider. B&A recommends that the OMPP either require a report from MCEs on actual distance travelled (using paid claims) or that the OMPP validate the MCE's submissions on Report 0903 similar to what was shown in Exhibit V.4. B&A recommends that the focus be on high-volume Medicaid services such as primary care, dental, OB/GYN, behavioral health and addiction services.

SECTION VI: FOCUS STUDY ON LEAD TESTING

Introduction

Lead testing has been a focused initiative of Indiana's Office of Medicaid Policy and Planning (OMPP) for a number of years. Enhanced attention occurred starting in Calendar Year (CY) 2016 when lead was identified in the soil of a housing project in East Chicago, Indiana that resulted in the demolition of the project and relocation of approximately 1,000 citizens most of whom were enrolled in Medicaid.

During this time, the managed care entities (MCEs) under contract with the OMPP provided on-the-ground outreach, education and coordination to their impacted members. On a statewide level, enhanced coordination occurred between the OMPP and the Indiana State Department of Health (ISDH) on lead testing and immunizations more broadly. Since the beginning of 2017, the ISDH Division Director has met on a quarterly basis with the MCEs to discuss data findings from both the ISDH database and the MCEs' own data warehouse of claims related to lead testing.

Currently, lead testing is measured in two ways. The primary method is through the ISDH's STELLAR database. The laboratories that conduct the lead testing submit data to STELLAR as is required by state law (IC 16-41-39.4-3). The physician authorizing the test is captured when the tests are submitted to STELLAR. The database tracks, among other items, the date of the test, the testing method (capillary or venous), the test result and demographic information about the child. The STELLAR database tracks lead tests for all children in Indiana, regardless of payer.

On a monthly basis, the ISDH exchanges a file of recent tests it has received with DXC, the OMPP's fiscal agent. DXC identifies from this file the children enrolled in Medicaid and the program that they are enrolled in—Hoosier Healthwise (HHW), Hoosier Care Connect (HCC), or fee-for-service (FFS). DXC sends this enrollment information back to the ISDH along with the member's name, Medicaid ID, date of birth, gender, ethnicity and address. The ISDH then remits back to the OMPP a consolidated file with test information and demographic information about each Medicaid member who was tested.

The OMPP then analyzes the ISDH file and creates a series of reports for distribution to each MCE. The reports include information such as:

- Total number of tests received by age of child (up to and including age 6);
- Total number of unique members tested by age of child;
- Total enrolled members by age;
- Percentage of members tested by age;
- Total members with a test level greater than 5 μg/dL (micrograms per deciliter)

OMPP uploads reports specific to each MCE to a secure site along with the detailed data file containing information about the children who were tested.

Another method that lead tests are tracked is through claims submitted by laboratories to the MCEs. Claims paid for lead testing are identified by the presence of CPT code 83655. The drawback to the claims repository is that although the number of tests can be tracked, the result of the lead test (elevated level or not) cannot be determined. Starting in CY 2019, the OMPP has required the MCEs to report on a quarterly basis the rate of lead testing for children who turned age one, who turned age two and who turned age three through six over a recent 12-month study period.

Methodology for Conducting the Study

In this year's EQR, Burns & Associates (B&A) repeated a study originally conducted in the CY 2017 EQR and later updated in CY 2018 in order to assess if the rate of lead testing among Medicaid-enrolled children has improved. To do this, B&A independently tracked the rate of lead testing among children in the OMPP's managed care programs. Due to the low volume of young children in the HCC program, all results tabulated by B&A include children in the HHW and HCC programs combined. B&A examined lead testing rates in a variety of ways:

- Percentage tested at a point-in-time age (up to age six)
- Percentage tested if ever tested at any age (up to age six)
- Percentage tested by county
- Ratio of all tests with elevated lead levels to non-elevated levels
- Counts of elevated lead levels by zip code

B&A received data from the ISDH STELLAR database for tests administered to Medicaid children in CYs 2018 and 2019. This is the same data that are provided to the MCEs on a monthly basis. This data was appended to data previously reported to allow for trend analysis across the four-year period CY 2016 through CY 2019. MCE claims data was compiled for CYs 2018 and 2019 as well to include lead tests identified through that route. B&A identified Medicaid children identified as having a lead test either through the ISDH database, through MCE claims, through both methods, or neither method.

B&A examined the percentage of managed care members with a lead test by age two. For CYs 2018 and 2019, B&A also examined the lead test rates by age for each MCE. Lead testing rates among children ages one and two in CY 2019 were also examined at the county level for OMPP's total managed care program as well as for each MCE individually.

B&A also identified children who were born in CYs 2014 and 2015 who were continuously enrolled in Medicaid to determine if each child had ever received a lead test even beyond the recommended age two. The results were compared to the cohort population that B&A defined in the previous study who were born in CYs 2012 and 2013.

B&A analyzed the proportion of Medicaid children with elevated lead levels (defined as a rate greater than 5µg/dL) from CY 2016 through 2019. For children identified with an elevated lead test level in CY 2018, B&A analyzed to see if there was evidence of follow-up testing for each child. B&A tracked the location of Medicaid children in CY 2019 with elevated test levels by zip code to determine if there are portions of the state of greater concern for elevated lead levels.

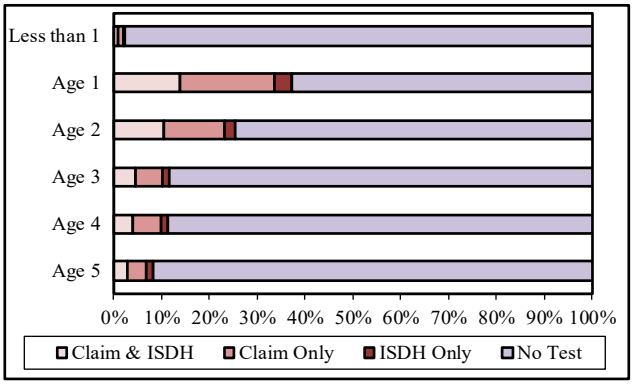
A new item in this year's lead test focus study is the review of the claims-based results for lead testing reported by each MCE to the OMPP on the new report introduced by the OMPP in the 1st Quarter of 2019. B&A compared the results that each MCE reported for HHW children for the experience period January 1 – December 31, 2019 against B&A's independent tabulation of results using the ISDH database and MCE claims as the source to count lead tests observed.

Findings

Exhibit VI.1 shows the number of Medicaid children among the total within each age group where a lead test was found through both an MCE claim and in the ISDH database, through a claim only, through the ISDH only, or neither. The percentage of children age 1 with a test found (through claims or ISDH) increased from 37.1% in CY 2016 to 47.6% in CY 2019. The percentage of children age 2 with a test found increased from 25.6% in CY 2016 to 34.1% in CY 2019.

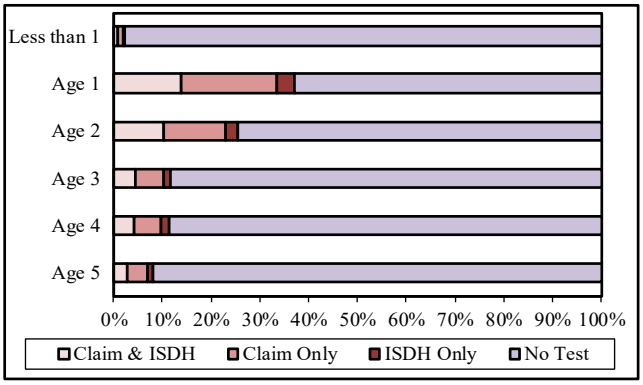
Exhibit VI.1
Percent of Medicaid Children Tested By Data Source Used to Track Tests, by Year

Percent of Members Tested in CY 2016 by Age



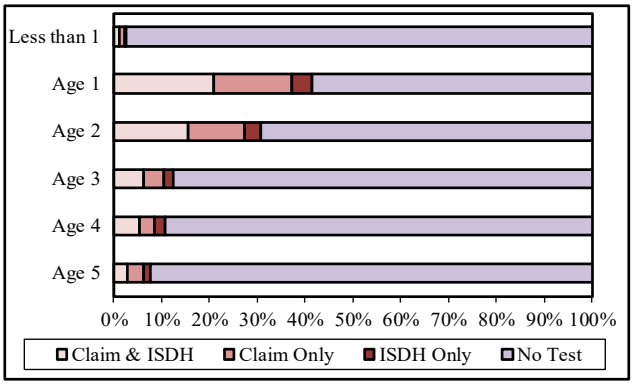
	Data Source to Find Test (# Members)			
	Claim & ISDH	Claim Only	ISDH Only	No Test
Less than 1	421	523	175	47,534
Age 1	7,395	10,562	1,964	33,722
Age 2	4,891	6,030	1,167	35,205
Age 3	2,035	2,585	645	39,947
Age 4	1,801	2,551	702	39,175
Age 5	1,278	1,707	527	39,831

Percent of Members Tested in CY 2017 by Age



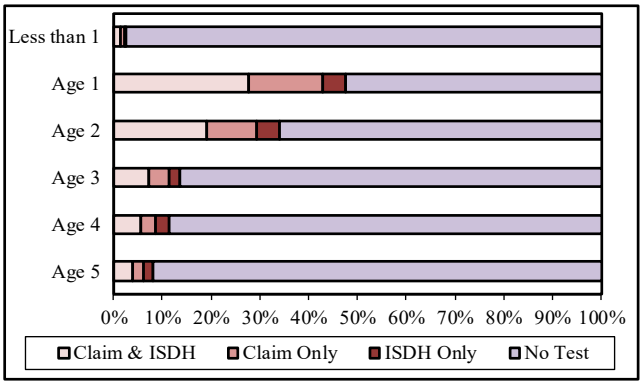
	Data Source to Find Test (# Members)			
	Claim & ISDH	Claim Only	ISDH Only	No Test
Less than 1	472	386	146	47,077
Age 1	9,552	9,138	1,864	29,924
Age 2	6,614	6,031	1,352	32,503
Age 3	2,831	2,363	843	40,683
Age 4	2,691	1,730	928	38,908
Age 5	1,713	1,345	593	39,931

Percent of Members Tested in CY 2018 by Age



	Data Source to Find Test (# Members)			
	Claim & ISDH	Claim Only	ISDH Only	No Test
Less than 1	621	506	126	47,974
Age 1	11,197	8,681	2,328	31,288
Age 2	7,724	5,817	1,722	34,276
Age 3	3,136	2,204	930	44,576
Age 4	2,791	1,561	1,180	45,389
Age 5	1,441	1,631	631	44,703

Percent of Members Tested in CY 2019 by Age



	Data Source to Find Test (# Members)			
	Claim & ISDH	Claim Only	ISDH Only	No Test
Less than 1	763	395	201	51,068
Age 1	15,124	8,436	2,505	28,745
Age 2	10,061	5,431	2,479	34,677
Age 3	3,779	2,207	1,160	45,016
Age 4	3,075	1,664	1,442	48,681
Age 5	2,031	1,283	941	49,115

Lead Testing Rates by MCE

Lead test rates for children age 1 and 2 improved for each MCE between CY 2018 and CY 2019. Further, each MCE has testing rates in CY 2019 within five percentage points of each other for age 1 and within six percentage points of each other for age 1.

Exhibit VI.2
Lead Testing Rates for Children Age 1 and 2 in CYs 2018 and 2019, by MCE

	CY 2018		CY 2019	
	Age 1	Age 2	Age 1	Age 2
Anthem	37.1%	29.9%	47.8%	35.6%
CareSource	40.1%	30.0%	48.0%	34.5%
MDwise	43.0%	29.6%	46.9%	31.9%
MHS	48.1%	36.2%	51.9%	37.9%

When comparing the testing rates for 1- and 2-year-olds in CY 2017 and CY 2019 by county, the number of counties statewide with a test rate of 30% or better increased from 54 in CY 2017 to 66 in CY 2019. The number of counties with 30% or better test rate for children age 1 and 2 in CY 2019 by MCE was between 59 counties (CareSource) and 71 counties (Anthem).

Exhibit VI.3
Change in Counties Based on Percent Tested Rates for Lead for Children Age 1 and 2
CY 2017 and CY 2019
Numbers Represent the Counties in this Category (out of 92 statewide)

	Statewide		Anthem		CareSource		MDwise		MHS	
Percent of Children Tested	2017	2019	2017	2019	2017	2019	2017	2019	2017	2019
Less than 10% in the County	2	1	2	1	18	3	5	0	4	2
10.1 to 20% in the County	13	6	9	4	27	7	10	10	14	4
20.1 to 30% in the County	23	19	24	16	23	23	21	20	26	20
More than 30% in the County	54	66	57	71	24	59	56	62	48	66

Exhibit VI.4 that appears on the next page shows the lead testing rates for children ages 1 and 2 in CY 2019 by county for the OMPP programs overall. Exhibit VI.5 appears on pages VI-6 and VI-7 and displays the same information but for each MCE individually.

Statewide, there is only one county with a lead testing rate under 10 percent (Dubois 9%) and five counties with a lead testing rate between 10 and 20 percent (LaGrange 15%, Noble 19%, Ohio 19%, Perry 16% and Pulaski 19%). The county with the highest lead testing rate is Monroe at 66%.

Many of the counties with lower lead test rates statewide were the same counties found for each MCE:

- Anthem had one county with a rate below 10% and three between 10 and 20 percent
- CareSource had three counties with a rate below 10% and seven between 10 and 20 percent
- MDwise had no counties with a rate below 10% and ten between 10 and 20 percent
- MHS had one county with a rate below 10% and four between 10 and 20 percent

Exhibit VI.4

Percent of Medicaid Children Age 1 or 2 who had a Lead Test in CY 2019, by County

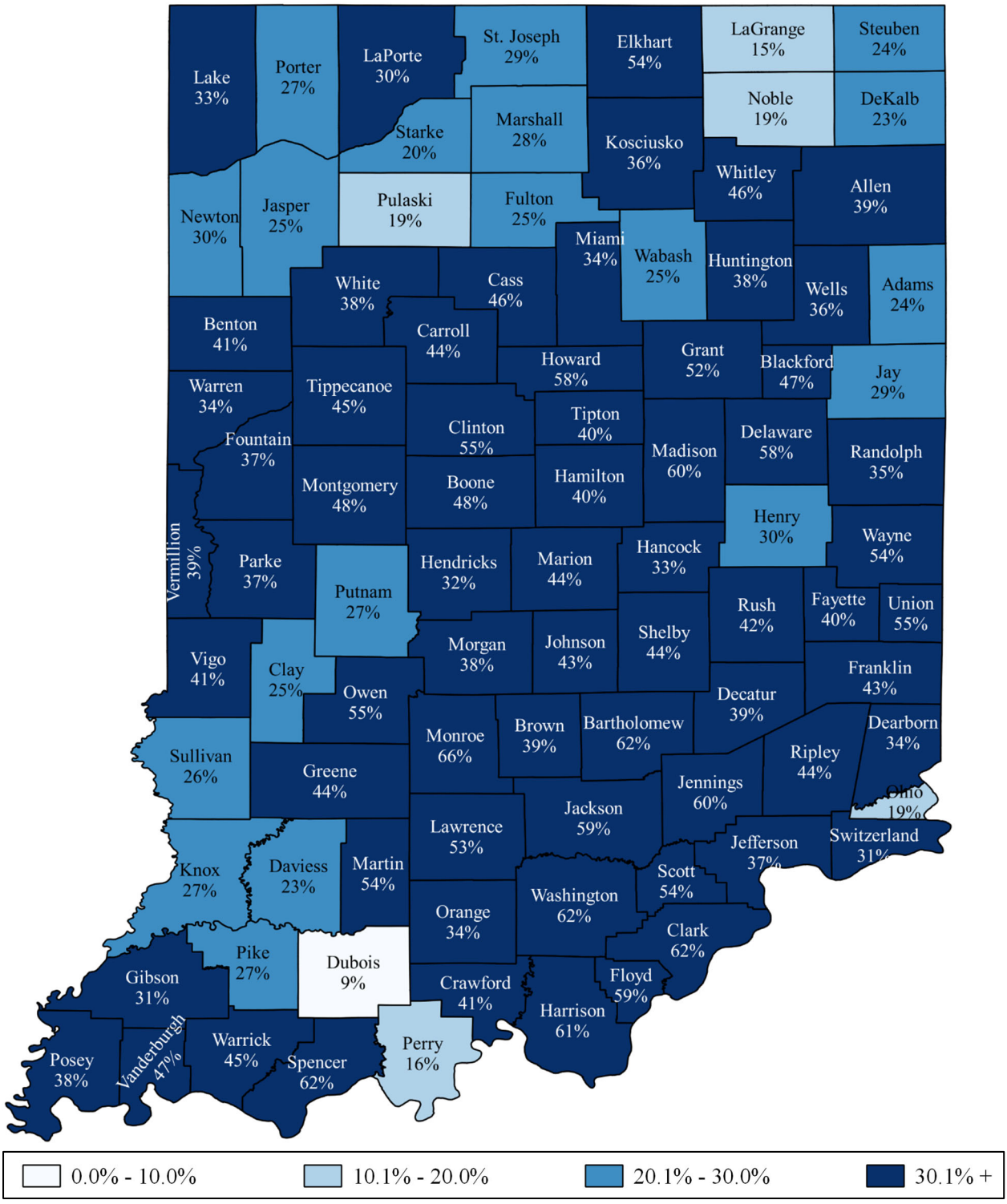


Exhibit VI.5

Percent of Medicaid Children Age 1 or 2 who had a Lead Test in CY 2019, by MCE/County

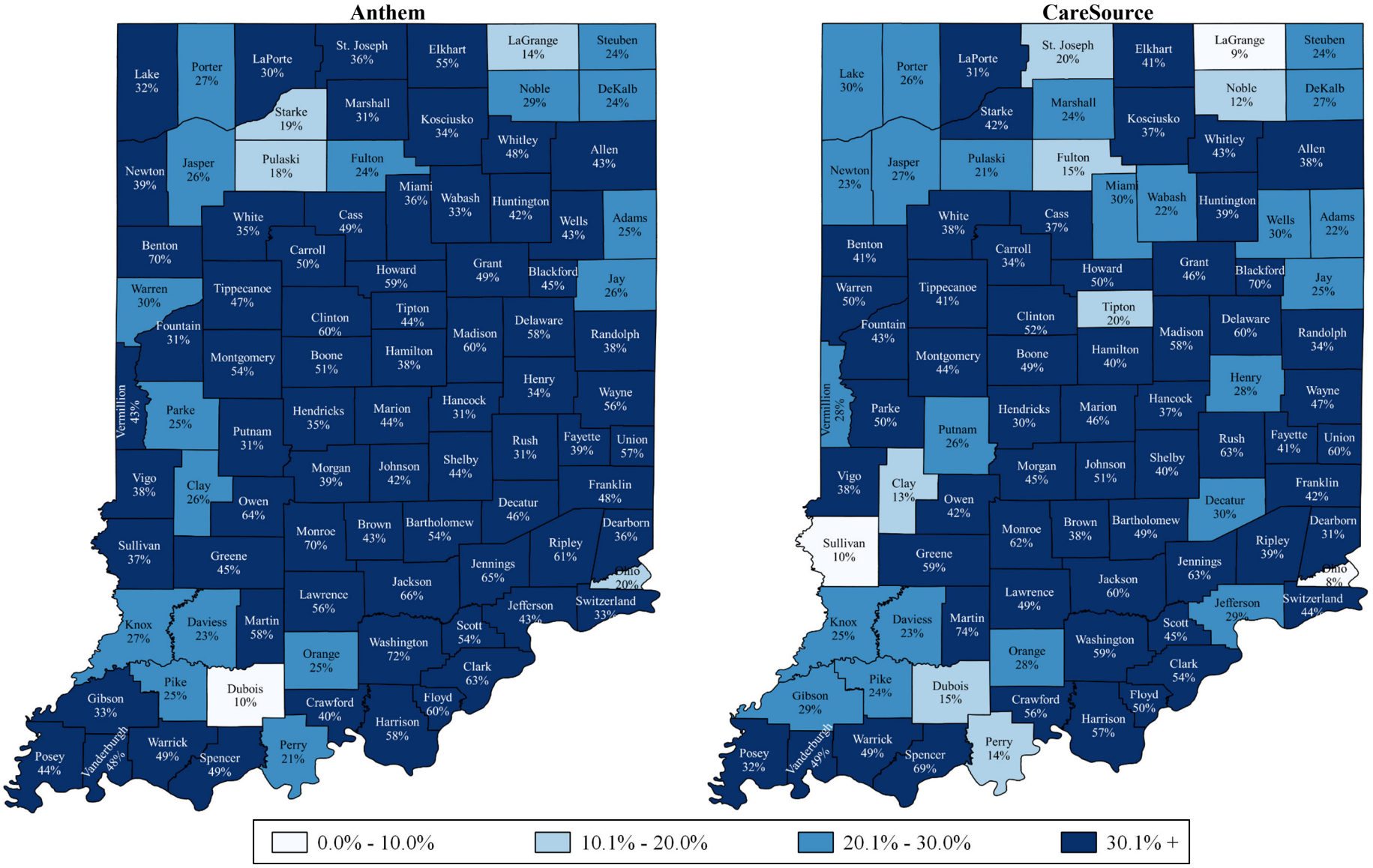
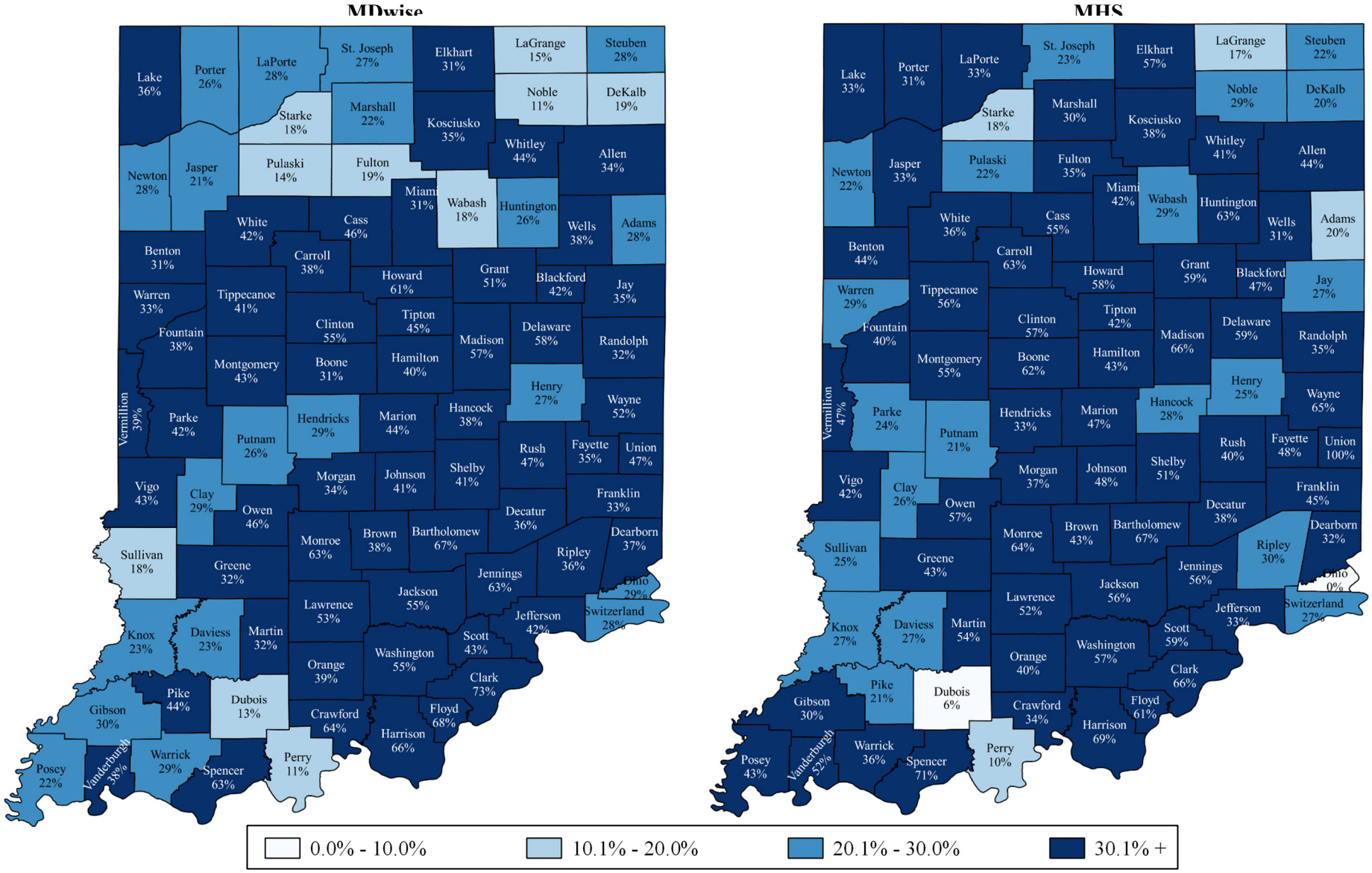


Exhibit VI.5 (continued)

Percent of Medicaid Children Age 1 or 2 who had a Lead Test in CY 2019, by MCE/County

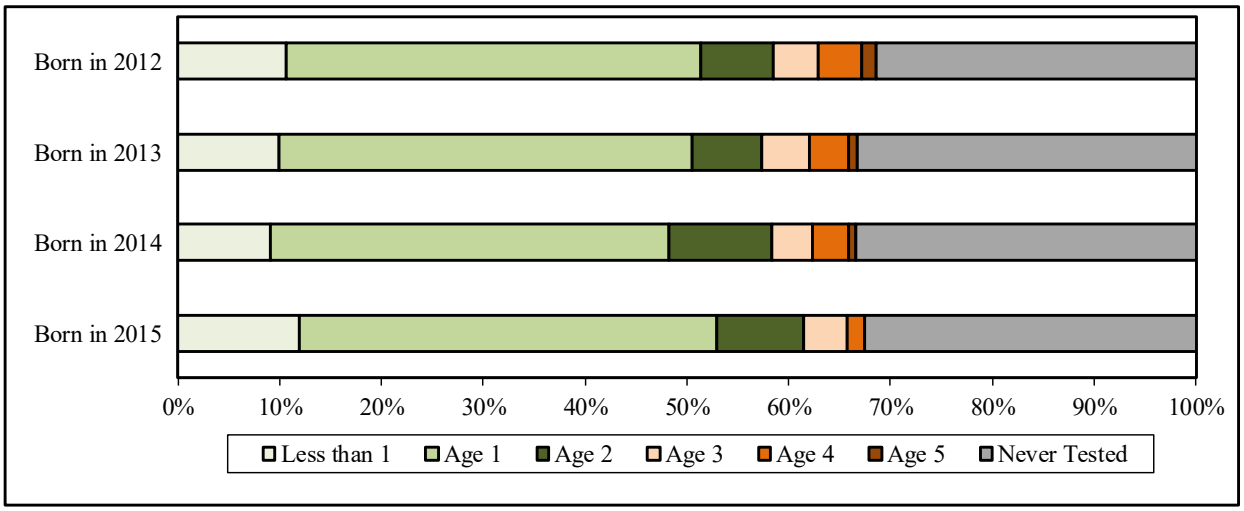


Impact of Continuous Enrollment on Lead Testing Rates

B&A found in our previous study that children who are continuously enrolled in Medicaid may not receive a lead test at age 1 or 2, but many receive a test at age 3, 4, or 5. Comparisons were made for children continuously enrolled in Medicaid who were born in 2012, 2013, 2014 and 2015 to assess their lead test status as of December 2019.

The percentage of children with no evidence of a lead test (through claim or ISDH record) remained steady at 31% to 33% each year. There was improvement, however, in the rate of children who received the test at age 1 or 2, particularly for children born in 2015.

Exhibit VI.6
For Children Continuously Enrolled in Medicaid and Tested for Lead, Age of First Screening



Medicaid Children	Less than 1	Age 1	Age 2	Age 3	Age 4	Age 5	Never Tested	Total
Born in 2012	1,722	6,606	1,163	706	698	234	5,092	**16,221**
Born in 2013	1,880	7,630	1,284	879	724	158	6,267	**18,822**
Born in 2014	1,998	8,618	2,193	882	792	164	7,332	**21,979**
Born in 2015	3,036	10,481	2,155	1,089	455	n/a	8,303	**25,519**

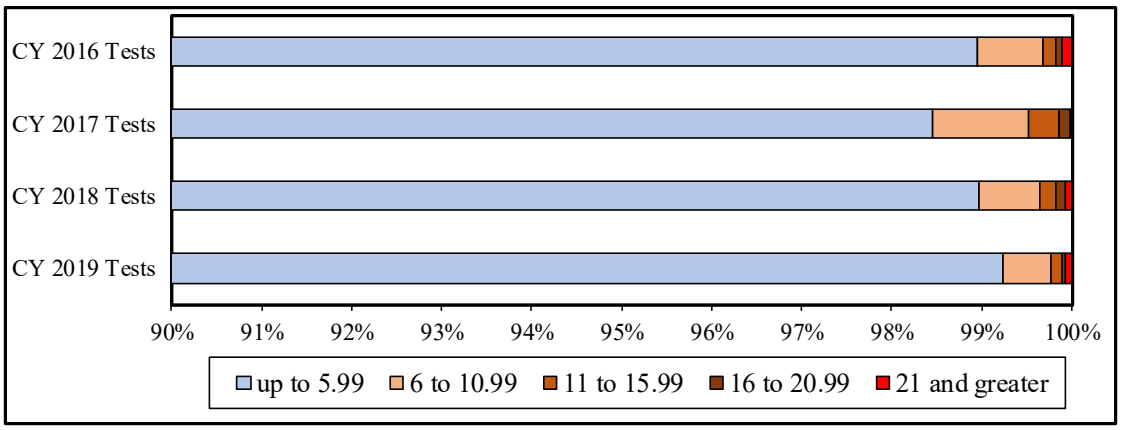
Lead Test Results

Using the ISDH data where test results are available, B&A measured the percentage of tests for Medicaid children at different levels of micrograms per deciliter (µg/dL). The CDC guidance now states that follow-up should occur when tests show results > 5 µg/dL. B&A's latest review of results for Medicaid children showed that the percentage of children with a test > 5 µg/dL was highest in CY 2017 (1.5%) and lowest in CY 2019 (0.8%). *Refer to Exhibit VI.7 on the next page*.

Children that had a test result > 5 µg/dL in CY 2018 (n = 321) were further reviewed:

- 45% (146) had a follow-up test in 2018 or 2019 with result <5
- 31% (99) had a follow-up test in 2018 or 2019 with result >5
- 20% (63) did not have a follow-up test in the ISDH database, but a claim for a test was found with an MCE
- 4% (13) had no evidence of a follow-up test (ISDH or claims)

Exhibit VI.7
Lead Levels Reported Among Medicaid Children in ISDH Database



Measured as micrograms/deciliter

	up to 5.99	6 to 10.99	11 to 15.99	16 to 20.99	21 and greater	**Total**
CY 2016 Tests	27,199	200	40	22	27	**27,488**
CY 2017 Tests	31,225	338	106	42	5	**31,716**
CY 2018 Tests	30,915	211	57	29	24	**31,236**
CY 2019 Tests	38,119	201	47	15	28	**38,410**

There were 291 Medicaid children found to have lead tests with elevated levels (> 5 µg/dL) in CY 2019. These children live in 55 of the state's counties. The areas with the highest prevalence are:

- Allen County overall, 33 cases
- Allen County, zip code 46806, 11 cases (Fort Wayne)
- Elkhart County overall, 20 cases
- Elkhart County, zip code 46516, 9 cases (Elkhart)
- Lake County overall, 17 cases
- Marion County overall, 29 cases
- Marion County, zip code 46201, 9 cases (Tuxedo Park, Englewood)
- St. Joseph County overall, 42 cases
- St. Joseph County, zip code 46619, 10 cases (South Bend)
- St. Joseph County, zip code 46628, 11 cases (South Bend)

A map that plots the location where children with elevated lead levels live in the state appears in Exhibit VI.8 on the next page.

Exhibit VI.8
Locations of Medicaid Children in ISDH Database Having a Lead Test in CY 2019
With Blood Lead Level Greater than 5µg/dL

Validation of MCE Submissions to OMPP on Lead Testing

B&A ran an independent validation of the data on Report 0508 from the OMPP's MCE Reporting Manual. This is the report in which the MCEs are required to submit results pertaining to lead testing. The specific report validated by B&A was the report submitted by each MCE for Q1-2020 (experience period January-December 2019).

B&A used encounters submitted by the MCEs to the OMPP's data warehouse as of May 31, 2020 to conduct the validation. The ISDH data is also reported by MCEs on this report to OMPP. B&A used ISDH data sent to Medicaid for 2019 records through April 30, 2020.

The Report 0508 is intended to closely mirror the HEDIS measure or Lead Testing, but OMPP's report includes reporting for children across multiple age categories. B&A applied continuous enrollment criteria (allowance for a 1-month gap) using member month data through May 31, 2020 as per the OMPP's specification. Data was validated on MCE members at age 1, age 2 and ages 3-6.

Findings from the validation:

- When reviewing the final result of the percentage of children age 1, 2 and 3-6 that had a lead test in CY 2019, B&A closely matched the results reported by three of the four MCEs (CareSource, MDwise and MHS). There was wide variation between B&A and Anthem's reported results.

- Although the overall results were similar between B&A and three of the MCEs,
    - B&A had similar results to CareSource on most values in the numerator and denominator values.
    - B&A identified more tests through claims but fewer tests found only through ISDH than what MDwise reported in each age group. This may be a claims lag reporting issue.
    - B&A identified more tests through claims and more tests found only through ISDH than MHS in each age group.
    - Every MCE reported fewer continuously-enrolled children in CY 2019 for age 2 and ages 3-6. This may be an issue pertaining to retroactive eligibility.

Recommendations

Recommendations to the MCEs

1. In an effort to support the ISDH in obtaining better compliance with high-volume test sites to submit lead tests, the MCEs are encouraged to cross-walk the tests that they are receiving from claims against the tests reported in the ISDH database at the individual provider level. This can serve as a feedback loop both to the provider community and to the ISDH.

2. In conjunction with the recommendation above, the MCEs should consider building a provider report card. This report card could be directed at physician offices, clinics or lab companies. The scorecard can show the gaps between the claim submissions and the ISDH submissions.

3. Each MCE should monitor the IHCP monthly reports to track children with lead test results above 5 μg/dL to ensure that a follow-up test has been conducted and that other mitigation strategies are not required.

4. The MCEs are encouraged to interrogate the ISDH CHIRP database (the immunization registry) as well as its own claims repository for its members who received an immunization for MMR (measles, mumps, rubella) at 12 months of age against the lead database to identify missed opportunities since the MMR immunization and the lead test are often conducted in the same visit.

Recommendation to the OMPP

5. In conjunction with Recommendation #4 to the MCEs, B&A recommends that the OMPP support and facilitate the filtering of data from ISDH's CHIRP database similar to what the OMPP does with the STELLAR lead testing database to assist the MCEs in identifying missed opportunities for lead testing at the time that immunizations (like MMR) are occurring.

6. As a way to validate the information submitted on the MCE Lead Testing Report 0508 on an ongoing basis, the OMPP is encouraged to verify the counts of members used in the denominator at each group (age 1, age 2, age 3-6) against its own enrollment reports published each month and the reports compiled by OMPP data analytics staff on the ISDH results.

SECTION VII: FOCUS STUDY ON THE UTILIZATION AND DELIVERY OF NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

Introduction

One of the services that is a covered benefit for individuals in Indiana's Medicaid program is non-emergency medical transportation (NEMT). This service can be described as transportation to Medicaid clients, planned in advance, to a medical service covered by Medicaid delivered by a contracted Medicaid provider.

All three tenets must be present—*covered Medicaid beneficiary, covered Medicaid medical service, and contracted Medicaid provider*—in order for an NEMT trip to be approved. The one exception may be if a managed care entity (MCE) offers NEMT trips as an "enhanced" benefit to its Medicaid enrollees as assistance related to their Medicaid coverage. A common example of this would be to coordinate trips to the local eligibility office when it is time to re-enroll in Medicaid. Another example may be for trips to an MCE-sponsored event for members such as an educational seminar for new mothers.

Each MCE under contract with the Office of Medicaid Policy and Planning (OMPP) has contracted with a transportation broker to assist in the coordination of the NEMT benefit for its Medicaid members. The same broker coordinates trips for all OMPP programs that the MCE is contracted under—Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC).

A focus study on NEMT in HHW and HIP was conducted in the CY 2014 External Quality Review (EQR). One of the key findings of this study was that there was no evidence that all of the NEMT trips that were delivered were provided to an eligible Medicaid member to a contracted Medicaid provider for a covered Medicaid service. Although there may be situations where the MCE is offering an enhanced benefit for trips as mentioned above, the finding from the CY 2014 EQR indicated that there were opportunities to strengthen the oversight of this benefit.

There has been significant work in the last two years conducted by the MCEs and the OMPP to strengthen the accuracy and completeness of encounter reporting—including for NEMT trips. There has also been an influx of trip requests from some managed care members with the introduction of new benefits from the State's substance use disorder (SUD) waiver approval in February 2018. With these changes, it seemed appropriate to revisit this study to assess progress on the oversight of NEMT.

The purpose of this focus study was to examine:

- Utilization trends and provider availability for transportation services;
- MCE policies and procedures for transportation services; and
- MCE delegation oversight of NEMT brokers.

As such, the study contained three main components which included:

- A quantitative analysis of NEMT trip requests and claims paid for trips;
- A desk review of MCE policies and procedures related to NEMT; and
- A qualitative component that included interviews with transportation brokers and the MCEs.

Methodology for Conducting the Study

B&A initiated the study by conducting interviews with each MCE and the staff responsible for oversight of its NEMT broker and the NEMT benefit. The questions posed related to this oversight responsibility. Shortly thereafter, a meeting was scheduled with each MCE and its NEMT broker to review the data request being made directly to the broker to obtain trip-level information from the study period of Calendar Year (CY) 2019. The purpose of this meeting specifically was to walk through the data request and to give the NEMT broker an opportunity to identify concerns with the ability to submit all requested information or to ask clarification questions about the data request.

The NEMT brokers were given three weeks after the data meeting to submit the data requested by B&A. Specific data requested included the following:

- *Trip requests*: All trips requested by members in CY 2019
- *Claims adjudicated*: All claims adjudicated by the NEMT broker in CY 2019
- *Provider report*: All providers contracted by the NEMT broker during CY 2019
- *Driver report*: All authorized drivers during CY 2019

Once received, B&A initiated an intake and validation process of all files received from the NEMT brokers. On an as-needed basis, follow-up questions were posed to each broker/MCE to obtain clarification on the data received. In some situations, updated files were provided to B&A.

Some standardization of the data was required. For example, some NEMT broker contracts include ambulance trips while others do not. For comparison purposes, all ambulance trips were excluded from the study. Additionally, each broker supplied a field to define the destination of the trip request, but these values varied. B&A standardized this field into seven rollup categories: residence, behavioral health/SUD provider, physician office or pharmacy, clinic, dialysis center, hospital, and all other.

Once the dataset was prepared for analysis, B&A examined the trip requests and the claims paid by the broker to NEMT providers across a number of dimensions including, but not limited to, the following:

- By OMPP program (HHW, HIP, HCC)
- By trip modality (e.g., ambulatory van, wheelchair van, other)
- By eight regions in the state (each of the 92 counties were mapped to a region as shown in Appendix A)
- By trip destination
- By number of miles
- By trip status (e.g., completed, cancelled, denied, unknown)
- Trips requested but not fulfilled (but also not cancelled)
- Timeliness of claims adjudication to NEMT providers

B&A also joined the trip requests received from each NEMT broker and compared these to the encounters submitted by the MCEs to the State's data warehouse. After excluding trip requests known to be cancelled or denied, B&A looked for matches between the trip date and any medical claim for the member on the same date of service as the trip date. For this comparison, institutional, professional, pharmacy and dental encounters were considered.

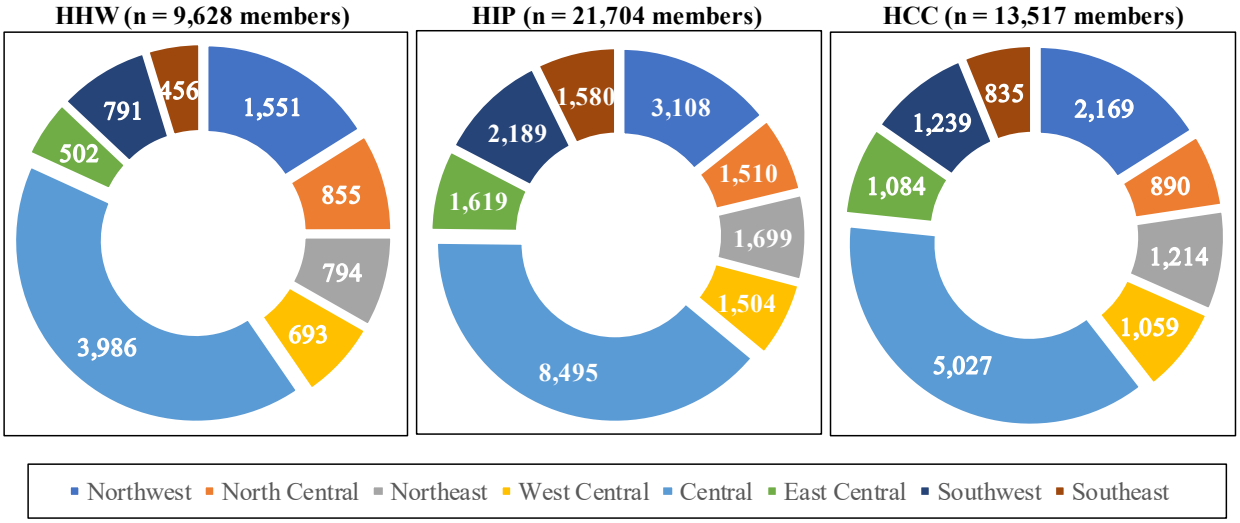
A webinar was scheduled with each MCE and its broker to share preliminary findings. In a separate meeting with just the MCE, B&A also reviewed the findings from its review of the MCE's oversight of the NEMT broker. Some follow-up information was provided to B&A to support the final findings.

Findings from the Review of NEMT Broker Data

Members Requesting NEMT

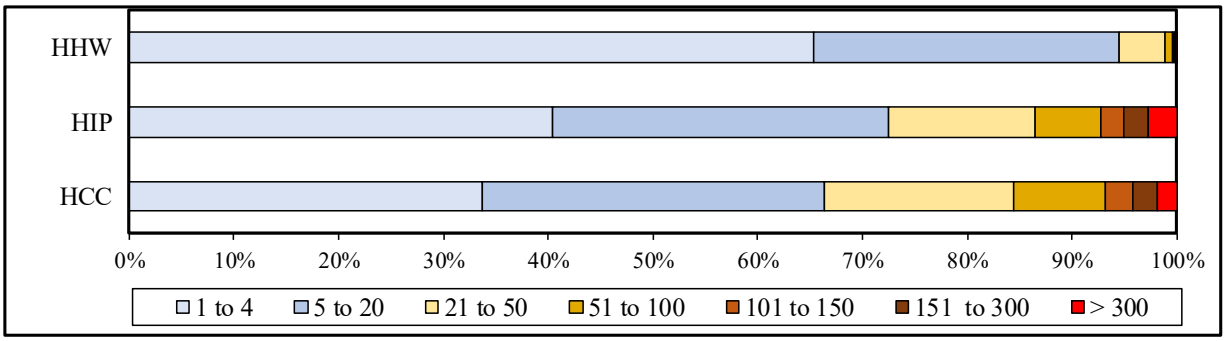
Exhibit VII.1 shows the unique requesters of NEMT in CY 2019 in each region. It was found that each region has a similar proportion of members using NEMT across the three OMPP programs. As a percentage of December 2019 enrollment in each program, HHW has 1.6% of its members requesting NEMT; for HIP, 5.2%; for HCC, 14.9%.

Exhibit VII.1
Count of Unique Medicaid Managed Care Members Requesting NEMT
Calendar Year 2019



When examining low-users against high-users, 65% of HHW members requesting NEMT had one to four trip requests in CY 2019; for HIP, 40%; for HCC, 34%. In contrast, 20.3% of HIP members had 21 to 100 trip requests and 7.3% had more than 100 requests. In HCC, 26.9% of members had 21 to 100 trip requests and 6.8% had more than 100 requests.

Exhibit VII.2
Percent of Individuals Who Received NEMT, Based on Number of Trips Requested in CY 2019



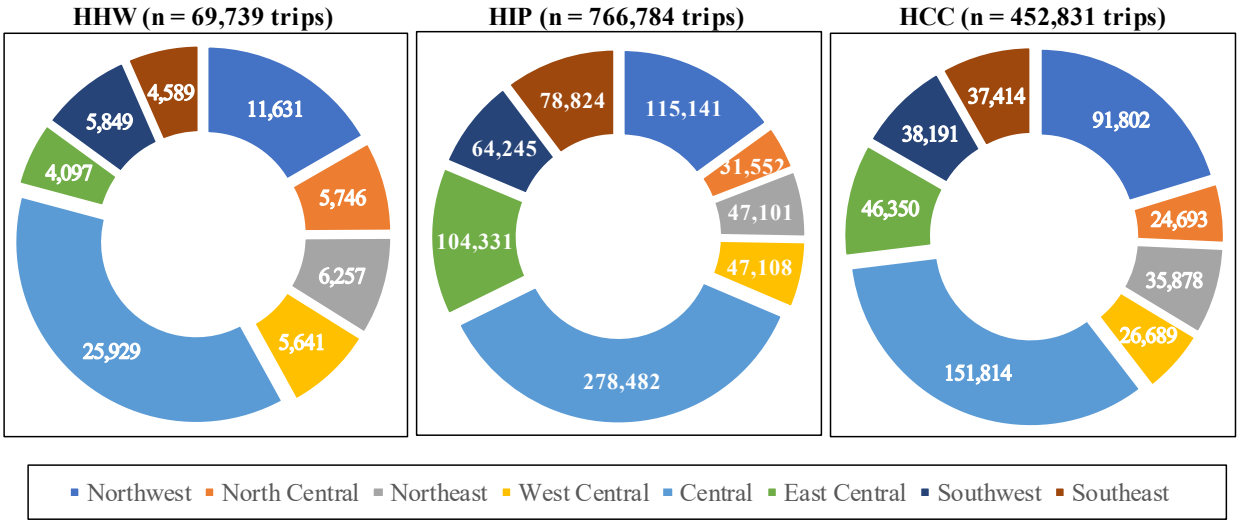
Number of Members	1 to 4	5 to 20	21 to 50	51 to 100	101 to 150	151 to 300	> 300	Total
HHW	6,291	2,806	416	74	13	14	14	**9,628**
HIP	8,777	6,961	3,033	1,359	485	487	602	**21,704**
HCC	4,561	4,407	2,447	1,180	363	316	243	**13,517**

Findings on Trip Requests

Exhibit VII.3 is depicted in the same manner as Exhibit VII.1, but this exhibit represents the total trip requests made to NEMT brokers in CY 2019 as opposed to members requesting NEMT. Each region has a similar proportion of trip across the three OMPP programs. However, HHW and HCC had a higher proportion in the Northern Regions than HIP.

As a ratio of December 2019 enrollment in each program, HHW had 0.1 trip requests per member. HIP had 1.7 trip requests per member. HCC had 4.5 trip requests per member.

Exhibit VII.3
Number of Trips Requested, by Region
Calendar Year 2019



The proportion of trip requests by OMPP program do vary somewhat across regions in HHW and HIP across the MCEs, but this appears to tie to the enrollment that each MCE has in each region (refer to Exhibit VII.4 on the next page). Proportionally, in both HHW and HIP, Anthem has more trip requests in the Southern regions, MDwise has more in the Central regions, and MHS has more in the Northern regions. The two MCEs in HCC have a similar proportion of NEMT requests by region.

Exhibit VII.4
Distribution of NEMT Trips Requests by Region
Calendar Year 2019

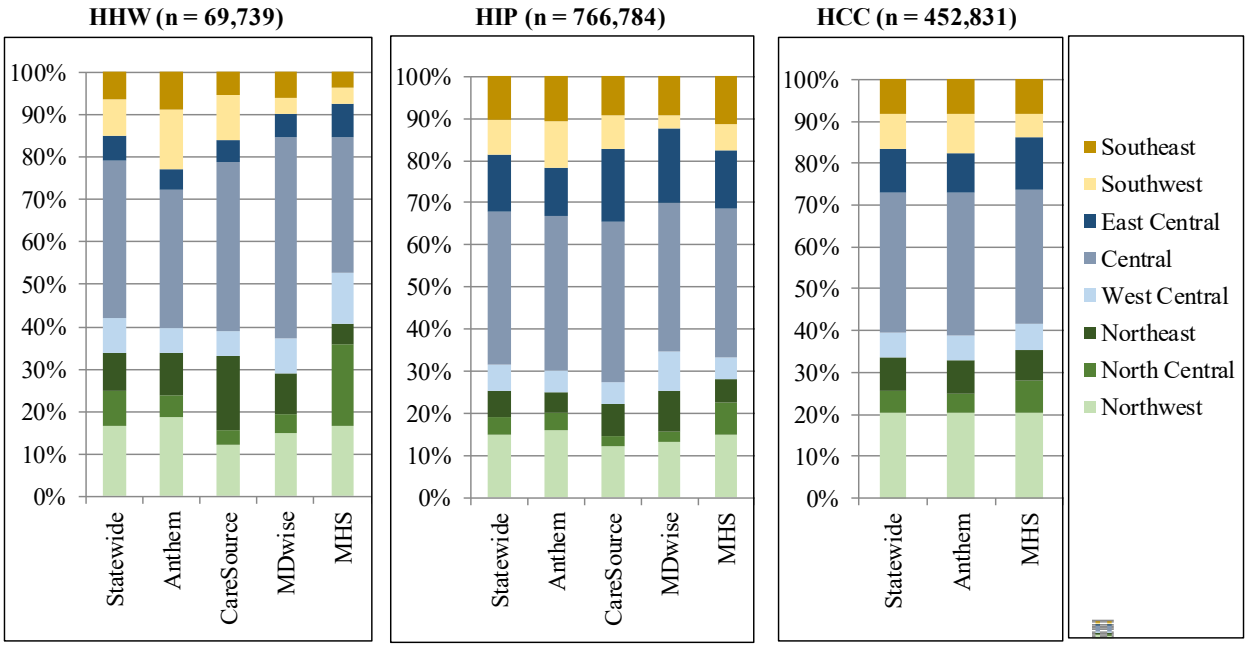


Exhibit VII.5
NEMT Trip Requests by Modality & Region - Statewide
Calendar Year 2019

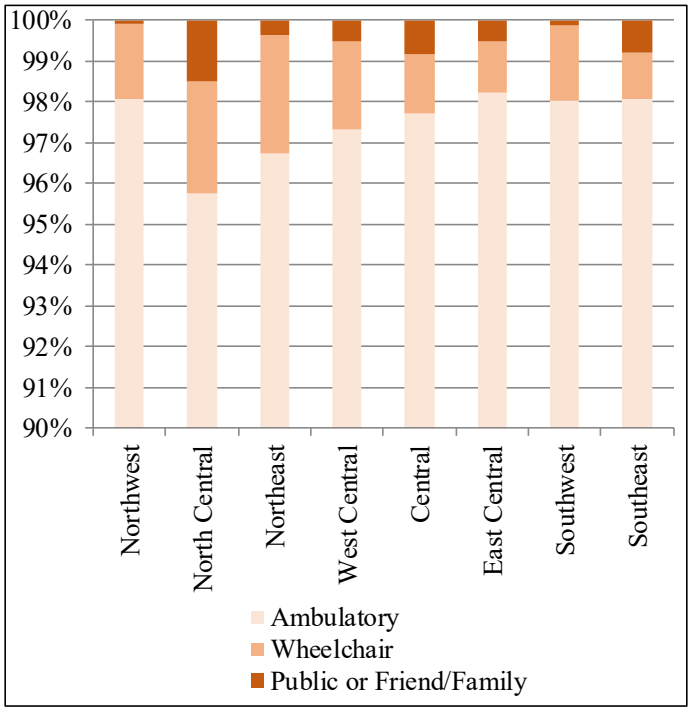


Exhibit VII.5 shows that ambulatory vehicles represent 97.7% of trip requests across all three OMPP programs (HHW, HIP, HCC). Wheelchair vehicles represent 1.7% of trip requests. Only 0.6% of trips were either for public transportation or mileage reimbursement to friends or family.

This distribution is similar for each OMPP program as well with the exception that the HCC program has a slightly higher proportion of wheelchair requests (3%).

Relatively speaking, there is little variance in the trip requests by modality at the regional level since all regions have at least 95% of trip requests as ambulatory vehicles. The slight variation is likely due to the availability of public transportation in some regions.

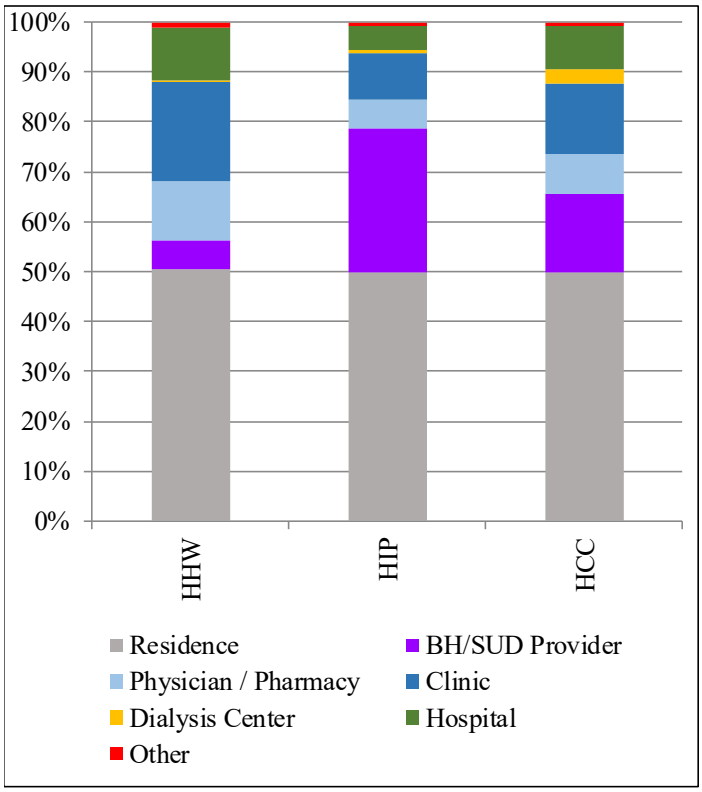
Exhibit VII.6 shows the distribution of trip requests by point of origin. It should be noted that trip requests are recorded for each trip "leg" separately. This is because some trip requests are one-way only while others are round-trip to and from the member's residence. Therefore, when reviewing trips by point of origin, about half will start at the member's home if the trip request is for round-trip.

The points of origin for trip requests varies between HIP and HHW. In HIP, there is a higher proportion originating from a behavioral health or substance use disorder (BH/SUD) provider.

At the MCE level, Anthem's and MDwise's proportions are similar to the statewide results.

CareSource and MHS have fewer trips to BH/SUD providers and more to physicians and pharmacies than the statewide results.

Exhibit VII.6
NEMT Trip Requests by Origin and Program - Statewide
Calendar Year 2019



Overall, average miles for one-way trips are similar for ambulatory trips across MCEs as shown in Exhibit VII.7 below. More variance was found in the average miles for wheelchair trips, but wheelchair trips in HHW are very small (only 316 in the year).

Exhibit VII.7
Average Miles Per One-Way Trip by Program / MCE / Modality
Calendar Year 2019

	All MCE Avg	Anthem	CareSource	MDwise	MHS
Ambulatory					
HHW	19.3	21.6	19.6	18.7	15.8
HIP	17.9	18.7	15.2	18.0	15.9
HCC	15.2	15.5			14.1
Wheelchair					
HHW	24.4	32.2	34.3	12.5	27.6
HIP	14.3	15.1	8.4	15.0	9.6
HCC	15.1	16.0			11.2

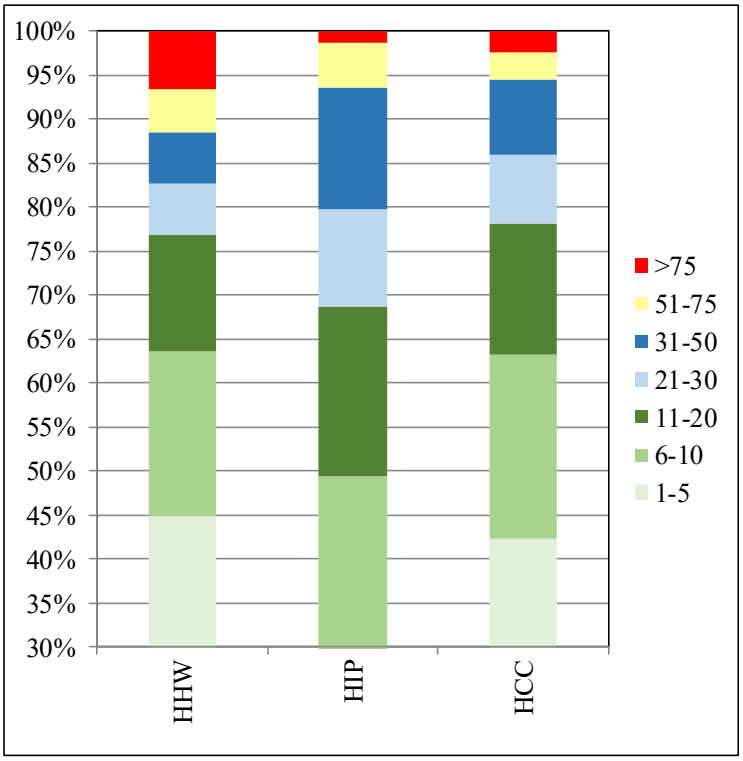
Exhibit VII.8
Average Miles Per One-Way Trip by MCE / Region
Calendar Year 2019

Greatest distances, on average, were requested from members for one-way trips are in the East Central region than in other regions. MDwise has three regions where the average distance request is greater than 20 miles. Anthem has two. CareSource has one. MHS has none.

Region	Anthem	CareSource	MDwise	MHS
Northwest	12.8	10.8	16.0	12.3
North Central	17.0	19.4	24.9	11.6
Northeast	14.5	14.9	16.5	13.5
West Central	19.2	18.4	12.1	14.8
Central	15.0	14.1	14.7	13.8
East Central	27.1	21.7	26.5	19.2
Southwest	19.1	13.2	19.0	18.6
Southeast	23.7	14.3	24.6	19.4

average above 20 miles

Exhibit VII.9
Distribution of NEMT Trips Requests by # Miles and Program
Calendar Year 2019



Although the average miles per trip request are shown above, there is variation to comprise this average. In HHW and HCC, 63% of trip requests were for 10 miles or less. Only 40% of HIP trips were for 10 miles or less.

Trip request for 11-50 miles were 19% for HHW, 30% for HIP and 23% for HCC.

Trip requests over 50 miles were 5.0% of HHW total trips, 5.1% of HIP total trips, and 3.1% of HCC total trips

The Northwest and Central Regions have more trips less than 10 miles than other regions (see Exhibit VII.10).

The East Central (39%) and Southeast Regions (30%) have more trips greater than 30 miles than other regions.

The West Central is the region with the most trip requests greater than 75 miles (3.4% of total).

At the MCE level, Anthem member trip requests with respect to mileage distance closely mirror the statewide averages. CareSource has higher average distance trips in the West and East Central regions but lower average distance in the Southeast and Southwest regions. MDwise has higher average distance trips in the three Northern regions than the statewide average, particularly in the North Central region.
MHS has more short-distance trips in the North Central, Northeast and Southeast regions than statewide.

Exhibit VII.10
Distribution of NEMT Trips Requests by # Miles & Region
Calendar Year 2019 - Statewide

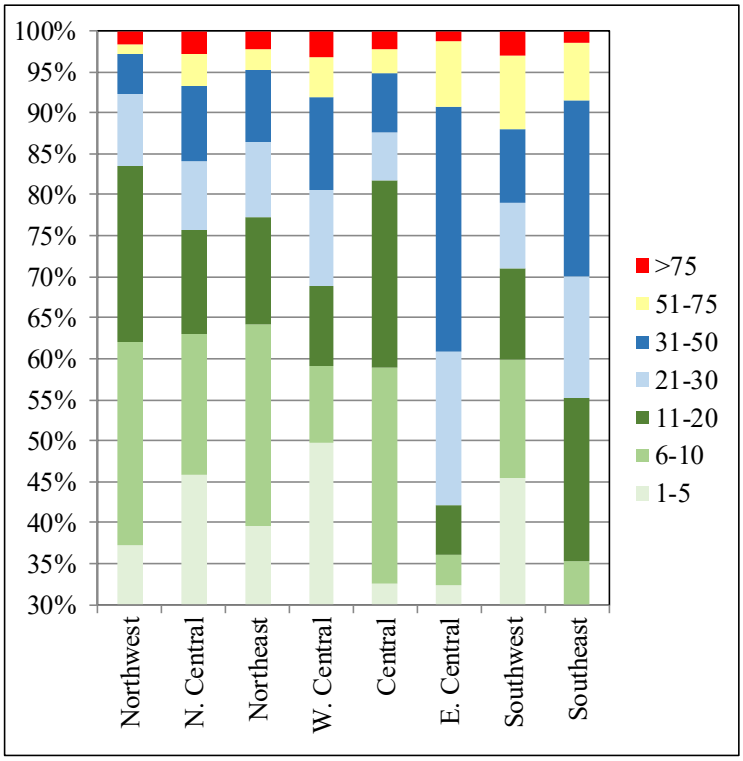
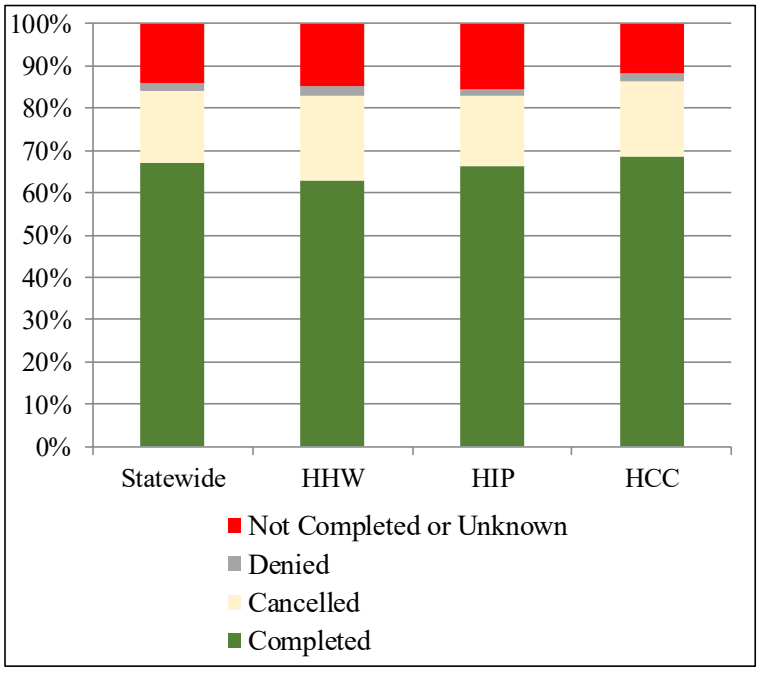


Exhibit VII.11
Status of NEMT Requests by Program
Calendar Year 2019



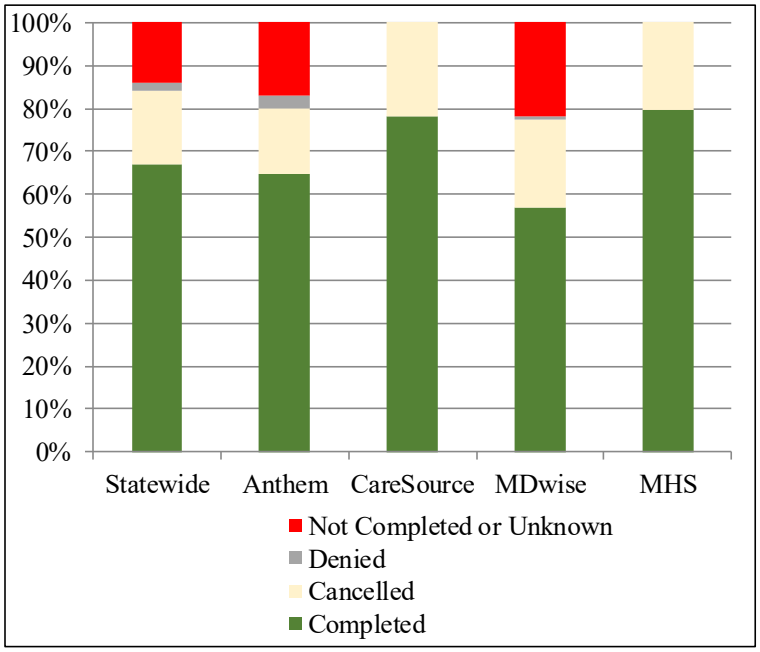
Among all trips requested, the NEMT brokers reported that 63% were completed in HHW. For HIP, 66%. For HCC, 69%.

Cancellations are high in each program: for HHW, the rate is 20%; for HIP, 17%; for HCC, 18%.

Approximately 2% of all trip requests are denied in each program.

There is a portion of trip requests that were either not completed or it could not be confirmed if they were. For HHW, this is 14.9% of all requests; for HIP, 15.4%; for HCC, 11.6%.

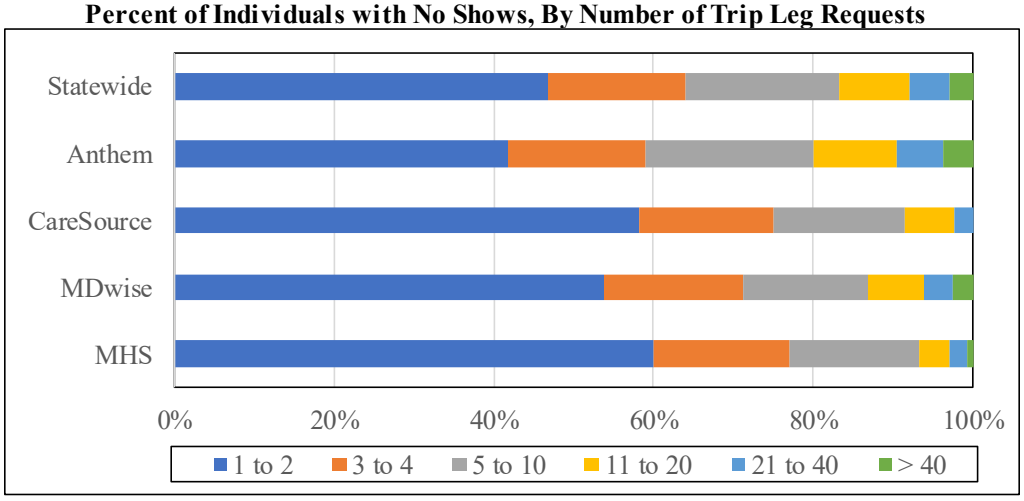
Exhibit VII.12
Status of NEMT Requests by MCE
Calendar Year 2019



The percentage of trip requests not completed or unknown are specific to two MCEs. B&A matched the trip request files from each NEMT broker to the claim file that they provided. When a paid claim was found that tied to a trip request, the trip was tagged as completed. There were trip requests from both Anthem and MDwise where B&A could not find a claim match but the trip request was not identified as being cancelled or denied. Therefore, the final status cannot be determined from the data provided. Anthem had 17.1% of its trip requests in the Not Completed or Unknown category and MDwise had 22.0% of its trip requests in this category. It cannot be determined if these were intended to be completed but could not (e.g. no provider available) or it was a last-minute member cancellation.

There were 18,794 MCE members (all three programs combined) who had a no-show trip recorded in CY 2019. This is 42% of all members that used NEMT (see Exhibit VII.13). Among those using NEMT that had a no-show, 15% of the members are 'chronic' no-shows (that is, 11 or more no-shows in the year). Anthem had more chronic no-show members than other MCEs.

Exhibit VII.13
Percent of Individuals with No Shows, By Number of Trip Leg Requests



Provider no-shows are significantly lower than member no-shows, but they do occur. MDwise had the most providers with any no shows (total of 113 providers). But Anthem had the highest percentage of providers deemed 'chronic' no-shows (that is, 11 or more no-shows in the year).

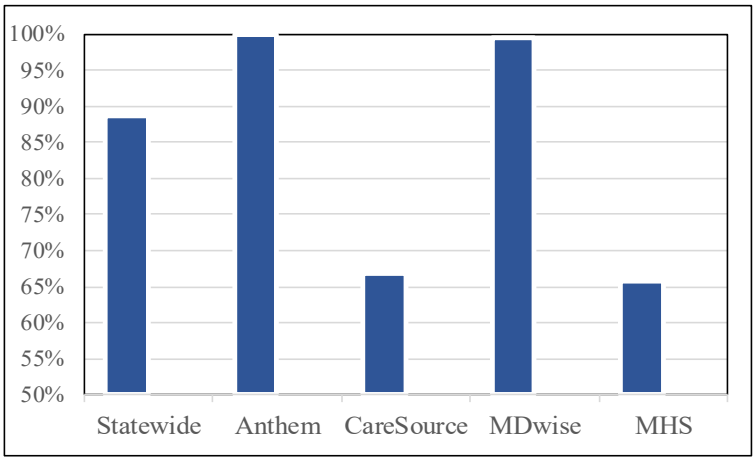
Findings on NEMT Broker Operations

The MCE's NEMT brokers are limited to contracting with transportation providers that are also enrolled with the OMPP. As such, the net number of entities that each broker contracts with are similar for each MCE (refer to top section of Exhibit VII.14). The total vehicles and drivers can vary, however, if the NEMT broker backfills vehicle demand with some of its own vehicles. This approach is used by some of the NEMT brokers.

Exhibit VII.14
Broker Relationships with Providers, Vehicles and Drivers
Calendar Year 2019

	Statewide Average	Anthem	CareSource	MDwise	MHS
Contracted Providers					
Was Enrolled at Start of CY 2019	64	58	57	85	57
Terminated in CY 2019	13	9	5	34	5
New in CY 2019	17	16	12	27	12
Net Number at End of Year	**68**	**65**	**64**	**78**	**64**
Vehicles					
Was Enrolled at Start of CY 2019	604	681	531	674	531
Terminated in CY 2019	69	30	21	204	21
New in CY 2019	82	84	47	151	47
Net Number at End of Year	**618**	**735**	**557**	**621**	**557**
Ambulatory Vehicles	**464**	564	433	426	433
Wheelchair Vehicles	**154**	171	124	195	124
Drivers					
Was Enrolled at Start of CY 2019	831	874	625	1,198	625
Terminated in CY 2019	269	22	121	813	121
New in CY 2019	320	74	184	838	184
Net Number at End of Year	**881**	**926**	**688**	**1,223**	**688**

Exhibit VII.15
Percent of Clean Claims Adjudicated within 21 Days
Calendar Year 2019



More than 99.5% of clean claims submitted were adjudicated by Anthem's NEMT broker and MDwise's NEMT broker within 21 days in CY 2019.

CareSource and MHS both use the same broker. Its claim adjudication rate within 21 days was only 67%. It was determined that 100% were adjudicated within 30 days, however. The issue was that the claims were ready to be adjudicated within 21 days, but signatures were required on some claims to validate that trips occurred.

Exhibit VII.16
Average Payment Per Trip Leg by Modality
Calendar Year 2019

The average payment per trip leg paid for ambulatory trips varied from $34.46 in HCC to $41.53 in HHW during CY 2019. The average payment per trip leg paid for wheelchair trips varied from $95.13 in HIP to $114.77 in HHW. The average payment for public transportation or volunteer drivers was near $25.00 in all three programs.

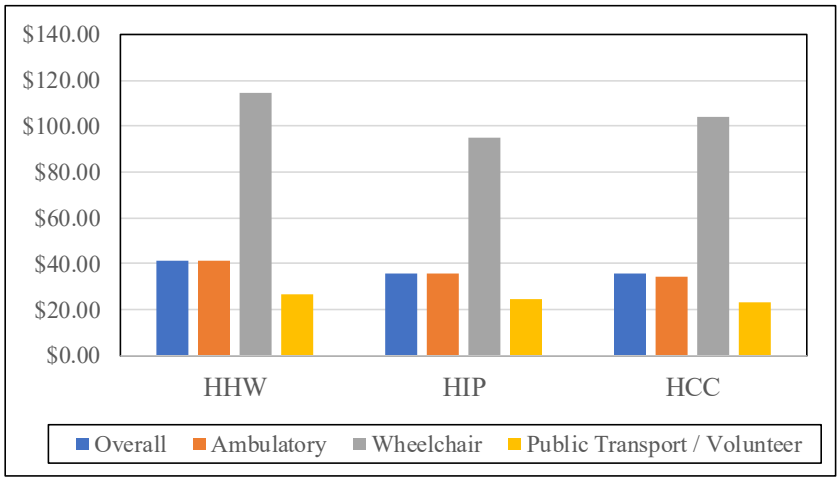
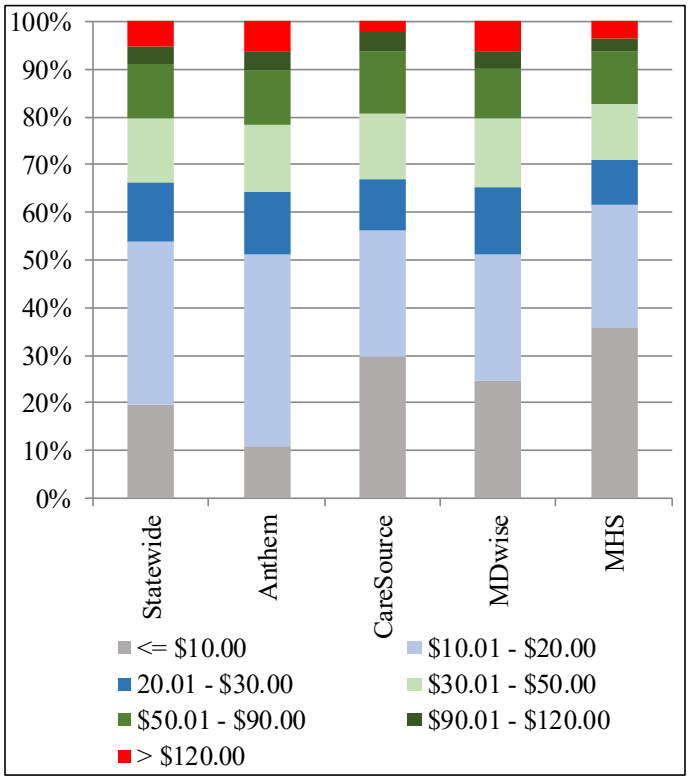


Exhibit VII.17
NEMT Trips Paid by Paid Amount
Calendar Year 2019



Although the average payment per trip was $36 statewide in CY 2019 (all programs, all modalities), there is variation when reviewed at the individual trip level. Each MCE has a variety of rates paid for trips.

The greatest variation is on the low end of rates. MHS and CareSource have more trips paid under $10 or between $10 and $20 than the other two MCEs.

Validation of Trips

There was a wide range in the no match rate across MCEs. B&A found medical claims for most of CareSource's and MHS's NEMT trips. The match rates were lower for Anthem and MDwise trips. For Anthem, 11.1% of trip requests could not be matched in HHW, 7.7% in HIP and 8.0% in HCC. For MDwise, 11.6% of trip requests could not be matched in HHW and 10.7% in HIP.

It should be noted that Anthem and MDwise were the two MCEs that had reported trip requests with a status of "unknown". These trips were excluded from the results shown in Exhibit VII.18, however.

Exhibit VII.18
Assess Transportation Trips to Medical Visit Claims
Calendar Year 2019

	Total Trip Legs Reviewed	Match to Medical Claim	No Match to Medical Claim	Percent No Match
HHW				
All-MCE Avg				**7.5%**
Anthem	16,799	14,935	1,864	11.1%
CareSource	3,231	3,187	44	1.4%
MDwise	11,445	10,112	1,333	11.6%
MHS	12,669	12,587	82	0.6%
HIP				
All-MCE Avg				**6.6%**
Anthem	285,349	263,449	21,900	7.7%
CareSource	35,661	35,283	378	1.1%
MDwise	101,078	90,250	10,828	10.7%
MHS	86,329	86,071	258	0.3%
HCC				
All-MCE Avg				**5.8%**
Anthem	222,864	205,069	17,795	8.0%
MHS	89,048	88,602	446	0.5%

Note: Trip requests that were cancelled, denied or undetermined have been excluded from the matching test.

B&A shared a table with each MCE to show the No Match trips and the destination that was recorded on the trip request to see if there was a pattern as to why medical claims were missing. No discernable pattern was found since the prevalence of missing claims varied across MCEs based on destination.

MCE Oversight of NEMT Brokers

B&A read each MCE's NEMT broker contract and completed a comparison across major contract provisions. In all, 25 areas were reviewed and collapsed into four themes: Member-focused items, Operations, Data / Systems-Related, and Reporting / Oversight. The 25 review areas are listed in Exhibit VII.19 below.

Exhibit VII.19
Focused Areas of Review in MCE Contracts with its NEMT Broker

Member-focused Items	1. Intake of Eligibility Files (834)
	2. Staff Training
	3. Member Services
	4. Telephone Access
	5. Written Materials
	6. Grievance Procedures
	7. Member/Provider Fraud & Abuse

Operations	8. Transportation Provider Network
	9. Driver Standards
	10. Vehicle Standards
	11. Credentialing Providers
	12. Prior Authorization
	13. Quality

Data / Systems Related	14. Data Breaches
	15. Security Control Review
	16. Security
	17. Data Reconciliation

Reporting/ Oversight	18. Deliverables from Broker
	19. Performance Audits
	20. Annual Audit Report
	21. Corrective Action Plan
	22. Sanctions
	23. Subcontracting
	24. Financial Statements
	25. Termination Without Cause

B&A applied a three-tier scoring mechanism for each contract provision. The results of this review are shown in Exhibit VII.20.

Exhibit VII.20
Reviewer's Assessment of NEMT Broker Contract Provisions

Contract language sufficient and appropriate
Documented in contract but language not robust
Not outlined in contract or language is vague

	Anthem			CareSource			MDwise			MHS		
Member-focused (7 Items)	6	0	1	7	0	0	7	0	0	6	0	1
Operations (6 items)	6	0	0	6	0	0	6	0	0	6	0	0
Data / Systems (4 items)	4	0	0	4	0	0	4	0	0	4	0	0
Reporting/ Oversight (8 items)	8	0	0	7	1	0	8	0	0	7	1	0

B&A also reviewed the materials provided by the MCE as well as feedback from the 1:1 interview with each MCE related to the MCE's oversight of its NEMT broker. In particular, B&A reviewed the reports that each MCE collects to conduct oversight of its vendor.

A list of the types of oversight reports collected by each MCE are shown in Exhibit VII.21 below.

Exhibit VII.21
Comparison of Reports Regularly Collected by Each MCE from its NEMT Broker for Oversight
An X indicates that the MCE collects a report on the topic.

	Oversight Category	Anthem	CareSource	MDwise	MHS
Overall	Broker Metrics Summary	X	X	X	X
Member-focused	Member Reconciliation Report	-	X	X	X
	Call Statistics Report	X	X	X	X
	Grievance Reports	-	X	X	-
	Significant Events Report	X	X	X	X
Trip-related	Trip Reports	X	X	X	X
	Authorization Report	-	n/a*	X	n/a*
	Trip Origin Report	X	X	-	-
	Modality Utilization	X	X	X	-
	Utilization Spike Report	-	X	X	X
	On Time Availability Report	X	X	X	X
	Distance Utilization Report	X	X	X	X
	Member Complaint Report	X	X	X	-
	Provider Complaint Report	X	-	-	-
Provider Network	Transportation Network Report	X	X	-	X
	Credentialing Report	-	X	-	-
Claims and Financial	Claims Report	X	-	X	X
	Encounter Reconciliation	-	X	X	X
	Subcapitation Report	-	X	X	-
Quality and Oversight	Mystery Ride Report	-	X	-	-
	Onsite Audit Report	-	X	-	-
	Fraud, Waste & Abuse	X	-	-	-

*CareSource and MHS do the NEMT authorizations themselves

Reviewers' Assessment of MCE Oversight of the NEMT Broker

- For Anthem, their annual audit of the NEMT broker is in-depth and includes detailed notes. B&A's overall assessment for Anthem is *Robust*.
- For CareSource, B&A observed that there was only a high-level review of the NEMT broker in the annual audit and this could be strengthened. Otherwise, B&A's overall assessment for CareSource is *Solid*.
- For MDwise, their annual audit of the NEMT broker is in-depth and includes detailed notes. Our assessment of MDwise for ongoing monitoring of its NEMT broker, however, is *Average*.
- For MHS, their annual audit of the NEMT broker is in-depth and includes detailed notes. B&A's overall assessment for MHS is *Solid*.

Recommendations

Recommendations to All MCEs

1. Each of the MCEs provided examples of periodic reports that they receive from their broker to monitor the NEMT broker's performance. One component that appeared to be missing for all MCEs is specific reporting on the number of trips that were requested that could not be fulfilled due to the lack of provider availability. B&A recommends that each MCE require that this be reported and differentiated from member no shows and provider no shows.

Recommendations to Specific MCEs

2. The NEMT brokers for Anthem and MDwise had recorded trips in a temporary status but the final disposition is unknown. B&A recommends that both Anthem and MDwise ensure that their broker assigns a final disposition on each trip as either completed, denied, cancelled, member no show or provider no show.

3. B&A recommends that CareSource and MDwise require a periodic provider complaint report in addition to the member complaint report that they receive. This will assist in outreach, as needed, by the MCEs to non-compliant members who utilize NEMT.

4. Both CareSource and MHS have a contract with the same NEMT broker. B&A's study found that the claims adjudication target of 21 days was not always met by this broker. The root cause of this finding was that the claims had been submitted electronically, but a signature was still required as validation that the trip was completed. Claims had been adjudicated within 30 days (OMPP's requirement for paper claims). The broker informed the B&A review team that a mechanism for electronic signatures was going to be effective in January 2021. B&A recommends that CareSource and MHS monitor claims adjudication after this electronic signature option takes effect to ensure that the 21-day adjudication requirement is met.

5. In a 1:1 meeting with the MCE, B&A offered recommendations to CareSource on options to create a more robust and detailed scoring in the annual audit of their NEMT broker.

6. In a 1:1 meeting with each MCE, B&A offered recommendations to Anthem and MHS to strengthen specific contract provisions with their NEMT broker.

Recommendations to the OMPP

7. The OMPP is encouraged to add a quarterly report to its reporting manual that summarizes trip requests within each of its programs using pre-defined destination categories and the count of trip requests and their final disposition. The destination categories will enable the OMPP to assess where transportation is in highest demand. Consideration may also be given to report trip requests by region of the state. There may need to be a 90-day reporting lag to allow for final trip dispositions to be determined.

SECTION VIII: FOCUS STUDY ON CLAIMS ADJUDICATION AND ENCOUNTER SUBMISSIONS

Introduction

A focus study on the claims adjudication function performed by the managed care entities (MCEs) was conducted in the CY 2017 External Quality Review (EQR). In this review, B&A performed a validation of claims adjudication reports that are submitted by each MCE for all three of OMPP's care programs. There were discrepancies found in the volume reported by each MCE for institutional and professional claim types compared to what was captured in the OMPP's data warehouse either as an accepted or rejected encounter.

This study was followed-up with an encounter validation focus study in the CY 2018 EQR. The study in this EQR focused on the *accuracy* of encounter submissions, the *timeliness* of encounter submissions, and the *completeness* of claims adjudicated and later submitted as encounters to the OMPP.

The focus of the study in the CY 2020 EQR is on claims adjudication timeliness as well as encounter timeliness and completeness. To that end, B&A will focus on the validation of the two reports submitted quarterly to the OMPP that are a part of the OMPP's MCE Reporting Manual:

- Report 0101 Claims Adjudication Summary; and
- Report 0102 Encounters Summary

In particular, to track timeliness, Burns & Associates, Inc. (B&A) performed an assessment of the turnaround time from the date of receipt of the clean claim from the provider to the date that the MCE adjudicated the claim (for claims). Separately, B&A assessed the turnaround time from date that the MCE adjudicated the claim to the date that the OMPP's data warehouse contractor acknowledged the claim as an encounter submission in the State's Enterprise Data Warehouse (EDW). In both studies, individual claims were examined and summary reports were tabulated for each OMPP program separately—Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC)—and by claim type (institutional, professional, pharmacy and dental).

To track completeness, B&A assessed the completeness rate of MCE adjudicated claims (paid and denied) that are being submitted as encounters. B&A compared the total encounters submitted by the MCEs in CY 2019 against the claims that they adjudicated in CY 2019. This analysis was also conducted for each MCE at the OMPP program level and claim type level.

Methodology for Conducting the Study

B&A requested four files from each MCE that represented all claims that were adjudicated during the period January 1 – December 31, 2019. One file was requested for each claim type—institutional (837I or UB-04), professional (837P or CMS-1500), pharmacy and dental.

Upon receipt, B&A read in 44.2 million claims. Key variables from each of the claim files were validated for use in the study. For example, the claim number assigned by DXC, the OMPP's fiscal agent, was checked to ensure it was not missing or invalid. The member's Medicaid ID was verified for use in assigning OMPP program and other attributes. Date fields were verified for completeness and valid format.

B&A read in the weekly response files sent by the OMPP's contractor to each MCE (called the Encounter Submission Summary Report, or ESSR, files) for the period January 1, 2019 – January 7, 2020. The ESSRs were provided to B&A by the OMPP for this study. Using SAS, B&A read in the ESSR files and matched them against the files submitted by the MCEs to assess encounter completeness. It should be noted that pharmacy claims were not included in the encounter completeness portion of the study because pharmacy encounters are not reported on the ESSR reports.

From the 44.2 million claims provided by the MCEs to B&A, a small number of claims were excluded from the study:

- 0.05% were excluded because the claim adjudication date was prior to January 1, 2019
- 1.15% were excluded because the claim was reported on an ESSR report but not on the MCE files

The final dataset included 43,673,115 claims.

B&A also read in the 0101 (Claims Adjudication) and 0102 (Encounters) reports submitted by the MCEs for the four quarters in CY 2019. These are reports submitted in a pre-defined Excel template on a quarterly basis to the OMPP. B&A validated key metrics reported by the MCEs on these reports to the source data submitted by the MCEs to B&A at the individual claim level including the following:

- Claim adjudication status (paid or denied)
- The ratio of claims adjudicated to claims received by each MCE in each quarter of CY 2019
- Turnaround time statistics from claim receipt by the MCE to claim adjudication
- Turnaround time statistics from MCE claim adjudication to encounter submission to OMPP

A 1:1 webinar meeting was conducted with each MCE to review the preliminary findings on each component of the study. Each MCE was given the opportunity to review its own results against all-MCE averages and to provide follow-up feedback to B&A on the data presented.

Findings

Findings Related to Encounter Completeness

Among 20.6 million non-pharmacy claims adjudicated by the MCEs in CY 2019, 7.0% did not appear as submitted encounters on ESSRs submitted to the OMPP by Jan 7, 2020 (refer to Exhibit VIII.1). Among the 7.0% not included in the ESSRs, B&A found that 46% of the claims were adjudicated in Dec 2019. Therefore, it is likely that these were submitted on ESSRs in early CY 2020 to OMPP. The remaining 54% (781,000 of 20.6 million) were adjudicated prior to Dec 2019, implying that they were not submitted within 30 days of adjudication.

There were some MCE/claim combinations with higher-than average non-complete encounter rates:

- MDwise/UB-04: 18.1% not submitted
- MDwise/CMS-1500: 12.3% not submitted
- MHS/Dental: 32.5% not submitted
- CareSource/Dental: 18.1% not submitted

Exhibit VIII.1
Assessing Completeness of MCE Claim Submissions as Encounters
Comparing MCE Submissions of Claims Adjudicated by MCEs in CY2019 Against CY2019 ESSRs
For the HHW, HIP and HCC Programs Combined, by MCE and by Claim Type

For All Claim Types except Pharmacy

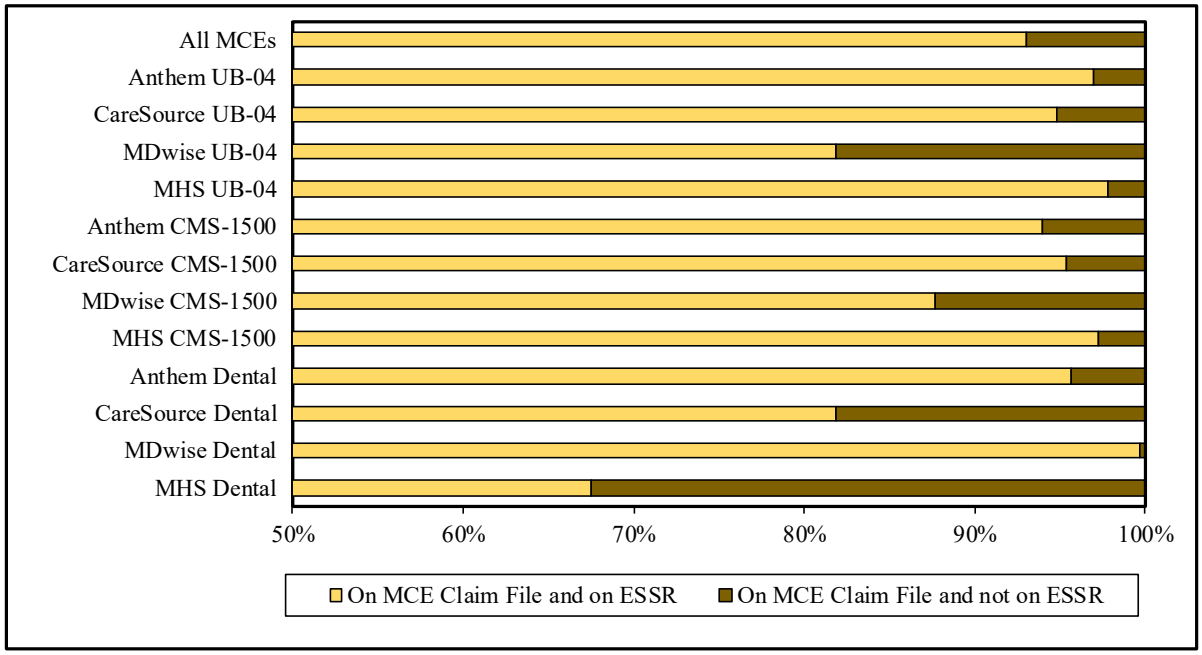


Exhibit VIII.2 shows that among 20.4 million non-pharmacy claims adjudicated by the MCEs in CY 2019 that appeared on ESSRs in CY 2019:

- 96.3% were the original claim
- 3.5% were replacement claims
- 0.2% were "other" (repeat versions of the same claim but not tagged as replacements)

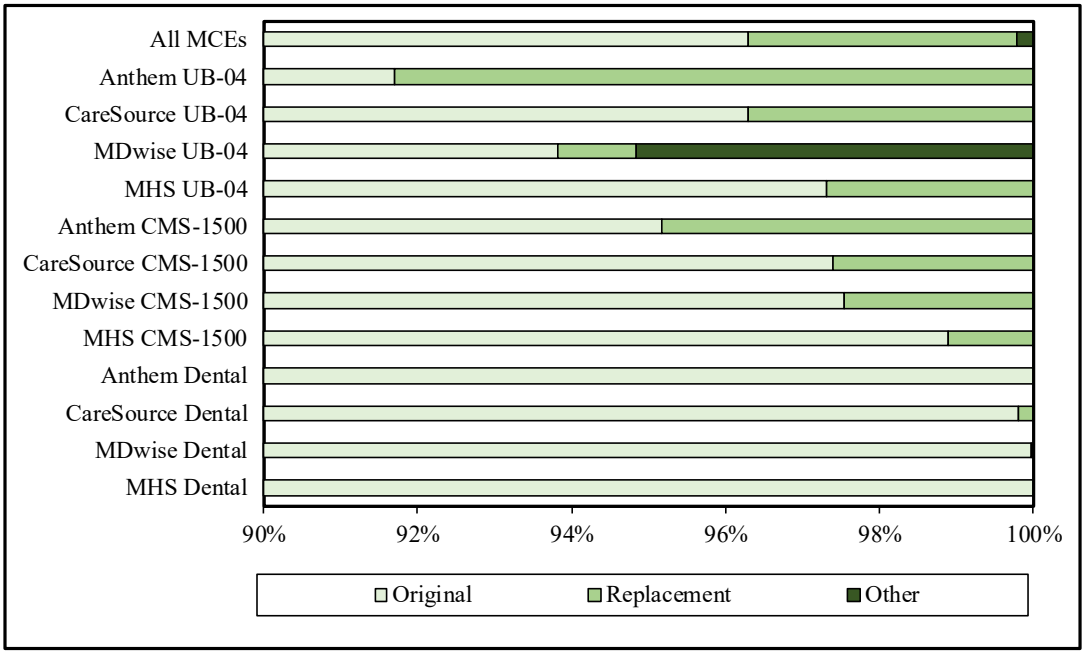
There were some MCE/claim combinations with higher-than average replacement rates:

- Anthem/UB-04: 8.3%
- Anthem/CMS-1500: 4.8%

MDwise is the only MCE with encounters in the "Other" category. They are all UB-04 claims (42,290 total out of their 769,563 UB-04 claims). These encounters were not tagged as original or replacements on the ESSR reports.

Exhibit VIII.2
Type of Claim Submitted as Encounter Submission in CY 2019 (*as reported on ESSR*)
For the HHW, HIP and HCC Programs Combined, by MCE and by Claim Type

For All Claim Types except Pharmacy

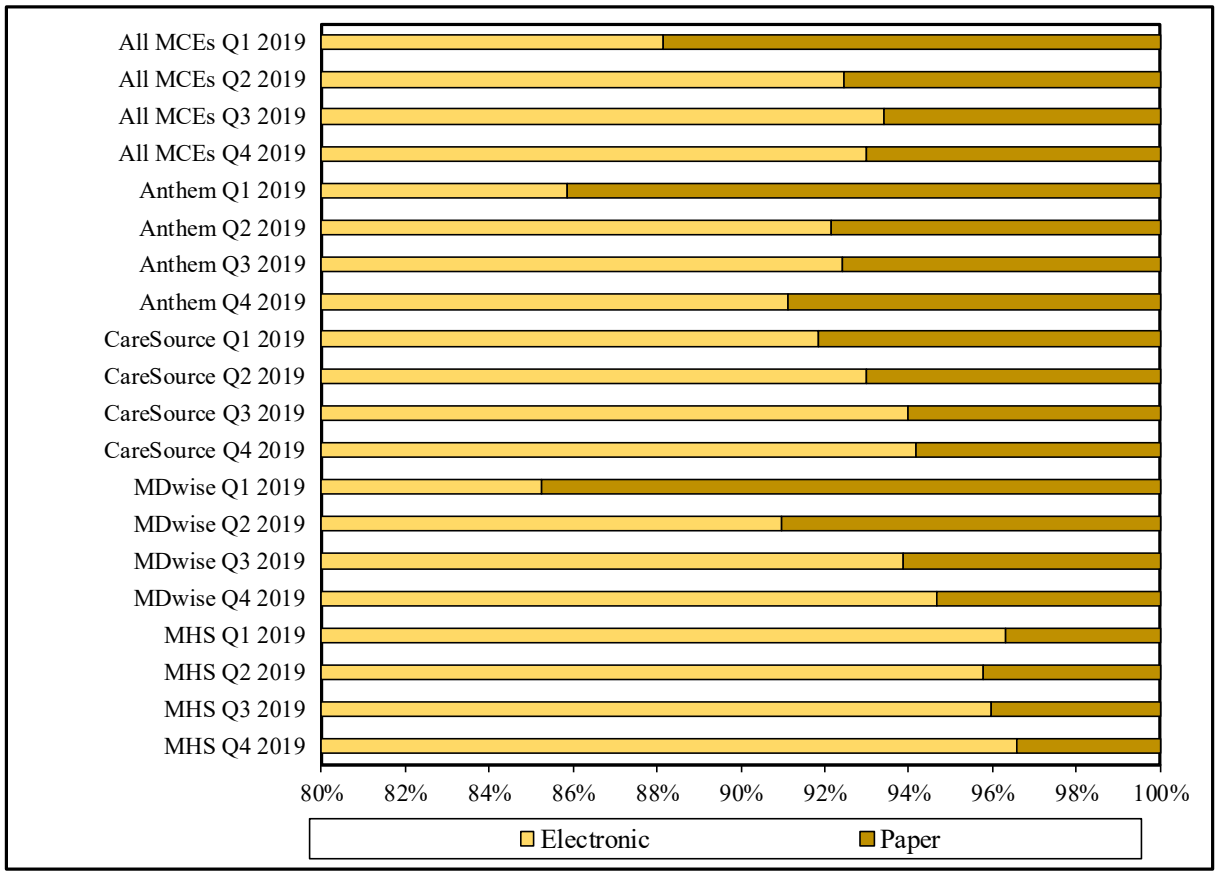


Findings Related to Claims Adjudication

The rate of paper submissions was highest in Quarter 1 of 2019 (11.9% of the total) but was closer to 7.0% in the other three quarters. The Q1 paper rate was high for Anthem and MDwise only.

This information is useful to know as it relates to claims adjudication timeliness because the OMPP requires the MCEs to adjudicate claims submitted electronically within 21 days and claims submitted on paper within 30 days.

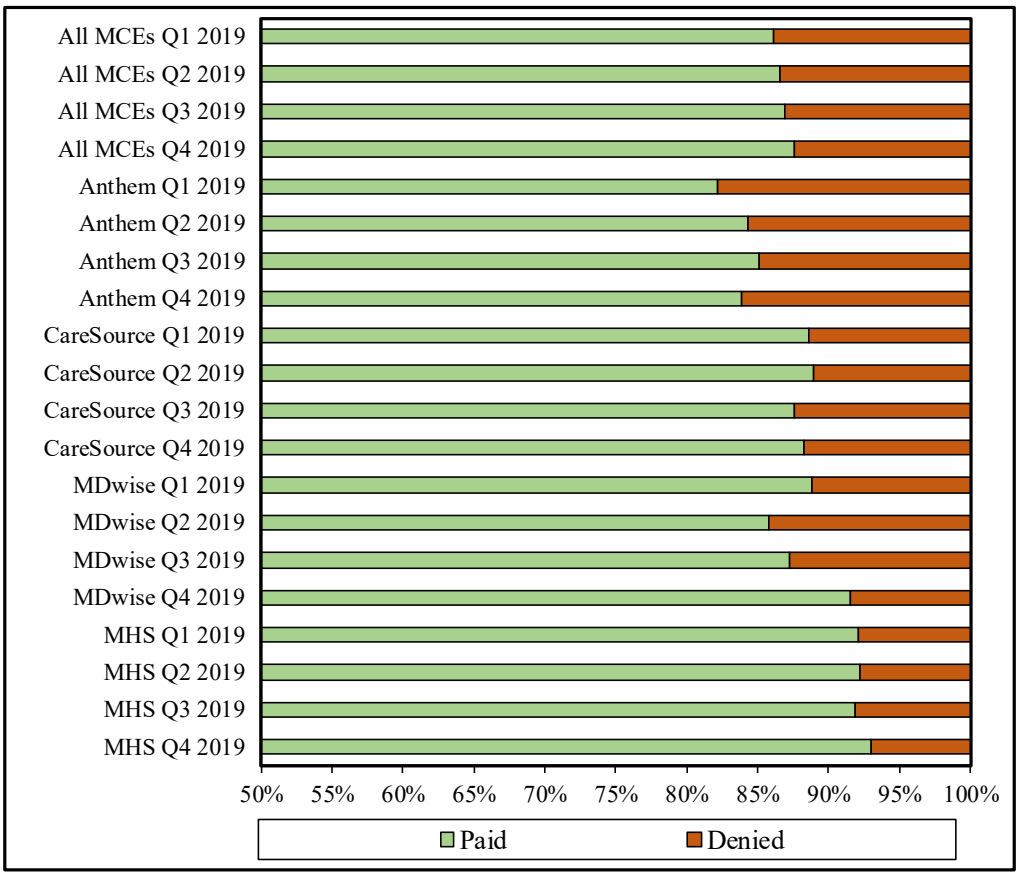
Exhibit VIII.3
Electronic and Paper Clean Claims Received
All Claim Types
By MCE and By Quarter
Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect Combined



The MCEs reported on the Report 0101 to the OMPP that the rate of denied claims as a percent of total claims overall (pharmacy excluded from this analysis) was between 12.4% and 13.8% in each quarter of CY 2019. When reviewed for each of the four quarters of CY 2019, the following denial rate ranges were observed:

- Anthem range: 14.9% to 17.8%
- CareSource range: 11.0% to 12.4%
- MDwise range: 8.4% to 14.2%
- MHS range: 6.9% to 8.1%

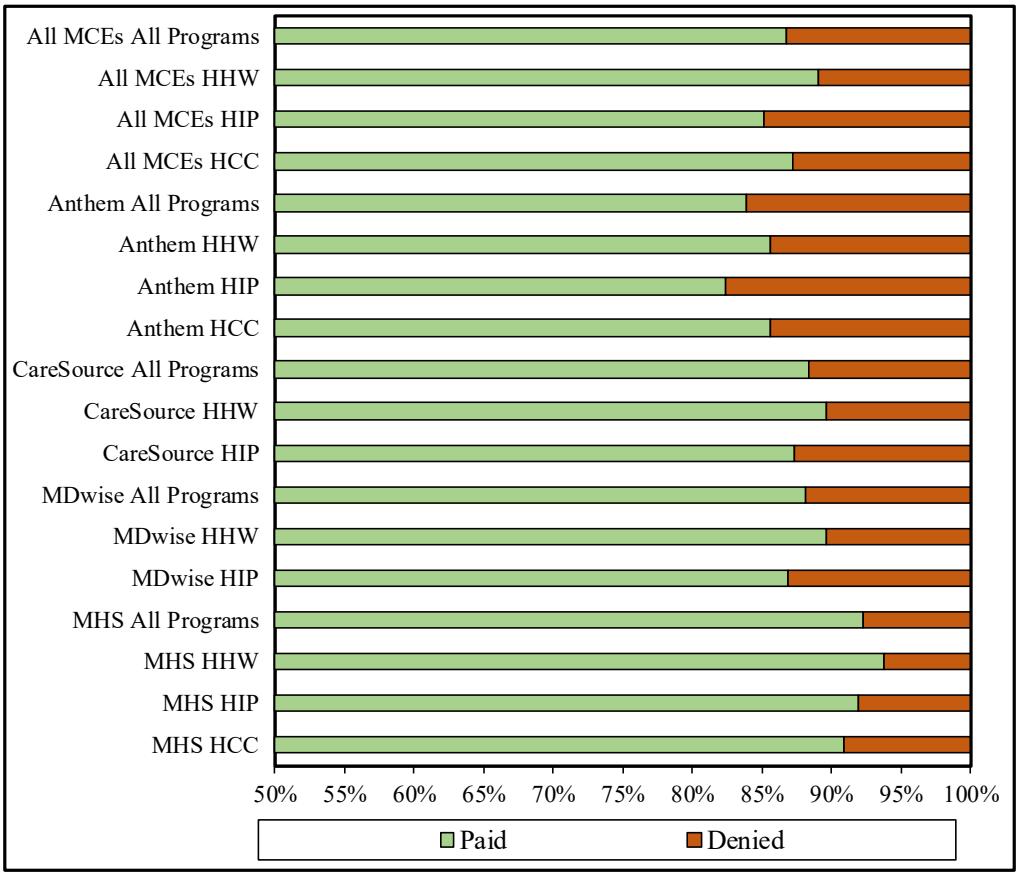
Exhibit VIII.4
Claim Status for Adjudicated Claims
All Claim Types except Pharmacy
By MCE and By Quarter
Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect Combined



The rate of denied claims as a percent of total overall, by program (pharmacy excluded from this analysis) was 13.2% across all programs in CY 2019 (as reported on Report 0101). The following denial rate ranges were observed for each MCE by OMPP program. The highest rate for each MCE was found in HIP.

- For Anthem: 14.4% to 17.6%
- For CareSource: 10.4% to 12.6%
- For MDwise: 10.3% to 13.1%
- For MHS: 6.2% to 9.1%

Exhibit VIII.5
Claim Status for Adjudicated Claims
All Claim Types except Pharmacy
By MCE and By Program for All of CY 2019



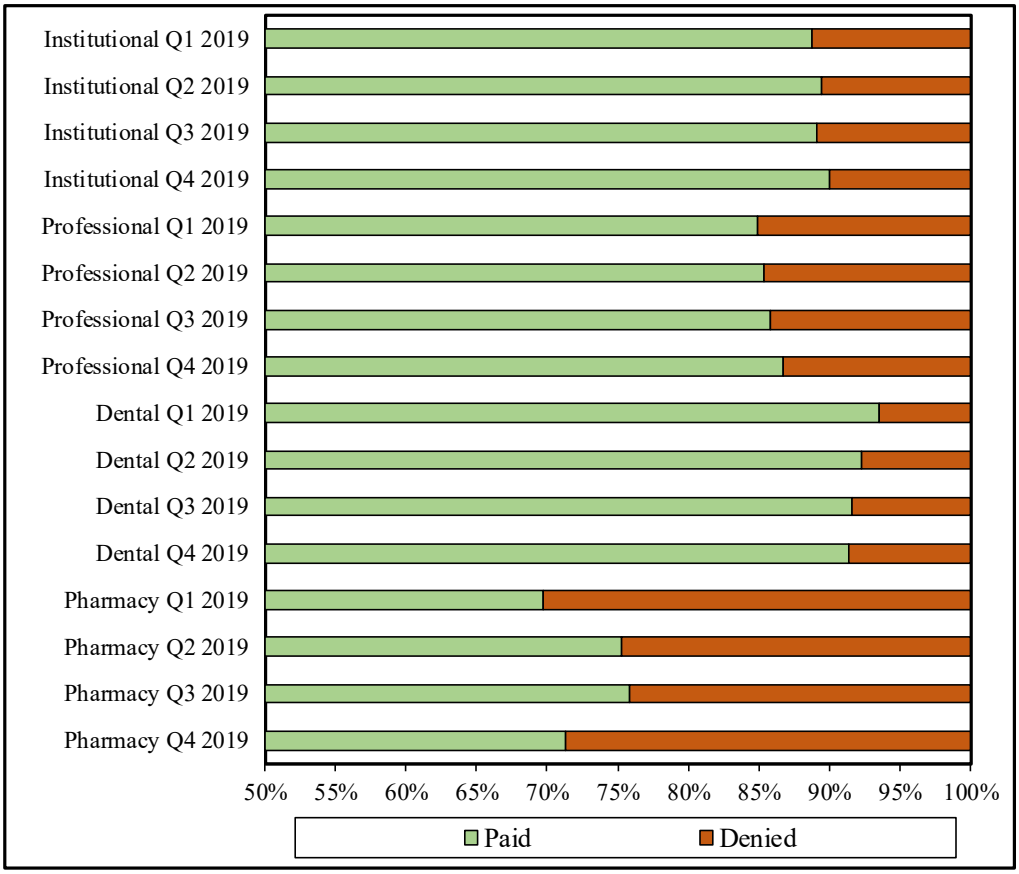
The rate of denied claims varies by claim type. The range across the four quarters in CY 2019, all MCEs combined, is shown below.

- Institutional claim type: 10.0% to 11.2%
- Professional claim type: 13.3% to 15.0%
- Dental claim type: 6.5% to 8.6%
- Pharmacy claim type: 24.1% to 30.3%

Denial rates were also reviewed by OMPP program, by MCE and by claim type for all of CY 2019 combined.

- Denial rates for the UB-04 claim type were similar across HHW, HIP and HCC.
- Denial rates for the CMS-1500 claim type and the Dental claim type were highest in HIP.
- Denial rates for Pharmacy claims were higher for HCC and HIP than in HHW.
- Anthem has the highest denial rates for Pharmacy in all three programs.

Exhibit VIII.6
Claim Status for Adjudicated Claims (as reported by the MCEs)
For All MCEs Combined By Quarter
Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect Combined



Starting in CY 2019, the OMPP's 0101 report now has a metric for the ratio of Claims Adjudicated to Total Clean Claims Received. Given that claims received are not necessarily adjudicated immediately, there can be fluctuation in this ratio to account for timing issues. This ratio is expected to range between 95% and 105% in most quarters.

Exhibit VIII.7 shows that there may be reporting issues on this measure for most MCEs:

- Anthem reported a ratio under 95% in three of the four quarters for CY 2019 without a counterbalancing ratio above 100% any quarter
- CareSource reported exactly 100% in all four quarters
- MDwise reported a ratio of 96% in two quarters and greater than 107% in two quarters
- MHS reported exactly 100% in three quarters, but 133% in Quarter 2

The trends shown above carried across all three OMPP programs as well. At the claim type level, there is a high degree of variation in the results for UB-04 and CMS-1500 claims. Dental and pharmacy claims are steady each quarter.

Exhibit VIII.7
Percent of Claims Adjudicated to Total Received
All Claim Types
By MCE and By Quarter
Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect Combined

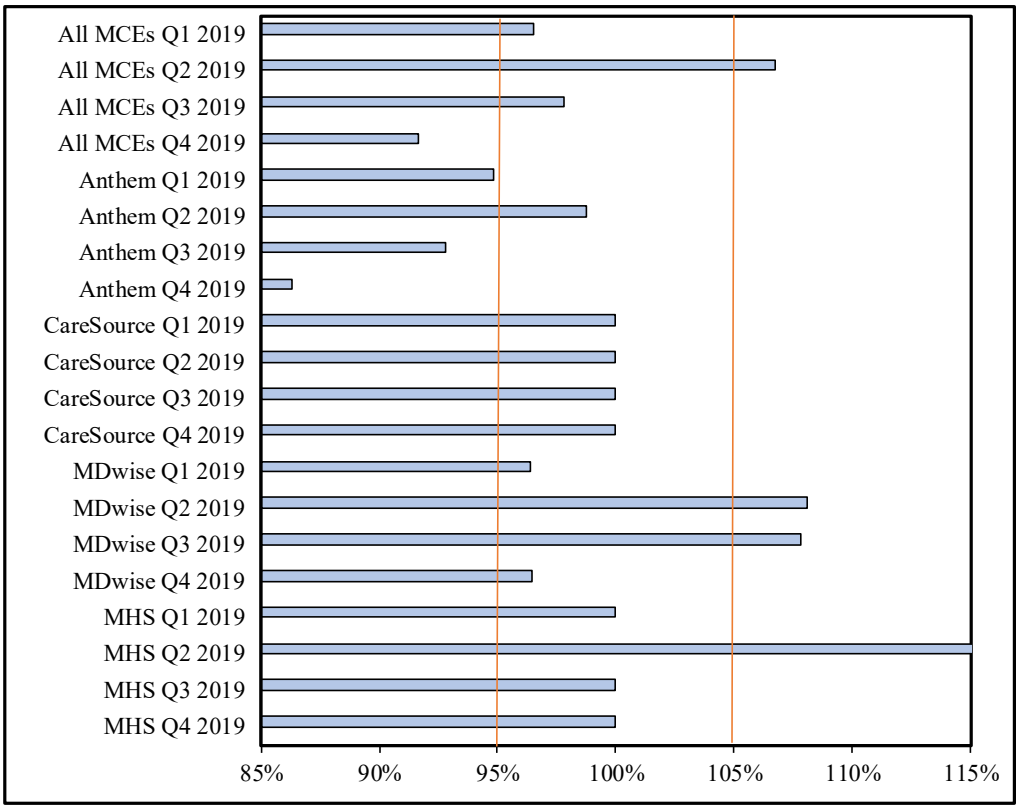


Exhibit VIII.8 summarizes the turnaround time rates for claims adjudication and encounter submissions that are self-reported by each MCE on Reports 0101 and 0102. The OMPP has set a contractual target of 100% of claims adjudicated within 21 days for claims submitted electronically. A target of 98% of encounters must be submitted within 21 days of MCE adjudication. The exhibit shows cells in red where each MCE did not meet these targets (allowing for a 2% allowance on the claims adjudication targets).

Exhibit VIII.8
Turnaround Time Measures for Claims Adjudication and Encounter Submissions in Calendar Year 2019

			Claims Adjudication w/in 21 Days of Receipt Target: 100% within 21 days (electronic) Cells in red are values below 98.00%			Encounter Submission w/in 21 Days of Adjudication Target: 98% within 21 days of adjudication Cells in red are values below 98.00%			
			UB-04	CMS-1500	Dental	UB-04	CMS-1500	Dental	Pharmacy
Anthem	HHW	Q1	99.7%	99.5%	100.0%	97.9%	97.5%	100.0%	98.9%
	HHW	Q2	98.7%	99.3%	99.9%	91.5%	95.4%	100.0%	99.8%
	HHW	Q3	98.1%	98.8%	99.1%	99.9%	93.7%	100.0%	100.0%
	HHW	Q4	97.9%	98.7%	99.5%	100.0%	98.6%	100.0%	100.0%
	HIP	Q1	98.2%	98.3%	100.0%	98.3%	98.9%	100.0%	90.3%
	HIP	Q2	98.1%	99.2%	99.9%	91.8%	99.7%	100.0%	99.8%
	HIP	Q3	98.1%	98.9%	99.6%	100.0%	98.8%	100.0%	100.0%
	HIP	Q4	93.3%	95.0%	99.5%	100.0%	97.3%	99.9%	100.0%
	HCC	Q1	99.6%	99.4%	100.0%	96.8%	97.3%	100.0%	99.1%
	HCC	Q2	98.6%	99.3%	99.9%	78.6%	97.3%	100.0%	99.8%
	HCC	Q3	98.2%	99.0%	99.7%	99.9%	96.5%	100.0%	100.0%
	HCC	Q4	97.3%	98.9%	99.5%	99.9%	94.3%	100.0%	100.0%
Care Source	HHW	Q1	99.2%	99.3%	99.8%	83.8%	82.5%	100.0%	98.6%
	HHW	Q2	99.8%	99.7%	100.0%	83.5%	79.2%	48.3%	100.0%
	HHW	Q3	99.8%	99.9%	100.0%	85.1%	94.4%	91.8%	99.6%
	HHW	Q4	98.1%	99.5%	100.0%	85.6%	91.2%	100.0%	100.0%
	HIP	Q1	99.3%	99.4%	99.7%	83.9%	92.1%	100.0%	90.4%
	HIP	Q2	99.7%	99.9%	100.0%	92.3%	86.4%	30.9%	100.0%
	HIP	Q3	99.5%	99.9%	100.0%	85.1%	95.8%	96.1%	99.7%
	HIP	Q4	99.0%	99.4%	100.0%	74.4%	81.0%	100.0%	95.7%
MDwise	HHW	Q1	87.0%	92.2%	100.0%	88.3%	61.1%	100.0%	100.0%
	HHW	Q2	83.3%	86.1%	100.0%	61.7%	45.2%	98.8%	100.0%
	HHW	Q3	90.4%	90.4%	100.0%	94.4%	93.8%	100.0%	100.0%
	HHW	Q4	99.8%	98.5%	100.0%	100.0%	99.6%	96.4%	100.0%
	HIP	Q1	86.2%	87.9%	100.0%	90.0%	63.3%	100.0%	100.0%
	HIP	Q2	80.0%	86.7%	100.0%	54.9%	56.4%	98.8%	100.0%
	HIP	Q3	81.1%	90.3%	100.0%	76.6%	86.8%	100.0%	100.0%
	HIP	Q4	99.6%	98.4%	100.0%	94.8%	99.4%	97.3%	100.0%
MHS	HHW	Q1	98.6%	99.4%	100.0%	98.3%	98.1%	95.2%	99.4%
	HHW	Q2	98.3%	99.5%	100.0%	99.5%	99.7%	99.4%	100.0%
	HHW	Q3	99.3%	99.6%	100.0%	99.9%	100.0%	83.6%	62.0%
	HHW	Q4	99.4%	99.8%	100.0%	99.4%	99.7%	98.6%	100.0%
	HIP	Q1	99.0%	99.6%	100.0%	99.2%	99.3%	97.9%	99.5%
	HIP	Q2	98.3%	99.5%	100.0%	99.4%	99.7%	99.7%	100.0%
	HIP	Q3	99.4%	99.5%	100.0%	94.4%	98.1%	81.6%	94.1%
	HIP	Q4	99.4%	99.8%	100.0%	99.1%	99.6%	99.1%	100.0%
	HCC	Q1	98.9%	99.4%	100.0%	98.5%	98.3%	94.5%	99.6%
	HCC	Q2	98.1%	99.2%	100.0%	99.6%	99.6%	99.3%	100.0%
	HCC	Q3	99.4%	99.4%	100.0%	99.9%	100.0%	88.9%	93.8%
	HCC	Q4	99.1%	99.7%	100.0%	98.9%	99.6%	98.2%	100.0%

B&A then compared what was reported by the MCEs on the 0101 reports for claims adjudication turnaround time in CY 2019 to our own computation using the claim files we received from the MCEs. (Refer to Exhibit VIII.9 on the next page.) When compared to what the MCEs reported to OMPP:

- B&A closely matched CareSource and MHS on institutional claims, but we found more claims adjudicated >21 days than what Anthem and MDwise reported.
- B&A found more professional claims adjudicated >21 days than what Anthem, CareSource and MDwise reported.
- B&A matched all MCEs on dental claims adjudication.

A similar process was conducted to compare the turnaround time from adjudication by the MCE to encounter submission. We compared what was reported by the MCEs on the 0102 reports in CY 2019 to our own computation using the claim files we received from the MCEs. The results appear in Exhibit VIII.10 on page VIII-13 and in Exhibit VIII.11 on page VIII-14. When compared to what the MCEs reported to OMPP:

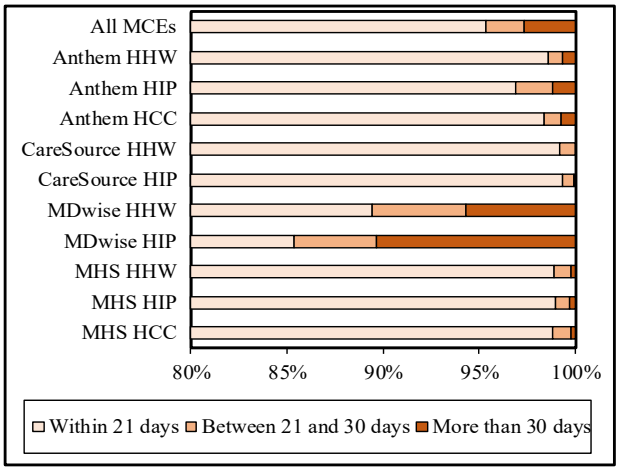
- CareSource and MDwise had challenges submitting institutional encounters within 30 days. Yet both MCEs reported worse results to OMPP than what B&A found.
- This same issue occurred for professional encounters for both CareSource and MDwise.
- CareSource had challenges submitting dental encounters. MHS did as well to a lesser degree.
- No MCE had issues submitting pharmacy encounters within 30 days except MHS in HHW.

In an effort to better understand these variances from the MCEs, B&A observed in the files given to us by the MCEs that there were many instances of the same claim that was adjudicated multiple times in CY 2019. B&A did not request unduplicated claims in its data request but, rather, all claims adjudicated in CY 2019. B&A ran a process to ensure that the claims examined were an unduplicated count. This is because the OMPP Reports 0101 and 0102 specifically state that only original claims get reported and not replacement or re-adjudicated claims. B&A has surmised that, in our de-duplication process, the claim that we selected for review when more than one appeared may not have been the same claim that the MCE used for reporting to OMPP. If B&A used a more recent claim than the original claim processed, this may extend the turnaround time on the claims adjudication report yet shorten the turnaround time on the encounter submission report.

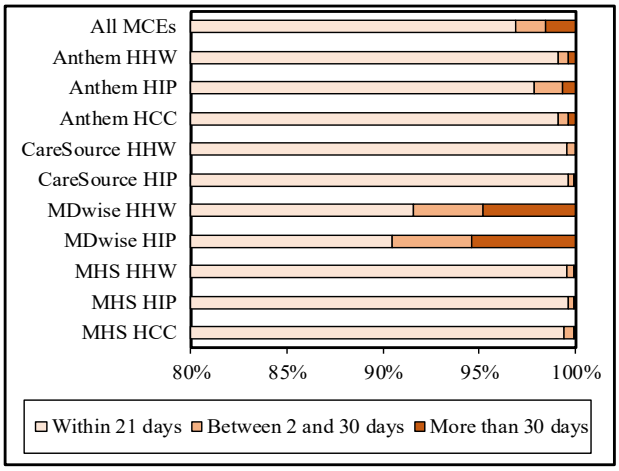
Exhibit VIII.9
Turnaround Time from Receipt to Claim Adjudication in CY 2019
For the HHW, HIP and HCC Programs by MCE and by Claim Type

As reported by the MCEs on Report 0101

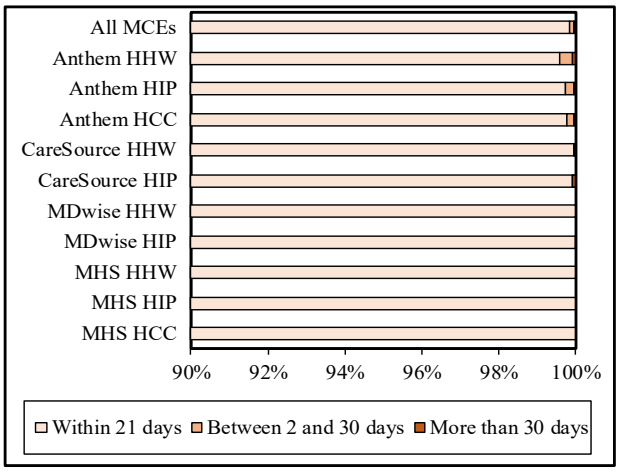
Institutional Claims



Professional Claims

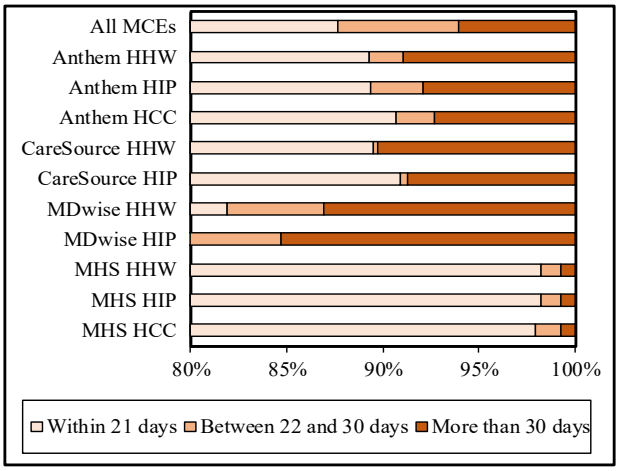


Dental Claims

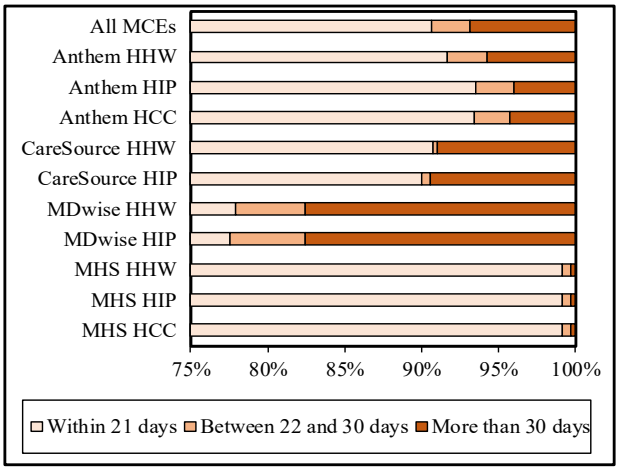


As reported by the MCEs to B&A at the claim level

Institutional Claims



Professional Claims



Dental Claims

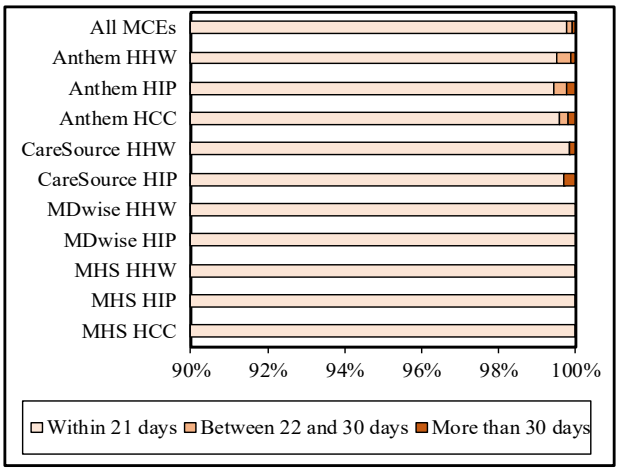
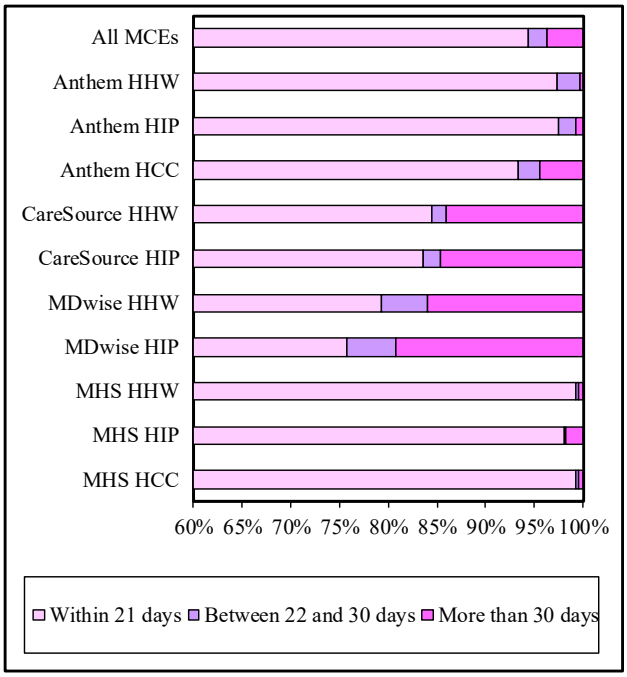


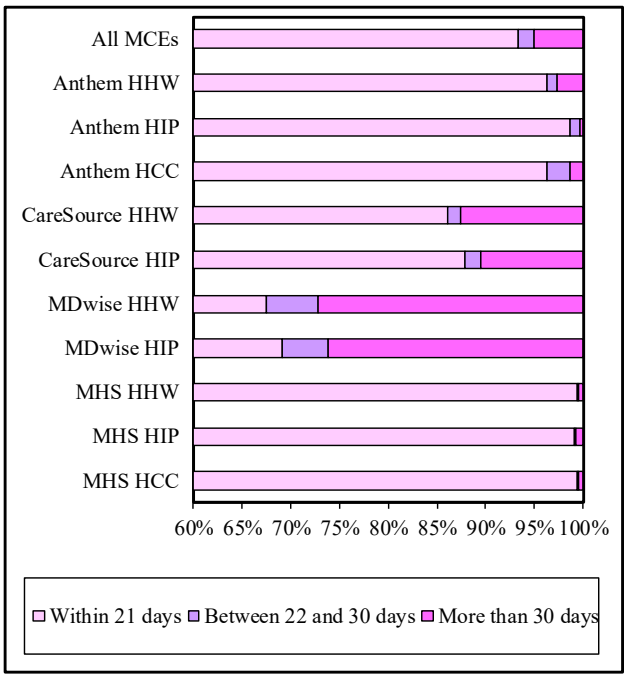
Exhibit VIII.10
Turnaround Time from Adjudication to Encounter Submission in CY 2019
For the HHW, HIP and HCC Programs by MCE and by Claim Type

As reported by the MCEs on Report 0102

Institutional Claims

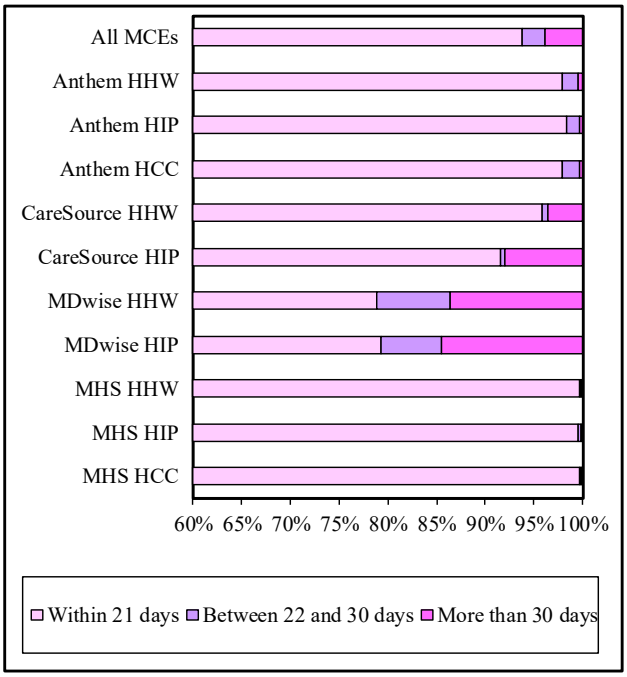


Professional Claims



As reported by the MCEs to B&A at the claim level

Institutional Claims



Professional Claims

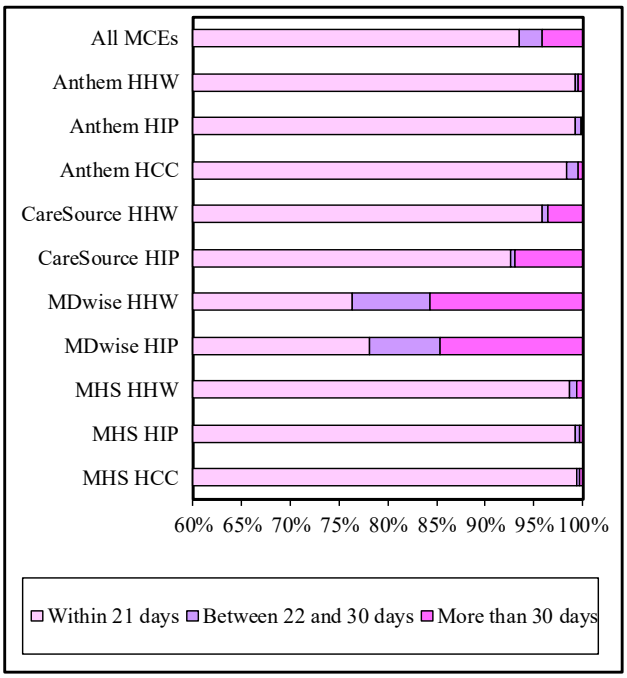
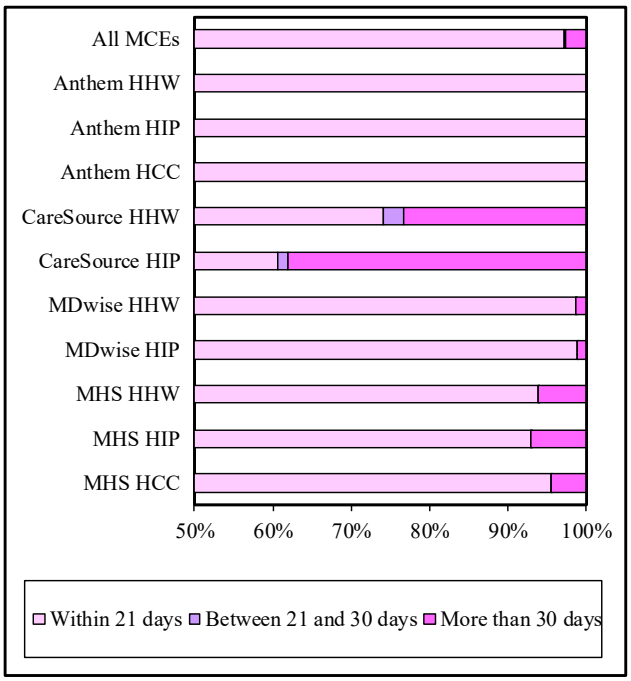


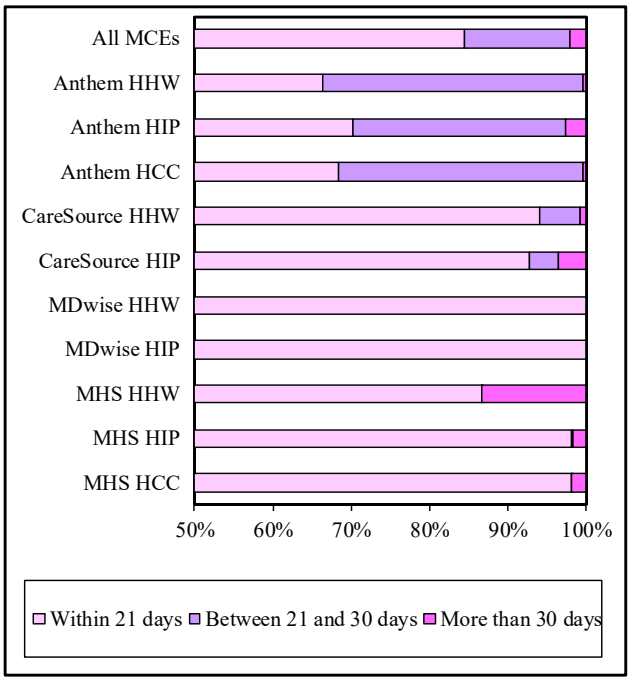
Exhibit VIII.11
Turnaround Time from Adjudication to Encounter Submission in CY 2019
For the HHW, HIP and HCC Programs by MCE and by Claim Type

As reported by the MCEs on Report 0102

Dental Claims

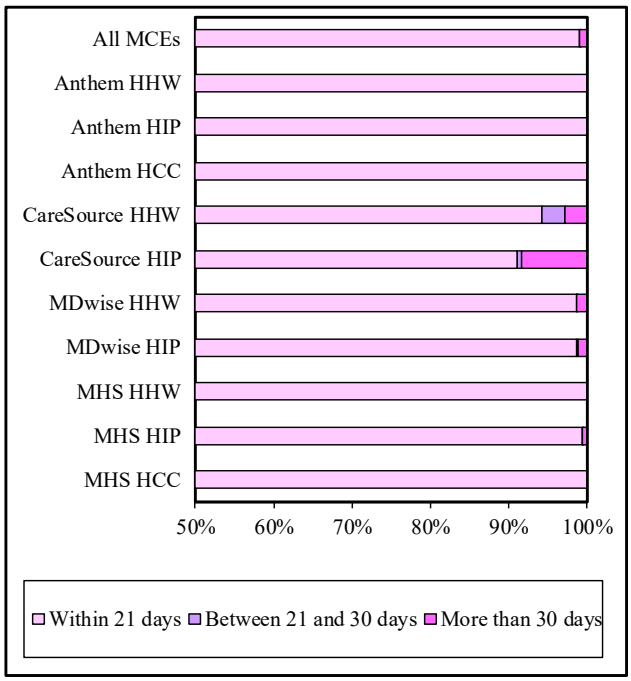


Pharmacy Claims

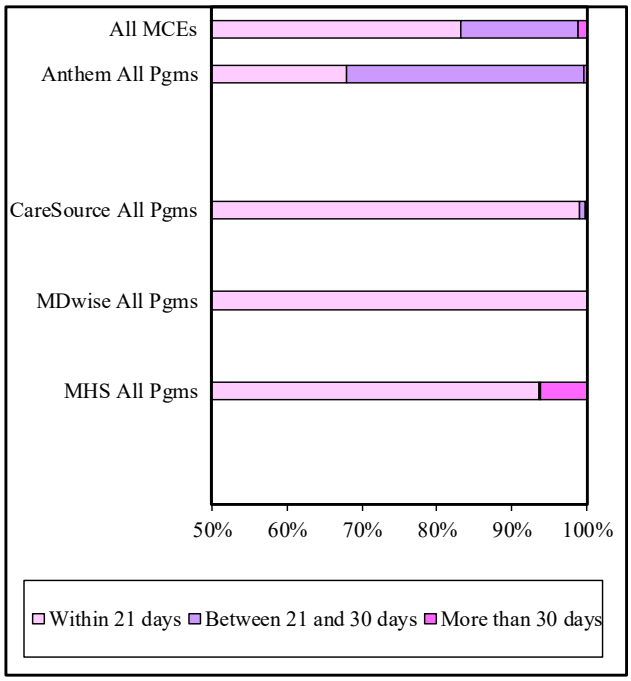


As reported by the MCEs to B&A at the claim level

Dental Claims



Pharmacy Claims



Recommendations

Recommendations to Specific MCEs

1. On the OMPP Report 0101 (Claims Adjudication), both CareSource and MHS need to correct their reporting of number of claims received to include all claims received in the quarter and not just those adjudicated in the quarter. This will correct the values reported in this study that showed both MCEs having an adjudicated-as-percent-of-received ratio of 100% in each quarter.

2. Anthem reported claim denial rates greater than their peers on professional and pharmacy claims. Anthem should be prepared to report to the OMPP the primary reasons for this difference and any educational efforts that have occurred with providers to reduce the denial rates.

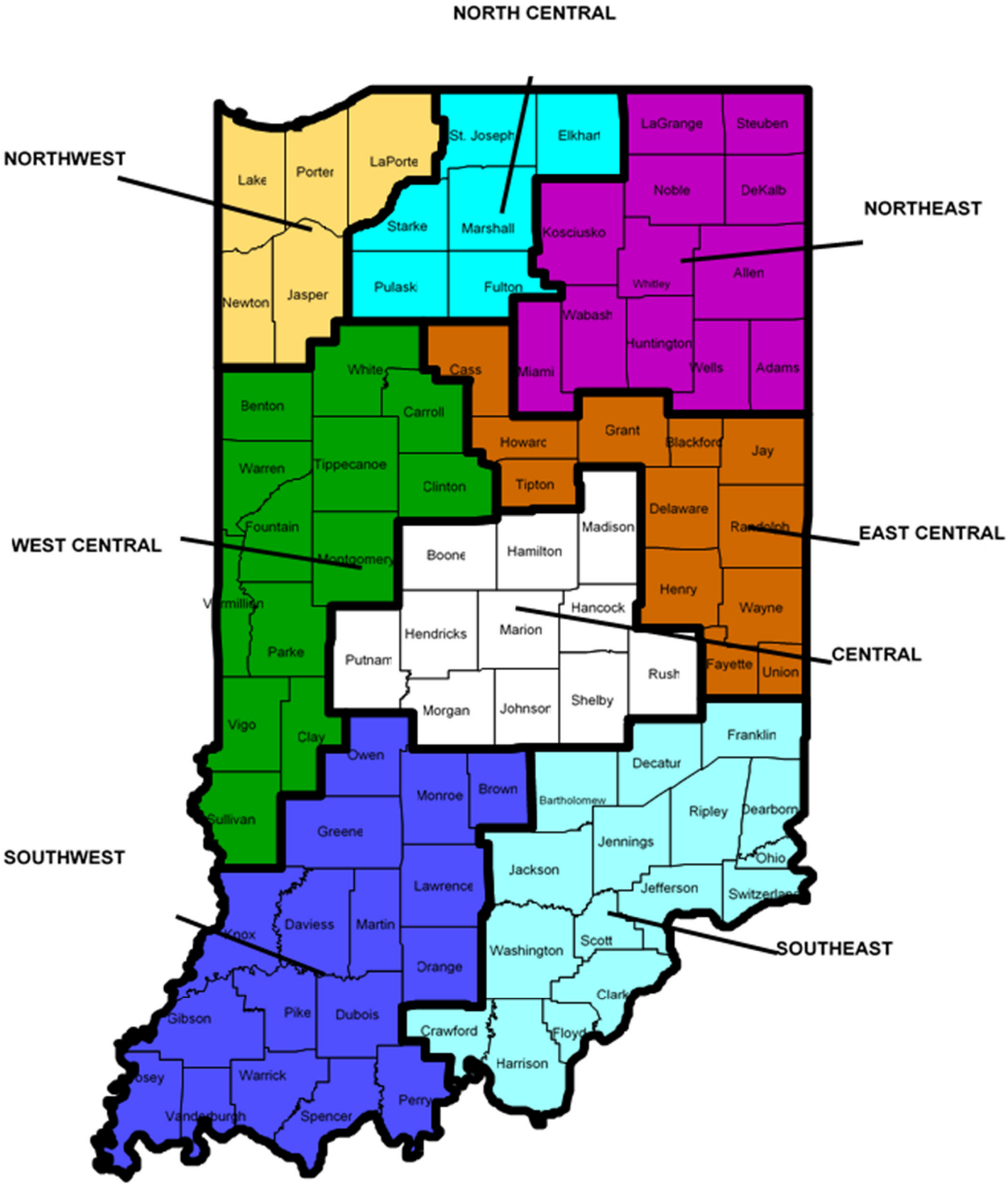
3. MDwise and CareSource should be prepared to report to the OMPP the corrective action it has taken to minimize the percentage of encounters submitted beyond the OMPP's contractual target of 30 days from adjudication.

Recommendations to OMPP

4. In this focus study, B&A compared the claims adjudicated as reported by each MCE through individual claim record reports to the summation of claims reported on Report 0101 (Claims Adjudication) and Report 0102 (Encounter Submissions). It was observed that—when reviewed on an individual claim level—some MCEs adjudicate significantly more claims than what are reported on the 0101 report because the instructions state that replacement or re-adjudicated claims are to be excluded from reporting. Although it may not be necessary to incorporate into Report 0101, B&A recommends that the OMPP require reporting by the MCEs on the volume or re-adjudicated claims to determine a re-adjudication factor (total claims adjudicated divided by original clean claims submitted) as a means to assess claims "churn" at each MCE.

5. The Report 0102 was designed to report encounter claim lines submitted as opposed to total encounters (full claims) submitted. This was for the convenience of the MCEs to use a response file that they receive from the OMPP's vendor that tracks the total encounters submitted. Unfortunately, this becomes difficult to assess the percentage of total claims submitted as encounters since the Report 0101 requires the count of total claims, not total claim lines. B&A recommends that the OMPP change the specification of Report 0102 to require the count of total claims rather than claim lines so that the comparison of claims to encounters can be completed across the two reports.

Appendix A
Map of Indiana's 92 Counties to Eight Regions



APPENDIX B

2020 EXTERNAL QUALITY REVIEW GUIDE FOR THE HOOSIER HEALTHWISE, HOOSIER CARE CONNECT AND HEALTHY INDIANA PLAN 2.0 PROGRAMS (Review of CY 2019 Operations)

TABLE OF CONTENTS

Separate Excel File:

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 its three health coverage programs—Hoosier Healthwise (HHW), Hoosier Care Connect (HCC) and Healthy Indiana Plan 2.0 (HIP).

The 2020 EQR will encompass both mandatory activities required by the Centers for Medicare and Medicaid (CMS) as well as optional activities, in particular, focus studies. Due to the pandemic and the shared interest in limiting face-to-face meetings, B&A has coordinated with the OMPP that most of the work completed in this year's EQR will be completed as a desk review. There will, however, be meetings conducted with each MCE via webinar. Some webinars will include interviews with selected staff members at each MCE or its subcontractors. Other webinars will be to review and discuss B&A's initial findings from each of the study topics in this year's EQR.

The topics selected for this year's EQR were made in coordination with the Office of Medicaid Policy and Planning. This review will encompass activities in Calendar Year (CY) 2019. Each of the focus studies is a continuation of a previous focus study conducted on the topic in a prior EQR:

1. Focus Study on Network Adequacy through the Validation of MCE Reports to the OMPP
2. Focus Study on Lead Testing
3. Focus Study on the Utilization and Delivery of Non-Emergency Medical Transportation (NEMT)
4. Focus Study on Claims Adjudication and Encounter Submissions
5. Validation of Performance Measures
6. Validation of MCE Quality Improvement Projects

Timeline

The OMPP is requesting that B&A deliver the draft report for this EQR by September 30, 2020. The final report is due to OMPP on October 31. B&A has already started the desk review on some tasks. But the schedule for this EQR effectively begins with the release of this EQR Guide.

The first items that are being requested from the MCEs are **due June 17**. Interviews by phone begin the first week of June. Webinars related to findings from data analytics from the multiple focus studies are scheduled for July and August. All data collection activities and MCE responsibilities are scheduled to be concluded by August 31. 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 webinar meetings are concluded. A full schedule may be found in Section C of this Guide.

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, but will most likely occur at the end of October. Each MCE will also receive a copy of the final EQR report that will be delivered to CMS.

The B&A Review Team

This year's EQR Review Team consists of seven individuals that have all served on previous EQRs of Indiana health coverage programs with one new team member:

- *Mark Podrazik*, Project Director, B&A: Mark has previously conducted 14 EQRs of the HHW program, 11 EQRs of the HIP and four EQRs of HCC as well as a review of its predecessor, Care Select.

- *Debbie Saxe*, Principal, B&A: Debbie has participated in EQRs conducted by B&A in 2016 and 2017. She also served on the team that reviewed the NEMT delivery model in Indiana's fee-for-service program in 2019. Debbie also serves as the Project Manager for B&A's engagement with the FSSA conducting the SUD Waiver evaluation.

- *Shawn Stack*, Senior Consultant, B&A: Shawn joins the EQR Review Team for the first having joined B&A in the latter part of 2019. One of his first projects at B&A was to work on the team that reviewed the NEMT delivery model in Indiana's fee-for-service program in 2019. Since then, he has worked with one state on the development of a provider profile database and is currently conducting a financial review of grant programs in another state.

- *Jesse Eng*, SAS Programmer, B&A: Jesse has conducted programming and analytic support on B&A's engagements with OMPP since 2009, in particular, B&A's Independent Evaluation of Indiana's CHIP and the annual EQRs. He worked on B&A's previous focus studies related to encounter reporting and network adequacy.

- *Akhilesh Pasupulati*, SAS Programmer, B&A: Akhilesh has worked on the most recent three EQRs as the programmer on focus studies related medication adherence, pharmacy utilization and pregnancy. He also served as the programmer on B&A's recent engagement to review NEMT in Indiana's fee-for-service program.

- *Barry Smith*, Data Analyst, B&A: Barry has assisted in analytics for B&A's Independent Evaluation of Indiana's CHIP as well as the External Quality Reviews in Indiana since 2009. Barry worked closely with Mark Podrazik on the design and implementation of the report shells in the revised MCE Reporting Manual in last year's EQR as well as B&A's prior network adequacy studies.

- *Dr. Linda Gunn*, Subcontractor: Linda has assisted B&A on 11 previous EQRs encompassing all three of OMPP's programs.

- *Kristy Lawrance*, Subcontractor: Kristy assisted on seven previous EQRs encompassing all three of OMPP's programs.

B. Details on Topics in this Year's EQR

Topic #1—Focus Study on Network Adequacy through the Validation of MCE Reports to the OMPP

A focus study on network adequacy was completed in the CY 2019 EQR. In an effort to strengthen the oversight of the MCE's network adequacy, the OMPP implemented two new reports for the MCEs to submit beginning in CY 2019:

- Report 0902 Count of Enrolled Providers; and
- Report 0903 Member Access to Providers

The purpose of the CY 2020 review of network adequacy is to validate the results reported by the MCEs in these two reports. B&A recognizes that each MCE submitted follow-up reports to the initial reports delivered to the OMPP on October 31, 2019. B&A will confirm with each MCE the most recent version of each report to validate.

The primary objective in the validation of Report 0902 is to assess variation in the counts of providers reported for each provider category listed in the report. Specifically, B&A will assess variation of provider counts across OMPP programs *within* an MCE as well as provider counts *across* MCEs. Although it is not expected that each MCE will contract with the same number of providers within each category, a high-level comparison across MCEs will assess the reasonableness of the counts reported by each MCE on this report.

The validation of Report 0903 will be more in-depth. B&A will use encounter data for services rendered in CY 2019 to match member trips to providers and compute an average driving distance. This information will be available at a granular level (that is, by MCE/program/provider specialty/county) and also at a macro level (that is, a dashboard that shows potential areas of access issues by specialty within each OMPP program).

B&A reported some provider specialty/county combinations with potential challenges in the CY 2019 EQR. A follow-up review will be conducted to assess if there has been improvement in access where these baseline findings were observed.

B&A recognizes that Report 0903 does not require the MCEs to report exactly which providers that members sought services; rather, the report requires the availability of providers to members based on the MCE's provider network roster. Members have freedom of choice to seek providers further away than a provider closer to their home. This may be especially true for specialty providers. However, assessing where members are seeking services and comparing this to the reported availability may be indicative of true access to providers. Therefore, the intent of this validation is not to match exactly to the counts of members outside the access requirement for each provider category. Instead, the intent is to assess the reasonableness of the information reported by each MCE on Report 0903 and to assess provider adequacy trends across OMPP programs and MCEs.

B&A anticipates that this focus study will be conducted as a desk review only with no interviews with the MCE. There will be a webinar scheduled, however, with each MCE to serve as a touch-point to share preliminary findings. These webinars will be scheduled on **June 23** and **24**.

Topic #2—Focus Study on Lead Testing

A focus study on lead testing was completed in the CY 2017 EQR as a result of an outbreak of lead exposure in the West Calumet Housing Project in East Chicago. A brief follow-up on the change in the rate of lead testing among children in Indiana's Medicaid program was conducted in the CY 2018 EQR.

The purpose of the follow-up study in the CY 2020 EQR is to assess if the rate of testing for Medicaid children is occurring at the appropriate age levels and if it has improved since the previous studies. B&A will once again use data from both the ISDH database of lead tests reported as well as MCE encounters showing billings for lead tests. B&A will compare the tests submitted in both datasets and will report on the frequency of tests that appear in the ISDH database, the encounters database, or both.

B&A will also assess the test levels reported for those tests reported in the ISDH database where this data is reported.

B&A will also validate a new report that was implemented with the Reporting Manual redesign launched at the beginning in CY 2019:

- Report 0508 Lead Testing (HEDIS specification)

B&A anticipates that this focus study will be conducted as a desk review only with no interviews with the MCE. There is no specific meeting scheduled with the MCEs on this topic, but it may be included in another data review webinar this summer.

Topic #3—Focus Study on the Utilization and Delivery of NEMT

A focus study on NEMT in HHW and HIP was conducted in the CY 2014 EQR. One of the key findings of this study was that there was not evidence that all of the NEMT trips that were delivered were provided to an eligible Medicaid member to a contracted Medicaid provider for a covered Medicaid service. Although there may be situations where the MCE is offering an enhanced benefit for trips other then Medicaid-covered services, the finding from the CY 2014 indicated that there were opportunities to strengthen the oversight of this benefit.

With the significant work conducted by the MCEs and the OMPP to strengthen the accuracy and completeness of encounter reporting—including for NEMT trips—it seemed appropriate to revisit this study to assess progress on the oversight of NEMT.

This focus study will examine:

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

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

- A quantitative analysis of NEMT trip requests and claims paid for trips;
- A desk review of MCE policies and procedures related to NEMT; and
- A qualitative component that will include interviews with transportation brokers and the MCEs

Steps of Review

1. B&A will conduct an interview with each MCE and the staff responsible for oversight of its NEMT broker and the NEMT benefit. The questions posed will relate to this oversight responsibility. These interviews are scheduled for **June 2** or **3**.

2. The MCEs should submit to their broker in advance of the meeting the templates included in the file attached to this EQR Guide 'File to Accompany EQR Guide.xlsx', specifically, tabs 3 through 6. B&A will be making a significant data request of each MCE related to NEMT utilization, but it is anticipated that the level of detail required resides with each NEMT broker. As such, B&A is also scheduling meetings with each MCE and its NEMT broker on **June 8**. The purpose of this meeting specifically is to walk through the data request and to give the NEMT broker an opportunity to flag concerns with the ability to submit all requested information or to ask clarification questions about the data request. After this meeting, B&A anticipates that all future interaction will occur only with the MCE. However, we thought that it would be helpful to have a discussion directly with each vendor who will likely be providing the information to us for this review.

3. Based on the discussions on June 2/3 and June 8, B&A will be requesting information from the MCEs for a desk review of the MCE's oversight of NEMT. Items that are anticipated to be requested include the contract between the MCE and the broker, periodic dashboard or other reports submitted by the broker to the MCE, delegation oversight reports, or meeting minutes with the broker during CY 2019. These materials will be due to B&A on **June 17**.

4. The specific data request to the NEMT brokers will be due to B&A on **June 30**.

5. B&A will intake and validate the information from the files submitted by the NEMT brokers/MCEs. Results will be complied HHW, HIP and HCC populations separately. Information will be compared across MCEs as well. Some of the ways that the data is intended to be stratified will be:
    a. By trip modality (e.g., ambulatory van, wheelchair van, ambulance, other)
    b. By region (county or zip code)
    c. By provider serving the MCE
    d. By trip destination
    e. By number of miles
    f. Demand vs subscription trip volume
    g. Trips requested and later cancelled
    h. Trips requested but not fulfilled (but also not cancelled)
    i. NEMT 'frequent flier' members
    j. Timeliness of claims adjudication to NEMT providers

There will be a webinar scheduled with each MCE to serve as a touch-point to share preliminary findings. These webinars will be scheduled on **Aug 11** and **12**. It is at the MCE's discretion whether they wish to invite their contracted broker to this session.

Based on our findings, B&A reserves the right to conduct an additional session with each NEMT broker (with the MCE in attendance). The reason for a meeting may be to clarify data that was reported or to ensure the correct interpretation of policies that are evident through the data analyzed.

Topic #4—Focus Study on Claims Adjudication and Encounter Submissions

A focus study on MCE claims adjudicated was conducted in the CY 2017 EQR. In the CY 2017 External Quality Review, B&A performed a validation of claims adjudication reports that are submitted by each MCE for all three of OMPP's care programs. There were discrepancies found in the volume reported by each MCE for institutional and professional claim types compared to what was captured in the OMPP's data warehouse either as an accepted or rejected encounter.

This was followed-up with an encounter validation focus study in the CY 2018 EQR. The study in this EQR focused on the *accuracy* of encounter submissions, the *timeliness* of encounter submissions, and the *completeness* of claims adjudicated and later submitted as encounters to the OMPP.

The focus of the CY 2020 study is on claims adjudication timeliness and encounter timeliness and completeness. To that end, B&A will focus on the validation of the following reports submitted quarterly to the OMPP:

- Report 0101 Claims Adjudication Summary; and
- Report 0102 Encounters Summary

Steps of Review

1. *Track Timeliness*. Intake files submitted directly from the MCE for claims adjudicated in CY 2019. Refer to the template included in the file attached to this EQR Guide 'File to Accompany EQR Guide.xlsx', specifically, tab 2. A similar format was requested by B&A in the CY 2018 EQR. As part of this process,

    a. An assessment of the cadence at which encounters are submitted by OMPP program and by claim type will be completed.
    b. Analytics will be conducted to compute the average number of days from (1) the date of receipt by the MCE to adjudication date, (2) the date from adjudication to initial encounter submission, and (3) the date from adjudication date to encounter acceptance by DXC (accounting for the fact that some encounters may be submitted multiple times before being accepted).

2. *Track Completeness*. B&A will intake from OMPP the ESSR files provided to each MCE by Optum that report the acceptance of encounters submitted by each MCE. From these reports,

    a. Analytics will be conducted to assess the completeness rate of MCE adjudicated claims (paid and denied) that are being submitted as encounters. This will be conducted at the MCE, OMPP program and claim type level.
    b. A specific analysis will be conducted on the rate of claim resubmissions (that is, void and replacements) to identify any specific patterns at the MCE, OMPP program and claim type level.

There will be a webinar scheduled with each MCE to serve as a touch-point to share preliminary findings. These webinars will be scheduled on **July 28** and **29**.

Topic #5—Validation of Performance Measures

Many of the measures that B&A will validate are incorporated into the focus studies mentioned above. In particular, data elements from the following reports in the MCE Reporting Manual will be validated:

- For Topic #1 on Network Adequacy
  - Report 0902: Count of Enrolled Providers (all three programs)
  - Report 0903: Member Access to Providers (all three programs)

- For Topic #2 on Lead Testing
  - Report 0508: Lead Testing (HHW and HCC only)

- For Topic #4 on Claims Adjudication and Encounter Submissions
  - Report 0101: Claims Adjudication Summary (all three programs)
  - Report 0102: Encounters Summary (all three programs)

In addition to these measures, B&A will also validate the four measures reported on Report 0403: AHRQ Prevention Quality Indicator (PQI) Measures for the HIP and HCC programs. The four measures related to inpatient discharges for diabetes, COPD, heart failure and asthma. B&A will be examining the results reported for the four experience quarters representing CY 2019. B&A will mirror the technical specifications released by the AHRQ to compute our own results and compare these to the results reported by each MCE.

There will be a webinar scheduled with each MCE to serve as a touch-point to share preliminary findings. These webinars will be scheduled on **July 28** and **29**.

Topic #6—Validation of MCE Quality Improvement Projects

The purpose for this review is to fulfill our requirement to validate the results of selected performance improvement projects, or PIPs, as they are called by CMS in its protocol. For our purposes, PIPs are synonymous with Quality Improvement Projects, or QIPs, as defined by the OMPP.

B&A will conduct a desk review of each MCE's QIPs and then conduct interviews (by webinar) with each MCE about the results reported in their annual QIP submissions. Similar to what was introduced in last year's EQR, B&A will request additional information that is not reported in the annual QIP but supports the information reported. Specifically, we will request analytic files that each MCE tabulated to assess the effectiveness of interventions. We will also track the method in which this data is collected to assess the integrity and completeness of the data used to assess each intervention.

Data that each MCE used to capture the results of what they reported in the QIP Reporting template will be submitted in an ad hoc format based on how the MCE synthesized their results. In other words, no standardized reporting template is being released for the QIP validations.

The actual QIP annual reports will be submitted to B&A simultaneous to when they are submitted to the OMPP by **August 1**. The data that was used in support of QIP findings will be submitted by each MCE to B&A by **August 7**. Webinar meetings will be held with each MCE individually **August 25 and 26** to go over the QIPs under review. This will include a walk-through of the data files used in support of each QIP report, follow-up questions from our desk review, and a discussion with the relevant staff who had primary responsibility for the interventions that were put in place for the QIPs that were selected. It is expected that the meeting with each MCE will take two hours.

C. Detailed Schedule of Meetings

The table below presents all webinars scheduled for this year's EQR. Within each day, there is a morning and an afternoon session. With four MCEs, that means that each MCE will be given one of the four slots over the two-day period. The one exception to this is Session #2 in which we would like to schedule all meetings with the NEMT brokers on one day, June 8.

We have flexibility as to which day we meet with each MCE. Therefore, in the Excel file labeled 'File to Accompany EQR Guide', in the first tab you will see an option for you to select which of the two days offered that your MCE would prefer to have the meeting on the topic. We will make every effort to accommodate specific MCE requests.

Please submit the Meeting Schedule Preferences tab in the accompanying file directly to Mark Podrazik no later than **Tuesday May 26** at mpodrazik@burnshealthpolicy.com. Specific dates/times for meetings set and the final schedule will be released to the MCEs by **Friday May 29**.

Unless specifically requested in advance, MCE staff do not need to prepare any materials for the interview sessions or the webinars in which data findings will be shared. For the webinars related to interviews, a semi-structured process will take place. The questions that the B&A team intends to ask will be sent out in advance of the meeting so that the MCE can ensure that the appropriate team members can attend the meeting.

Please note that all onsite interviews will cover all OMPP programs—HHW, HIP and HCC.

Type of Meeting	Date	Time	Topic
Webinar	June 2	9:00 – 10:30 1:00 – 2:30	Interview MCE staff about NEMT oversight
	June 3	9:00 – 10:30 1:00 – 2:30	
Webinar	June 8	10:00-11:00 11:30-12:30 2:00-3:00 3:30-4:30	Meet with each NEMT broker to discuss specifics regarding the data request
Webinar	June 23	1:00 – 2:30 3:00 – 4:30	Review initial results of network adequacy / validations with MCEs
	June 24	1:00 – 2:30 3:00 – 4:30	
Webinar	July 28	1:00 – 2:30 3:00 – 4:30	Review initial results of encounter study and AHRQ measure validation
	July 29	1:00 – 2:30 3:00 – 4:30	
Webinar	Aug 11	1:00 – 2:30 3:00 – 4:30	Review initial results of NEMT analytics
	Aug 12	1:00 – 2:30 3:00 – 4:30	
Webinar	Aug 25	9:00 – 11:00 1:00 – 2:30	Discuss annual QIP reports and supporting data
	Aug 26	9:00 – 11:00 1:00 – 2:30	

D. Information Requests Related to the EQR

The table below outlines the due dates for information to be submitted to B&A. Unless otherwise specified, all information listed below with due dates in June should be uploaded to the OMPP Sharepoint site in the following folder: Managed Care\HIP\2020\06 (June). All information listed below with due dates in August should be uploaded to the OMPP Sharepoint site in the following folder: Managed Care\HIP\2020\08 (August).

For convenience, all information submitted for this year's EQR, even if it pertains to other OMPP programs, will be uploaded to the HIP folder.

Please contact Mark Podrazik directly at 703-785-2371 or by email if you have specific questions about the report templates that accompany this EQR Guide.

Information Due for Submission Directly to Mark Podrazik via email by **May 26**:

- Meeting preference form

Information Due for Submission to Sharepoint by **June 17**:

- Claims/Encounter Submission Files
- Agreement between the MCE and its NEMT broker (the payment terms may be redacted)
- Examples of reports periodically submitted by the NEMT broker to the MCE that show evidence of MCE oversight (to be discussed further with each MCE during the interview on June 2 or 3)
- Any delegation oversight summary document related to the NEMT broker conducted in CY 2019

Information Due for Submission to Sharepoint by **June 30**:

- NEMT Trip Data from the NEMT Broker
- Claims Adjudicated by NEMT Broker
- Roster of Transportation Providers Contracted in CY 2019
- Roster of Authorized Drivers in CY 2019

Information Due for Submission Directly to Mark Podrazik via email by **August 1**:

- Annual QIP Reports

Information Due for Submission to Sharepoint by **August 7**:

- Supporting files related to each QIP regarding analytics related to measure results and interventions results

Template: MCE Claim Inventory for CY 2019 Adjudicated Claims

Submit files that show all claims that were adjudicated by your MCE during the period Jan 1, 2019 - Dec 31, 2019 regardless of date of service or date of receipt.
Our preference is to receive 4 files organized by claim type below. If file size becomes an issue, it is fine to break up a claim type into multiple files.

File 1 is UB-04/837I claims.
File 2 is CMS-1500/837P claims.
File 3 is Pharmacy claims.
File 4 is Dental claims.

If possible, please merge all programs (HHW, HCC, HIP) that you are contracted for together for each claim type.
We will know which program that each claim falls under based on the Plan Provider ID.

Submit files in either .csv or .txt format. Zip each file up to save space and upload to your Sharepoint site as instructed in the EQR Guide.

For reference, a similar request was made of the MCEs in the CY2018 EQR. You submitted files to B&A on April 23, 2018.
The format shown below only slightly differs from the previous file layout.
B&A shows an indicator if each variable requested also appears on ESSR reports sent back to you by Optum.

on ESSR	on ESSR	on ESSR	not on ESSR	not on ESSR	on ESSR	on ESSR	on ESSR	not on ESSR	on ESSR	not on ESSR	on ESSR	not on ESSR
Plan Provider ID	ICN	MCE Claim ID	Member Medicaid ID (RID)	Billing Provider IHCP ID	Billing Provider NPI	Billing Provider Taxonomy Code	Header From Date of Service	Header To Date of Service	Claim Iteration	Date Claim Received by the MCE	Date Claim Adjudicated by the MCE	Date Claim Submitted as an Encounter)

Plan Provider ID	Insert your MCE ID that is used when reporting information on 837s. Set the field as character, 10 byte.
ICN	The claim ID assigned by DXC when submitted as an encounter. If the claim has not been submitted as an encounter,
	or if the claim has never appeared on an ESSR report, then leave this field blank.
MCE Claim ID	Insert the claim number that you assigned to the claim in your internal system and reported on the 837s.
	On the ESSR Reports that you receive, the variable is called Other Payer ICN.
Member Medicaid ID (RID)	The ID assigned by OMPP to the member. Set the field as character, 12 byte format.
Billing Provider IHCP ID	The ID assigned by OMPP to the provider (not an MCE-specific provider ID). Set the field as character, 15 byte format.
Billing Provider NPI	Set the field as character, 15 byte format.
Billing Provider Taxonomy Code	Set the field as character, 10 byte format.
Header From Date of Service	Use YYYY-MM-DD format
Header To Date of Service	Use YYYY-MM-DD format
Claim Iteration	Enter the frequency code on the encounter (1- original, 7-replacement, 8-void)
Date Claim Received by the MCE	Use YYYY-MM-DD format
Date Claim Adjudicated by the MCE	Use YYYY-MM-DD format
Date Claim Submitted as an Encounter	Use YYYY-MM-DD format. Please enter the date *originally submitted* , even if the claim has been resubmitted. If the claim has never been submitted, please leave this field blank.

Template: NEMT Trip Report

Submit files that show all trips requested by members to your NEMT broker during the period Jan 1, 2019 - Dec 31, 2019. Use the trip appointment date as the anchor date.
Submit files in either .csv or .txt format. Zip each file up to save space and upload to your Sharepoint site as instructed in the EQR Guide.
Our preference is to receive 1 file. If file size becomes an issue, it is fine to break up the trips into multiple files.

Please share this template with your NEMT broker. In preparation for our meeting with you and your broker on June 8, we ask that your broker provides an index of the valid values that they retain for each variable shown below. The field descriptions below only show examples of the type of response we are requesting in each field.

Provider Name	Provider IHCP ID	Booking Mode	Member Medicaid ID (RID)	Member Last Name	OMPP Program	Trip Leg ID	Trip Leg	Mobility Type	Pickup Date	Pickup Time	Drop Off Time	Pickup Facility Name

Provider Name	The name of the transportation provider who is assigned the trip request.
Provider IHCP ID	The ID assigned by OMPP to the provider. Set the field as character, 12 byte format. Do not use an internal provider ID.
Booking Mode	The interest here is to distinguish one-time (on demand) trip requests from routine periodic (subscription) trips (e.g. dialysis treatment).
Member Medicaid ID (RID)	The ID assigned by OMPP to the member. Set the field as character, 12 byte format. Do not use an internal client ID.
Member Last Name	Enter the Medicaid member's last name. If the member's first and last name are stored in the same field in your system, that is permissible.
OMPP Program	Enter one of the following: HHW, HIP or HCC.
Trip Leg ID	The internal ID created to distinguish this one-way trip request.
Trip Leg	Enter the sequence within the full trip request that this specific trip represents. For example, if it is a round-trip request, use A and B or 1 and 2.
Mobility Type	Enter your broker-specific indicator. Examples may include: standard van, wheelchair van, ambulance, taxi.
Pickup Date	Enter the scheduled date of the pickup.
Pickup Time	Enter the scheduled time of the pickup.
Drop Off Time	Enter the scheduled time of the drop off.
Pickup Facility Name	Enter the name of the location of the pickup. This could be "home" for the member's home or a facility/provider office name.
Pickup Facility Type	Enter the type of facility. Examples could be "home", "hospital", "dialysis center", "provider office".
Pickup Street	Enter the street address of the pickup.
Pickup City	Enter the city of the pickup.
Pickup County	Enter the county of the pickup.
Drop Off Facility Name	Enter the name of the location of the Drop Off. This could be "home" for the member's home or a facility/provider office name.
Drop Off Facility Type	Enter the type of facility. Examples could be "home", "hospital", "dialysis center", "provider office".
Drop Off Street	Enter the street address of the Drop Off.
Drop Off City	Enter the city of the Drop Off.
Drop Off County	Enter the county of the Drop Off.
Miles	Enter the expected miles used to fulfill this trip.
Trip Leg Status	Enter the internal status given to this trip. Examples could be "scheduled" (not fulfilled), "fulfilled", "cancelled".
Cancel Reason	If the trip status is cancelled, indicate the cancel reason.

Pickup Facility Type	Pickup Street	Pickup City	Pickup County	Drop Off Facility Name	Drop Off Facility Type	Drop Off Street	Drop Off City	Drop Off County	Miles	Trip Leg Status	Cancel Reason

Template: NEMT Claim Adjudication Report

Submit files that show all claims adjudicated during the period Jan 1, 2019 - Dec 31, 2019. Use the claim adjudication date as the anchor date.
Submit files in either .csv or .txt format. Zip each file up to save space and upload to your Sharepoint site as instructed in the EQR Guide.
Our preference is to receive 1 file. If file size becomes an issue, it is fine to break up the trips into multiple files.

Please share this template with your NEMT broker. In preparation for our meeting with you and your broker on June 8, we ask that your broker provides an index of the valid values that they retain for each variable shown below. The field descriptions below only show examples of the type of response we are requesting in each field.

Internal Claim Number	Provider Name	Provider IHCP ID	Member Medicaid ID (RID)	Claim Source	Trip Leg ID	Date of Service	Date Claim Received	Date Claim Adjudicted	Adjudication Status	Paid Amount

Internal Claim Number	The internal claim number used by the broker to identify the claim received.
Provider Name	The name of the transportation provider who is assigned the trip request.
Provider IHCP ID	The ID assigned by OMPP to the provider. Set the field as character, 12 byte format. Do not use an internal provider ID.
Member Medicaid ID (RID)	The ID assigned by OMPP to the member. Set the field as character, 12 byte format. Do not use an internal client ID.
Claim Source	Enter the source of how the claim was received. Examples include Electronic or Paper (or E, P).
Trip Leg ID	The internal ID created to distinguish this one-way trip request. This should tie to the IDs reported on the Trip Report.
Date of Service	The date that the trip was delivered.
Date Claim Received	Use YYYY-MM-DD format
Date Claim Adjudicated	Use YYYY-MM-DD format
Adjudication Status	Enter the status of claim after adjudication. Examples include Paid or Denied (or P, D).
Paid Amount	If the claim was paid, enter the Paid Amount.

Template: NEMT Provider Report

Submit 1 file that shows all providers that were contracted with the NEMT broker at some time during the period Jan 1, 2019 - Dec 31, 2019.
Submit this file in Excel format. Upload the file to your Sharepoint site as instructed in the EQR Guide.

Please share this template with your NEMT broker.
In preparation for our meeting with you and your broker on June 8, we ask that your broker provides an index of the valid values that they retain for each variable shown below. The field descriptions below only show examples of the type of response we are requesting in each field.

Internal Provider ID	Provider Name	Provider IHCP ID	Start Date	Termination Date	Provider Type	Vehicle Number	Vehicle Type	VIN

Internal Provider ID	The internal Provider ID used by the broker to track this provider.
Provider Name	The name of the transportation provider.
Provider IHCP ID	The ID assigned by OMPP to the provider.
Start Date	Enter the date that the Provider started contracting with the broker. This date may be prior to CY 2019.
Termination Date	Enter the date that the Provider terminated contracting with the broker. If still active, then leave this field blank.
Provider Type	Enter an indicator such as "Contracted", "Non-Contracted", "EMS" or "Public Transportation".
Vehicle Number	Enter the unique ID assigned by the broker for each vehicle that is contracted for use in the fleet for this provider.
Vehicle Type	Enter the type of vehicle. Examples may include "ALS", "BLS", "Wheelchair Van", "Ambulatory Van", "Taxi".
VIN	Enter the Vehicle Identification Number as registered with the Department of Motor Vehicles.

Template: NEMT Driver Report

Submit 1 file that shows all drivers authorized with providers under contract with the NEMT broker at some time during the period Jan 1, 2019 - Dec 31, 2019.
Submit this file in Excel format. Upload the file to your Sharepoint site as instructed in the EQR Guide.

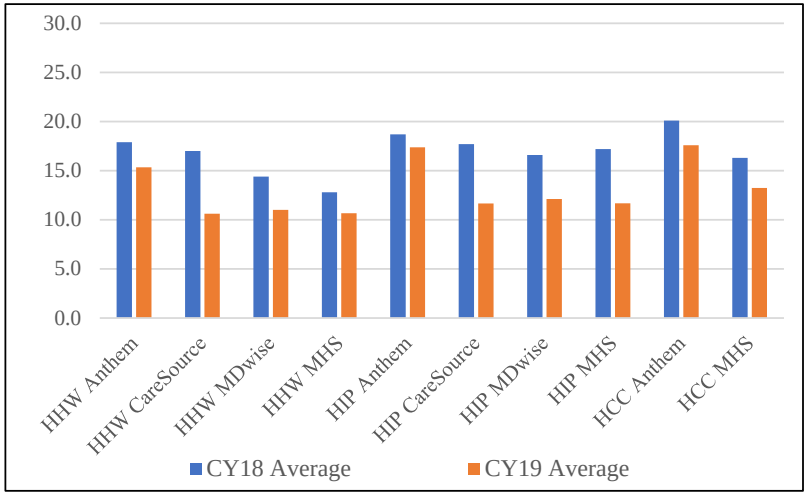
Please share this template with your NEMT broker.
In preparation for our meeting with you and your broker on June 8, we ask that your broker provides an index of the valid values that they retain for each variable shown below. The field descriptions below only show examples of the type of response we are requesting in each field.

Internal Provider ID	Provider Name	Provider IHCP ID	Driver Number	Driver Last Name	Start Date	Termination Date

Internal Provider ID	The internal Provider ID used by the broker to track this provider.
Provider Name	The name of the transportation provider.
Provider IHCP ID	The ID assigned by OMPP to the provider.
Driver Number	Enter the unique ID assigned by the broker for each driver that is contracted under this provider.
Driver Last Name	Enter the last name of the driver.
Start Date	Enter the date that the driver was authorized to start driving with the broker. This date may be prior to CY 2019.
Termination Date	Enter the date that the driver terminated with the broker. If still active, then leave this field blank.

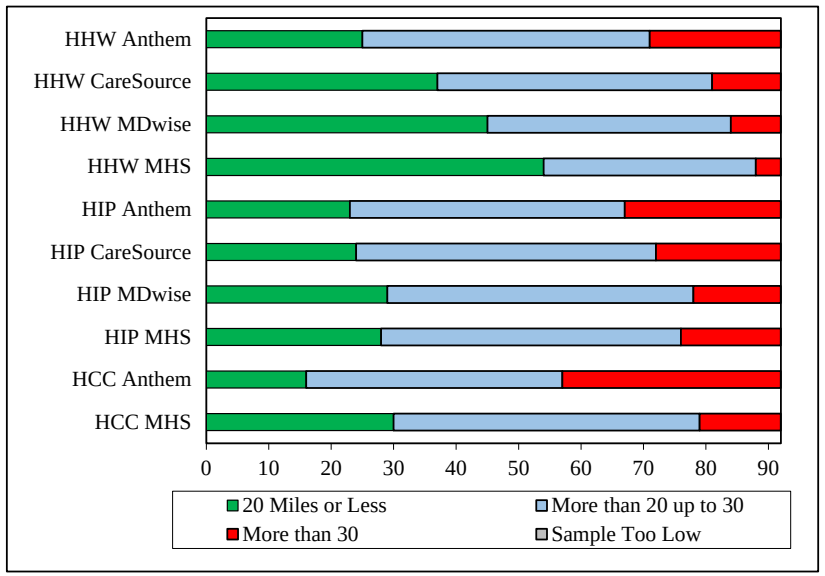
Appendix C:
Dashboard Reports Comparing Average Distance Travelled by Members for Five High-Volume Services, CY 2018 and CY 2019

Appendix C.1
Primary Care Unique Member Provider Trips
Average Driving Distance for Members, CY2018 and CY 2019, by MCE/Program

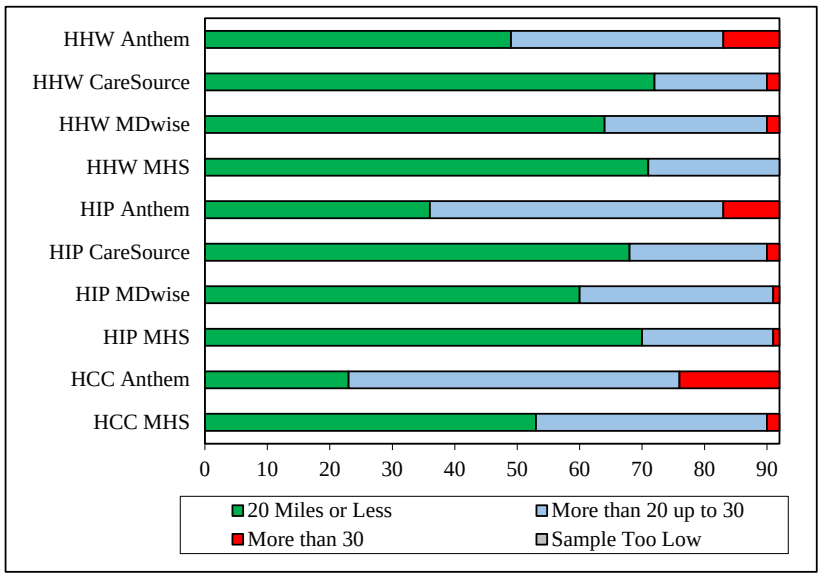


CY 2019 Update on CY 2018 Key Findings Across All MCEs				
Problem Counties CY 2018	Region	Better	Same	Worse
LaGrange	NE	X		
Wabash	NE	X		
Jasper	NW	X		
Newton	NW	X		
Crawford	SE	X		
Washington	SE	X		
Lawrence	SW	X		
Orange	SW	X		
Benton	WC	X		
Fountain	WC	X		
Warren	WC	X		

CY 2018 Colored Bars Plot # Counties (out of 92) in Each Distance Range



CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



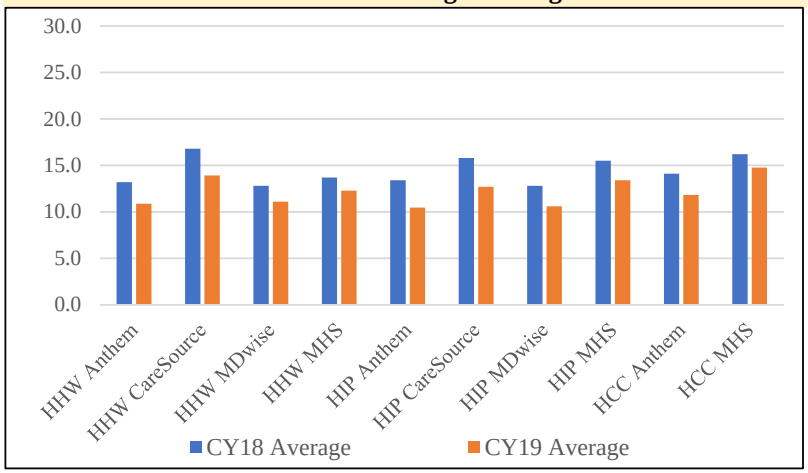
Unique Trips Analyzed in the CY 2019 Study

HHW Anthem	271,838
HHW CareSource	61,488
HHW MDwise	230,879
HHW MHS	174,553

HIP Anthem	285,393
HIP CareSource	46,188
HIP MDwise	153,201
HIP MHS	104,692

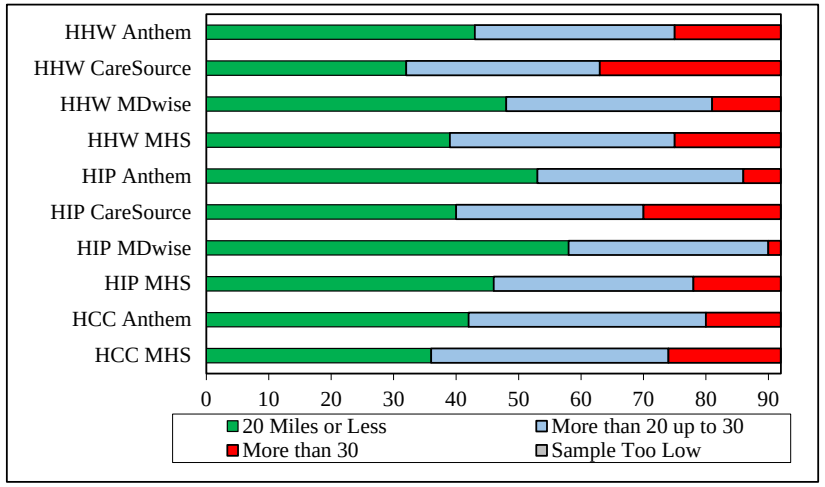
HCC Anthem	95,890
HCC MHS	50,368

Appendix C.2
Dental Unique Member Provider Trips
Average Driving Distance for Members, CY2018 and CY 2019, by MCE/Program

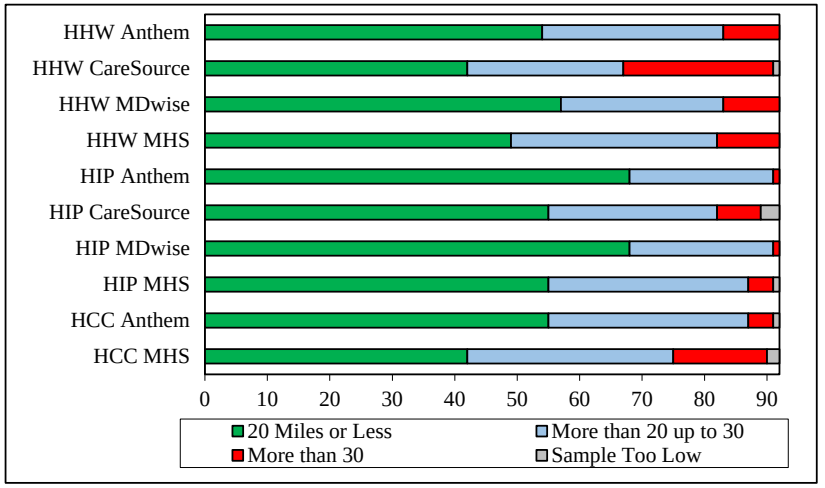


CY 2019 Update on CY 2018 Key Findings Across All MCEs				
Problem Counties CY 2018	Region	Better	Same	Worse
Union	EC		X	
Pulaski	NC		X	
Starke	NC	X		
Newton	NW		X	
Franklin	SE	X		
Jefferson	SE	X		
Ripley	SE		X	
Scott	SE	X		
Switzerland	SE		X	
Greene	SW	X		
Fountain	WC		X	
White	WC		X	

CY 2018 Colored Bars Plot # Counties (out of 92) in Each Distance Range



CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



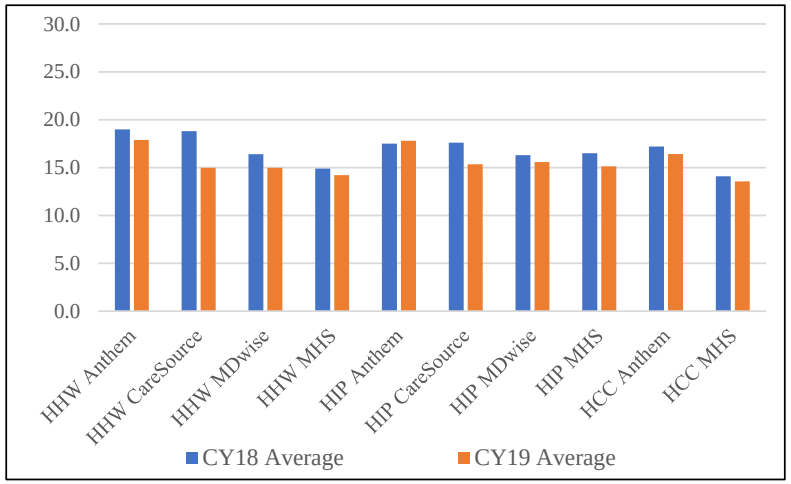
Unique Trips Analyzed in the CY 2019 Study

HHW Anthem	119,937
HHW CareSource	20,214
HHW MDwise	122,632
HHW MHS	71,740

HIP Anthem	69,210
HIP CareSource	9,151
HIP MDwise	43,355
HIP MHS	23,235

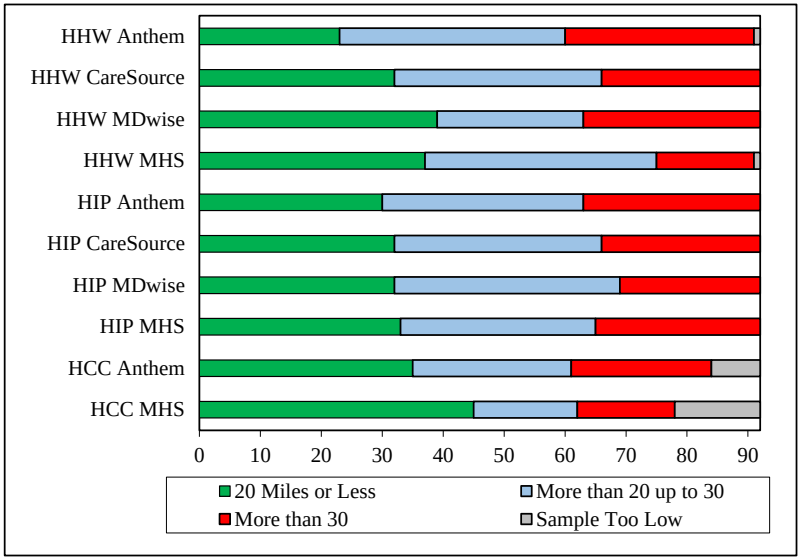
HCC Anthem	21,834
HCC MHS	12,126

Appendix C.3
OBGYN Unique Member Provider Trips
Average Driving Distance for Members, CY2018 and CY 2019, by MCE/Program

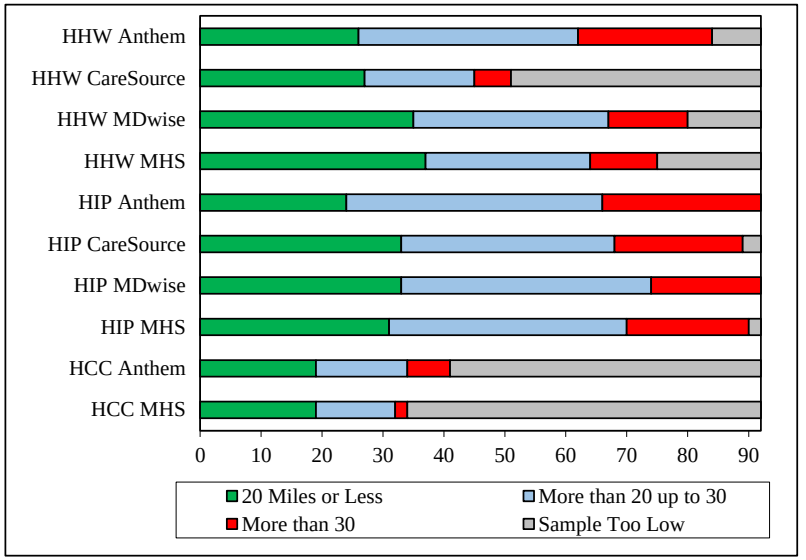


CY 2019 Update on CY 2018 Key Findings Across All MCEs				
Problem Counties CY 2018	Region	Better	Same	Worse
Howard	EC	X		
Kosciusko	NE		X	
LaGrange	NE		X	
Wabash	NE		X	
Jasper	NW		X	
Newton	NW		X	
Crawford	SE			X
Washington	SE		X	
Lawrence	SW	X		
Benton	WC	X		
Fountain	WC		X	
White	WC	X		

CY 2018 Colored Bars Plot # Counties (out of 92) in Each Distance Range



CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



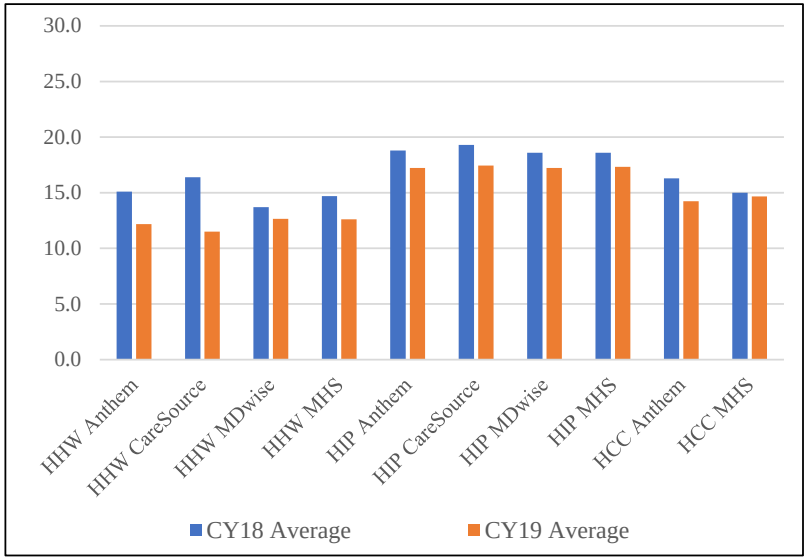
Unique Trips Analyzed in the CY 2019 Study

HHW Anthem	10,047
HHW CareSource	2,138
HHW MDwise	7,086
HHW MHS	6,293

HIP Anthem	52,134
HIP CareSource	11,151
HIP MDwise	34,884
HIP MHS	25,420

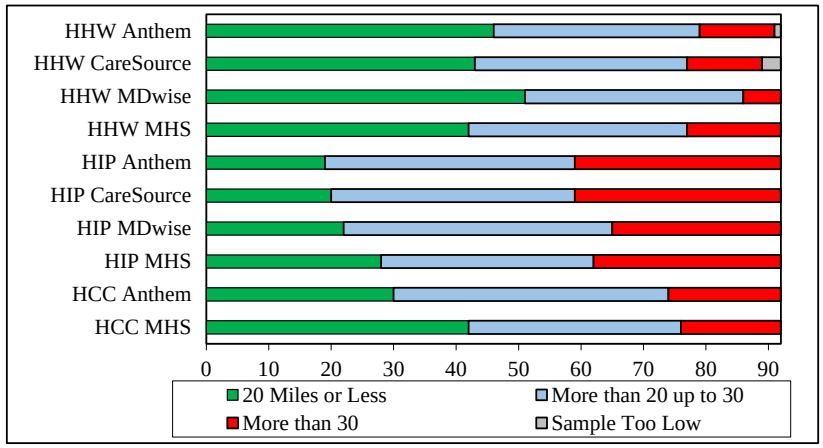
HCC Anthem	2,485
HCC MHS	1,744

Appendix C.4
BH SUD Unique Member Provider Trips
Average Driving Distance for Members, CY2018 and CY 2019, by MCE/Program

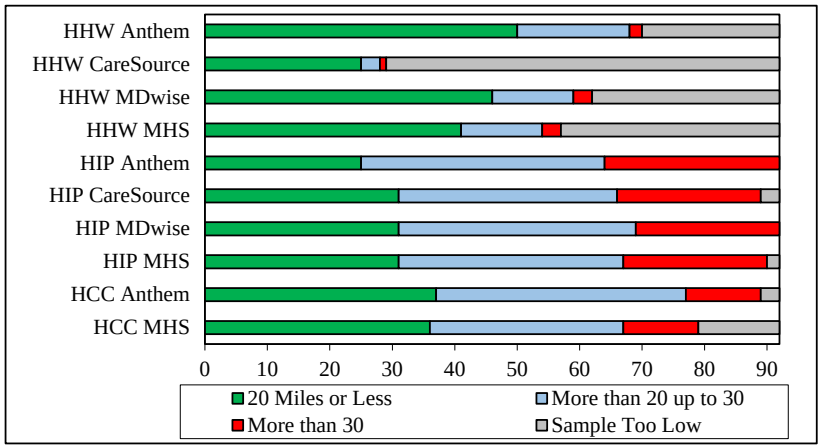


CY 2019 Update on CY 2018 Key Findings Across All MCEs				
Problem Counties CY 2018	Region	Better	Same	Worse
Rush	C		X	
Pulaski	NC		X	
LaGrange	NE			X
Steuben	NE		X	
Wabash	NE	X		
Jasper	NW	X		
Newton	NW	X		
Crawford	SE		X	
Decatur	SE		X	
Jefferson	SE			X
Jennings	SE			X
Ripley	SE	X		
Switzerland	SE		X	
Greene	SW	X		
Martin	SW	X		
Benton	WC			X
Fountain	WC			X

CY 2018 Colored Bars Plot # Counties (out of 92) in Each Distance Range



CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



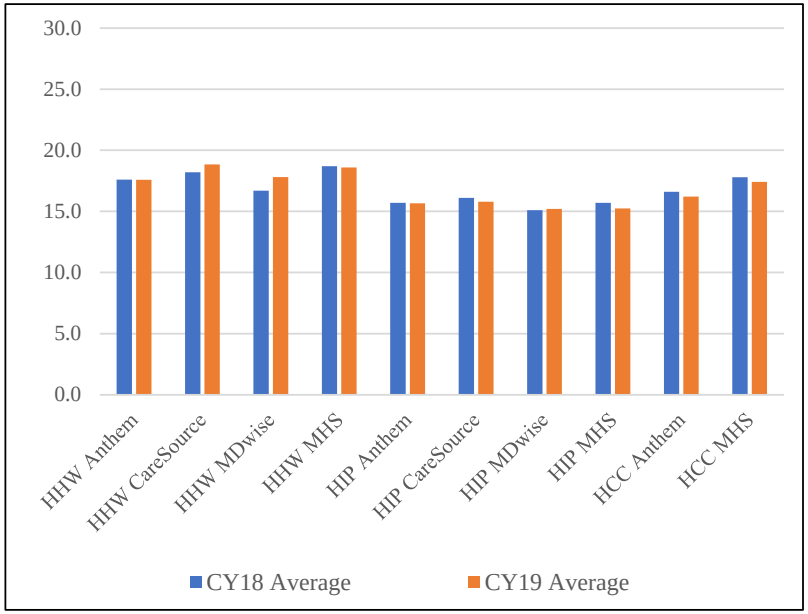
Unique Trips Analyzed in the CY 2019 Study

HHW Anthem	4,545
HHW CareSource	804
HHW MDwise	3,583
HHW MHS	2,749

HIP Anthem	52,862
HIP CareSource	10,196
HIP MDwise	26,258
HIP MHS	18,142

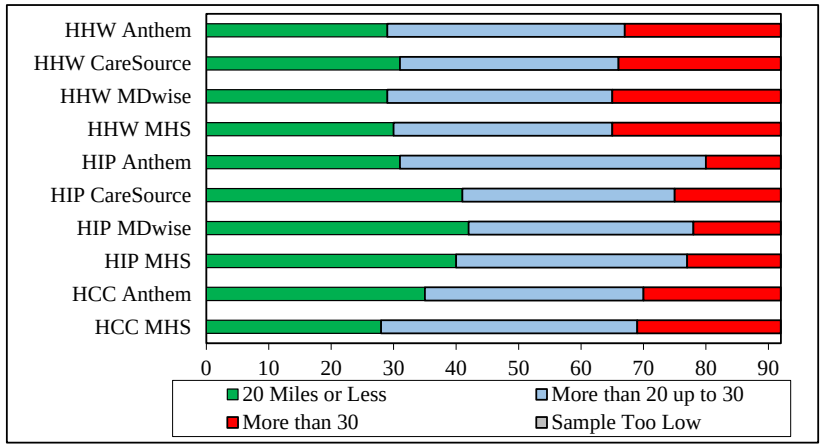
HCC Anthem	13,959
HCC MHS	7,111

Appendix C.5
BH SED/SMI Unique Member Provider Trips
Average Driving Distance for Members, CY2018 and CY 2019, by MCE/Program

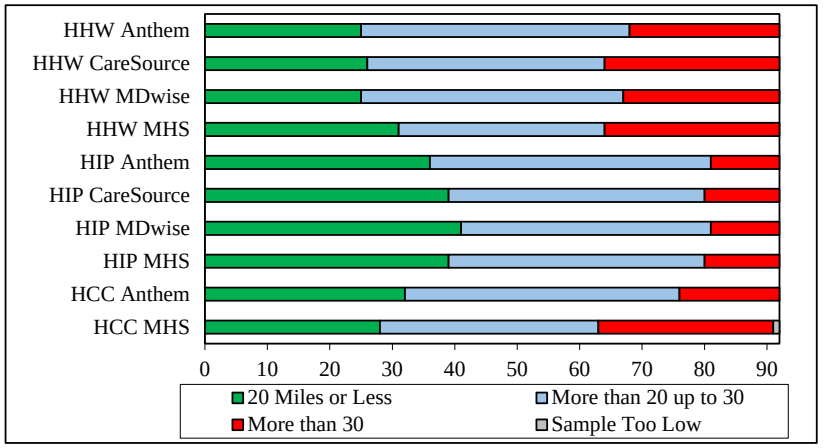


CY 2019 Update on CY 2018 Key Findings Across All MCEs				
Problem Counties CY 2018	Region	Better	Same	Worse
Rush	C		X	
Pulaski	NC		X	
LaGrange	NE		X	
Steuben	NE		X	
Wabash	NE	X		
Jasper	NW		X	
Newton	NW			X
Crawford	SE	X		
Decatur	SE			X
Jackson	SE		X	
Jefferson	SE			X
Jennings	SE		X	
Ripley	SE	X		
Scott	SE	X		
Switzerland	SE		X	
Greene	SW			X
Martin	SW			X
Benton	WC		X	
Fountain	WC			X

CY 2018 Colored Bars Plot # Counties (out of 92) in Each Distance Range



CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Unique Trips Analyzed in the CY 2019 Study

HHW Anthem	56,843
HHW CareSource	12,745
HHW MDwise	54,544
HHW MHS	36,342

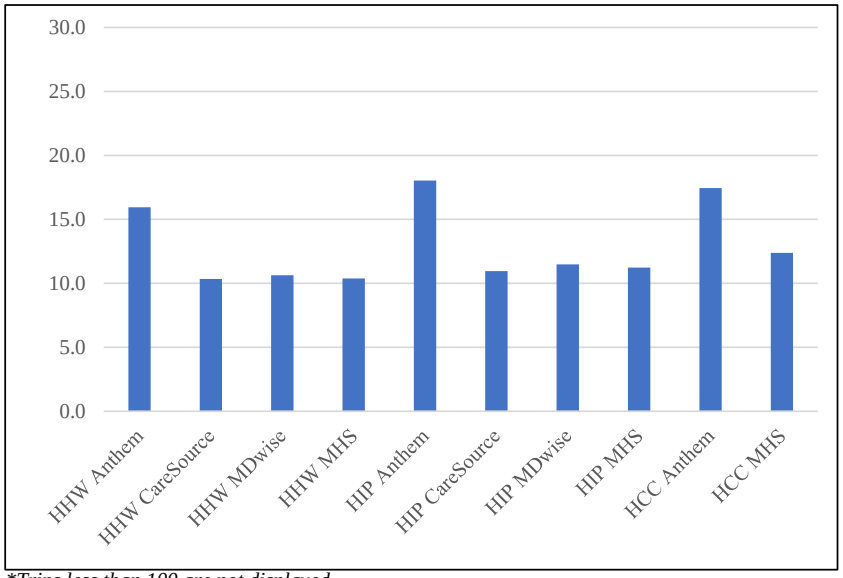
HIP Anthem	129,063
HIP CareSource	24,033
HIP MDwise	69,307
HIP MHS	45,909

HCC Anthem	56,182
HCC MHS	31,750

Appendix D:
Dashboard Reports Showing Average Distance Travelled by Members in CY 2019 for Each Provider Category Shown in OMPP Report 0903

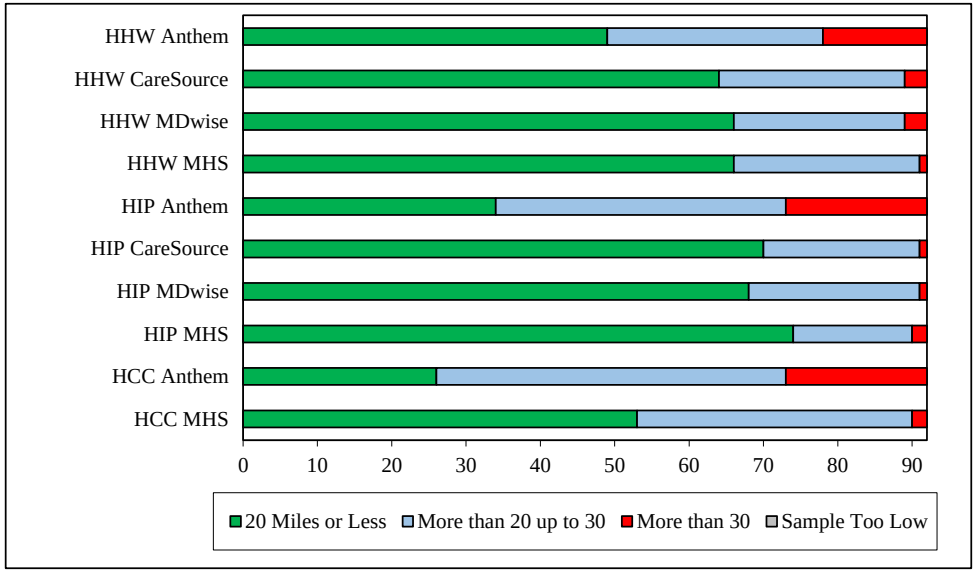
Appendix D.1
PMPs Physician Unique Member Provider Trips - with Place of Service and Rendering Provider Filters
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

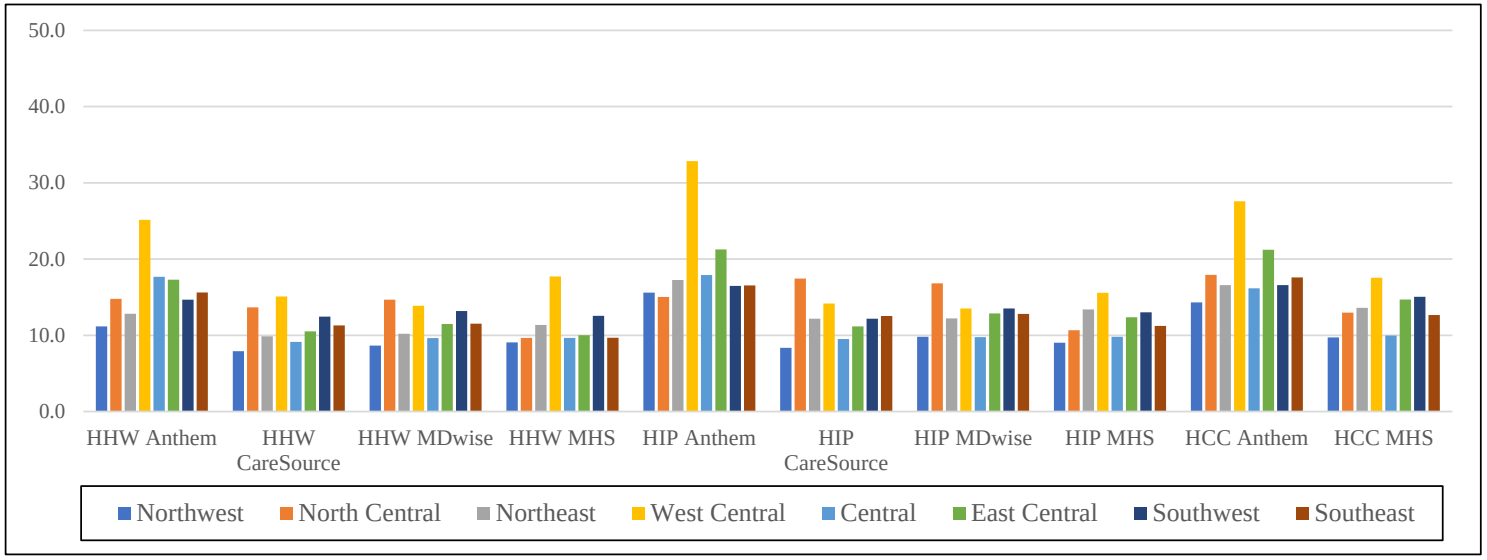


Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

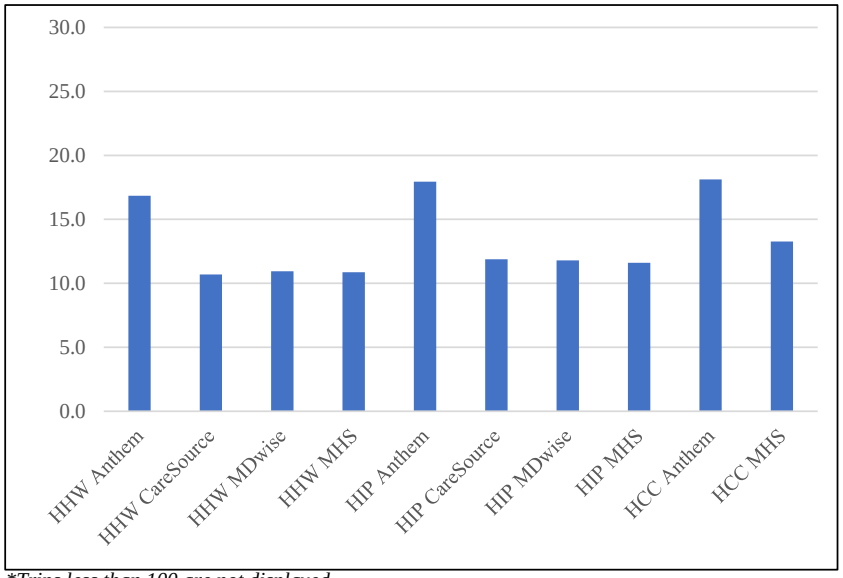


Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	205,700
HHW CareSource	46,853
HHW MDwise	172,816
HHW MHS	142,986
HIP Anthem	181,619
HIP CareSource	28,374
HIP MDwise	94,476
HIP MHS	67,540
HCC Anthem	66,868
HCC MHS	35,942

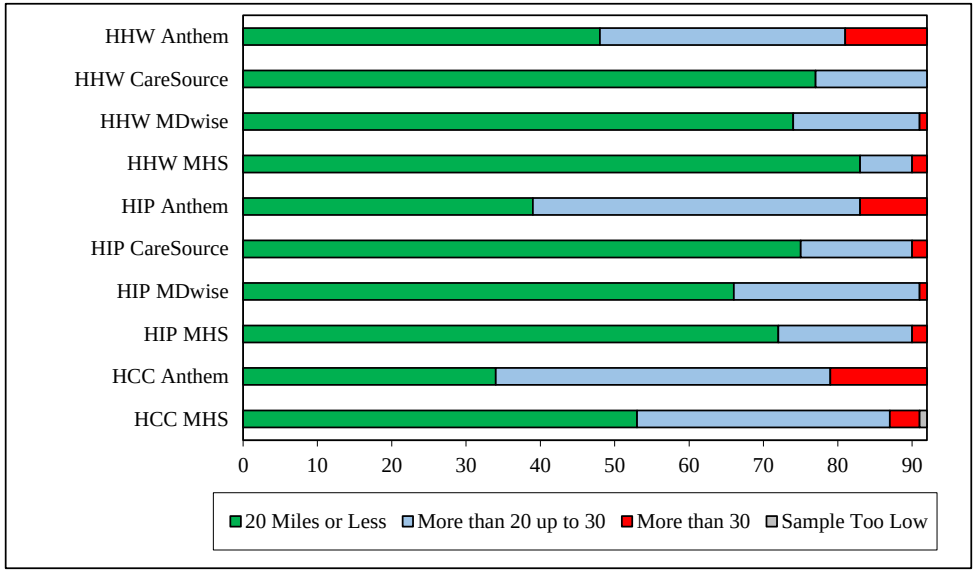
Appendix D.2
PMPs APRN Unique Member Provider Trips - with Place of Service and Rendering Provider Filters
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

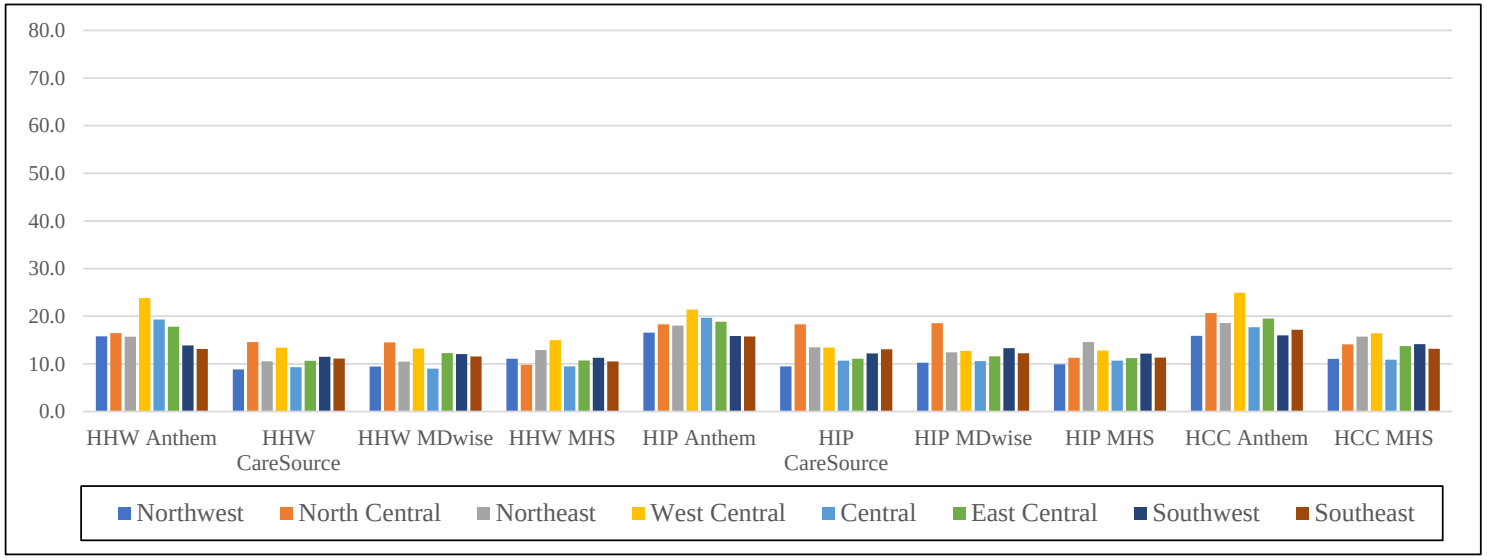


Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

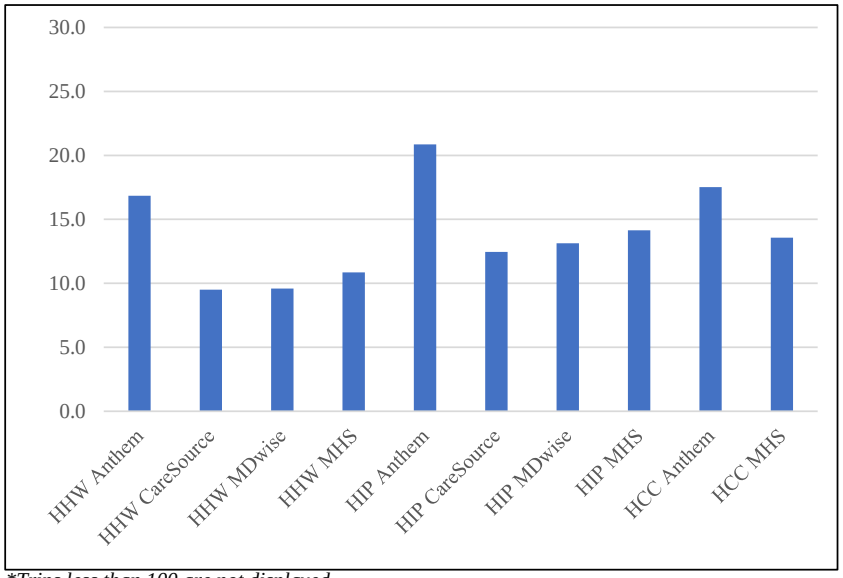


Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	73,516
HHW CareSource	23,027
HHW MDwise	82,428
HHW MHS	64,919
HIP Anthem	103,736
HIP CareSource	22,768
HIP MDwise	68,154
HIP MHS	51,558
HCC Anthem	31,319
HCC MHS	21,808

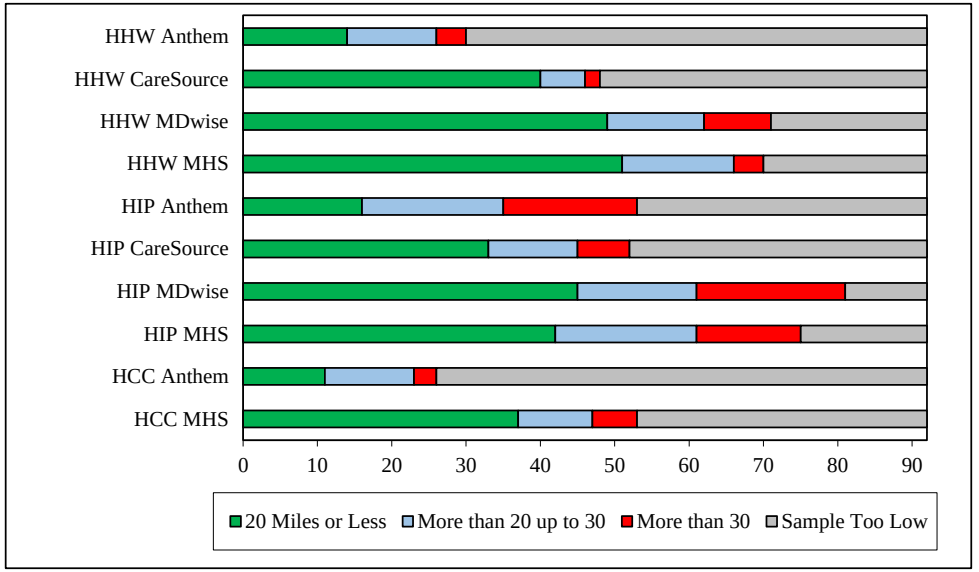
Appendix D.3
PMPs Physician Assistants Unique Member Provider Trips - with Place of Service and Rendering Provider Filters
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

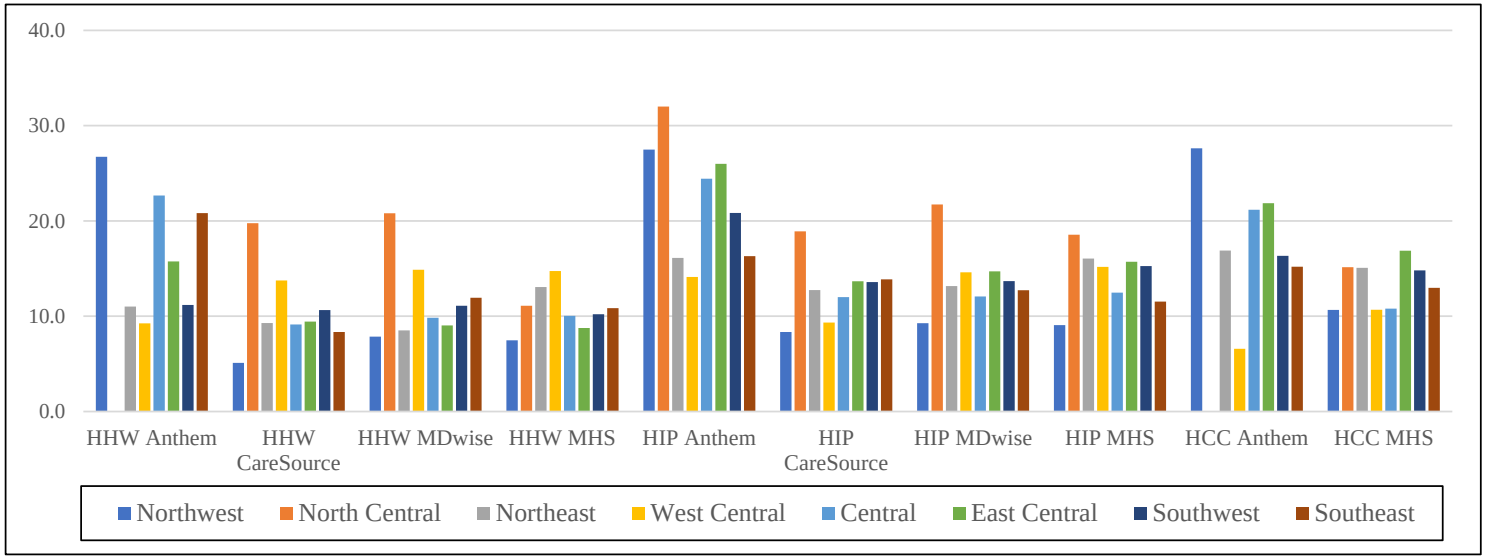


Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

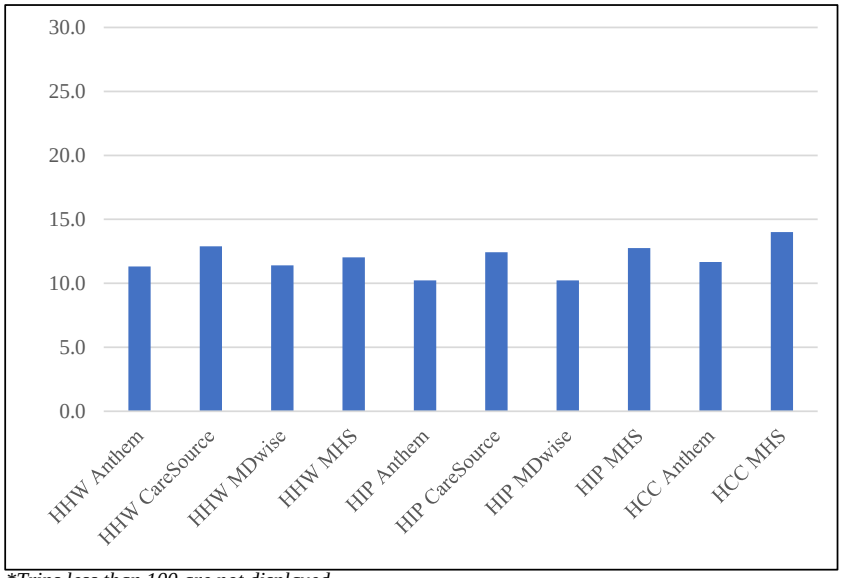


Trips less than 10 at region level are not displayed

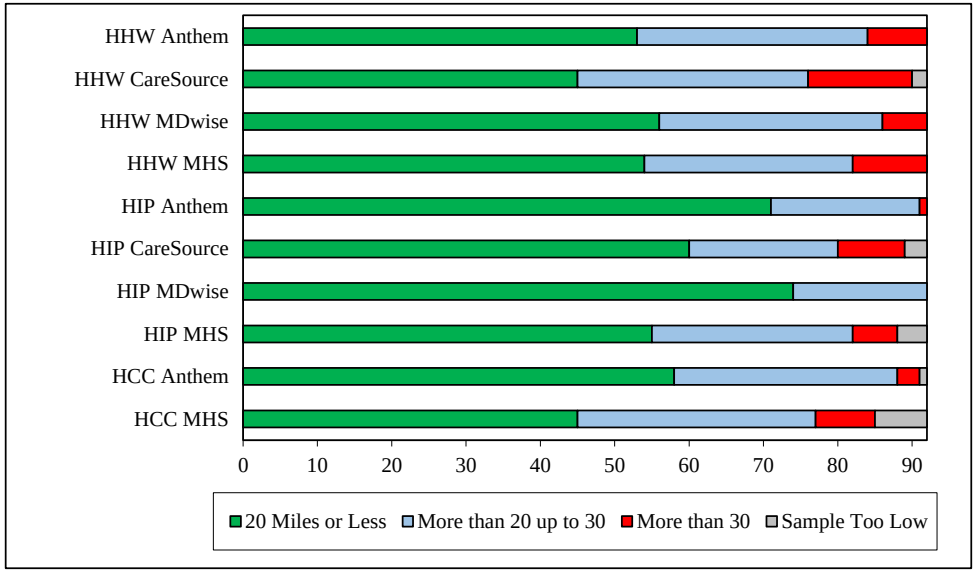
Unique Trips in Study	
HHW Anthem	3,298
HHW CareSource	2,367
HHW MDwise	9,713
HHW MHS	7,407
HIP Anthem	4,282
HIP CareSource	2,728
HIP MDwise	9,396
HIP MHS	6,630
HCC Anthem	1,154
HCC MHS	2,929

Appendix D.4
General Dentistry Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

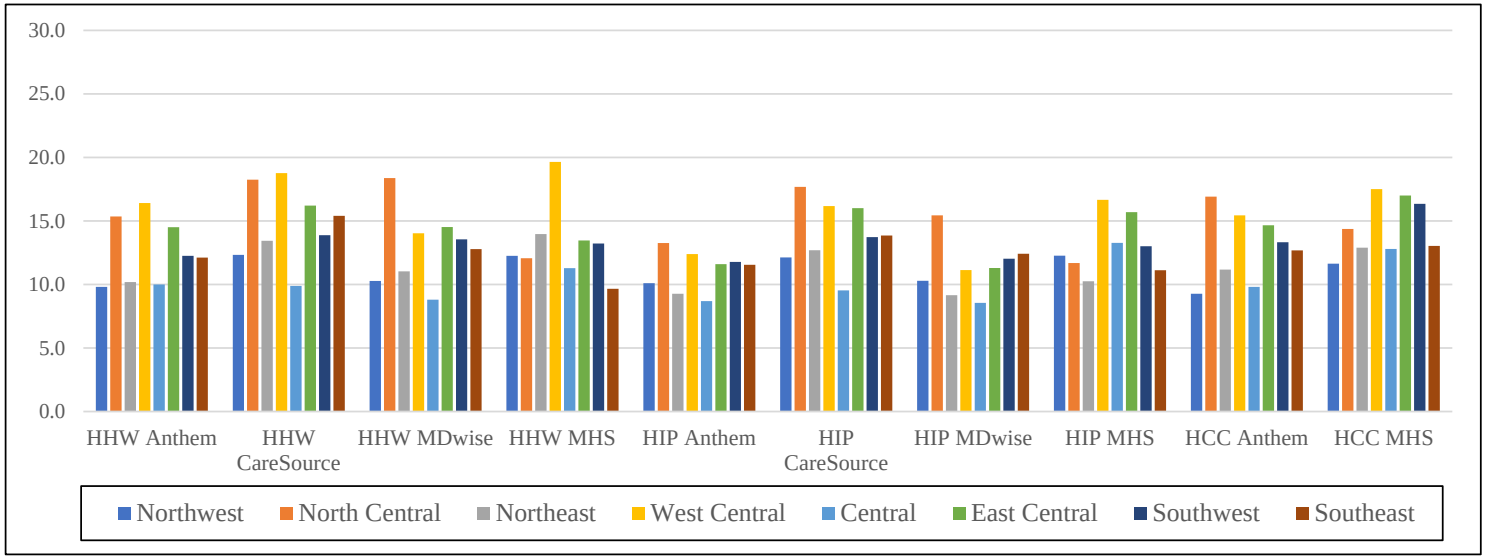


CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



**Trips less than 100 are not displayed*

Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

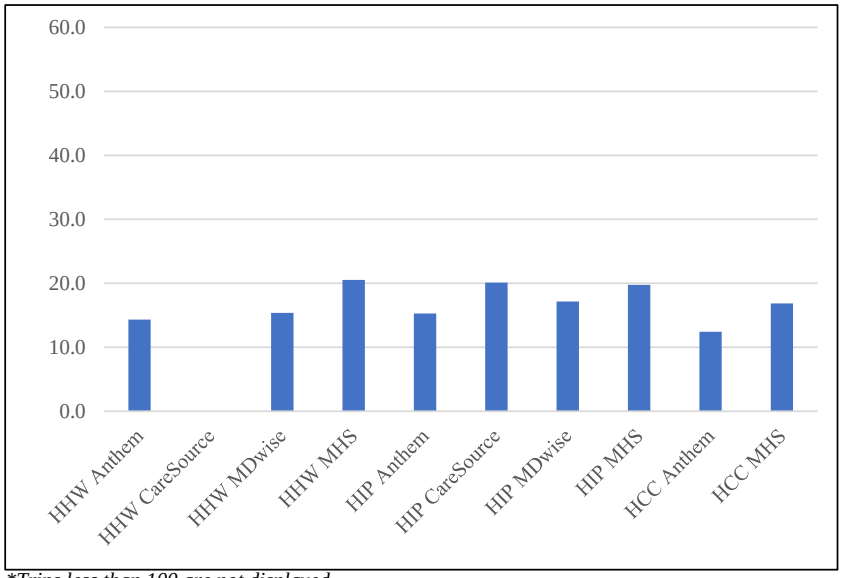


**Trips less than 10 at region level are not displayed*

Unique Trips in Study	
HHW Anthem	95,023
HHW CareSource	13,092
HHW MDwise	96,878
HHW MHS	62,777
HIP Anthem	54,263
HIP CareSource	13,711
HIP MDwise	34,039
HIP MHS	18,592
HCC Anthem	16,959
HCC MHS	9,793

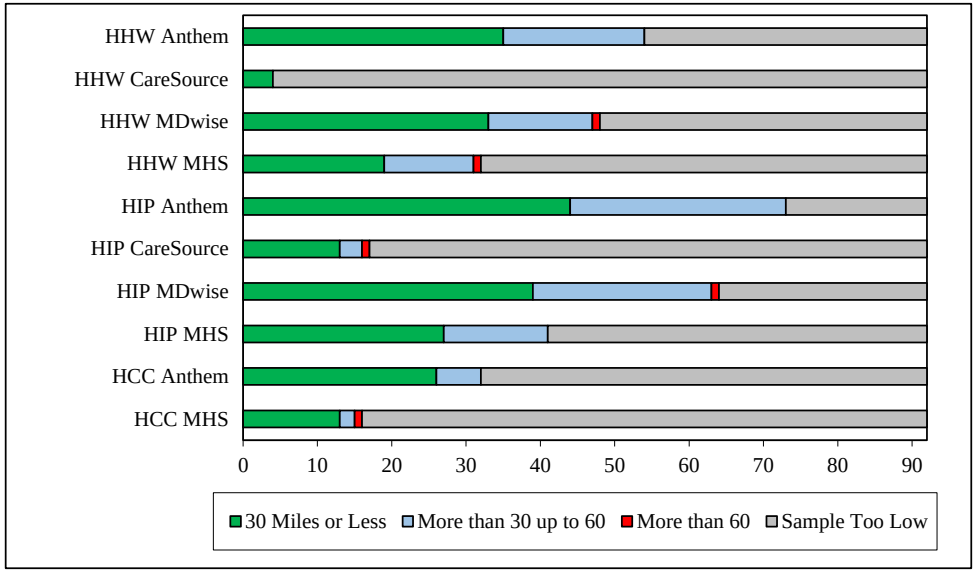
Appendix D.5
Dentists/Oral Surgeons Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

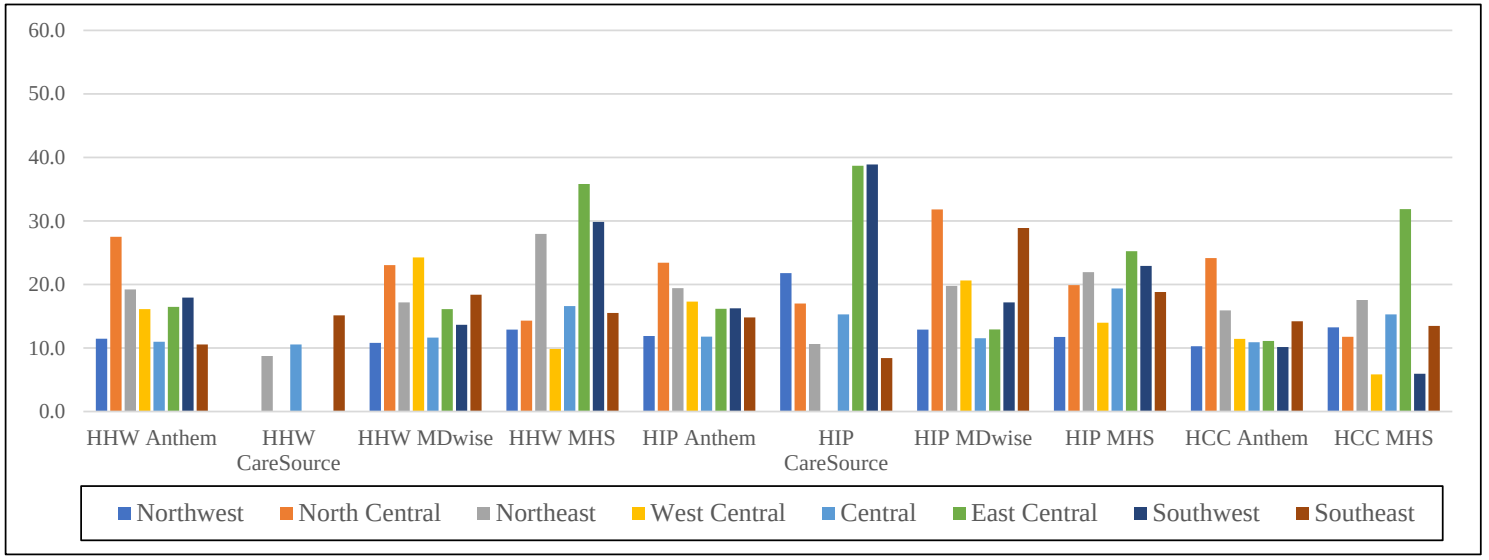


Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

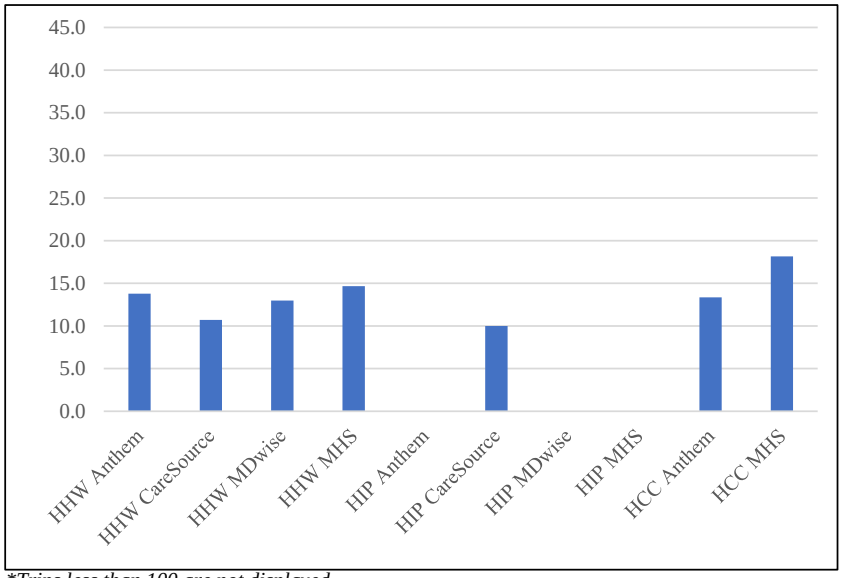


Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	2,442
HHW CareSource	96
HHW MDwise	2,354
HHW MHS	1,310
HIP Anthem	4,403
HIP CareSource	378
HIP MDwise	2,675
HIP MHS	1,233
HCC Anthem	1,017
HCC MHS	425

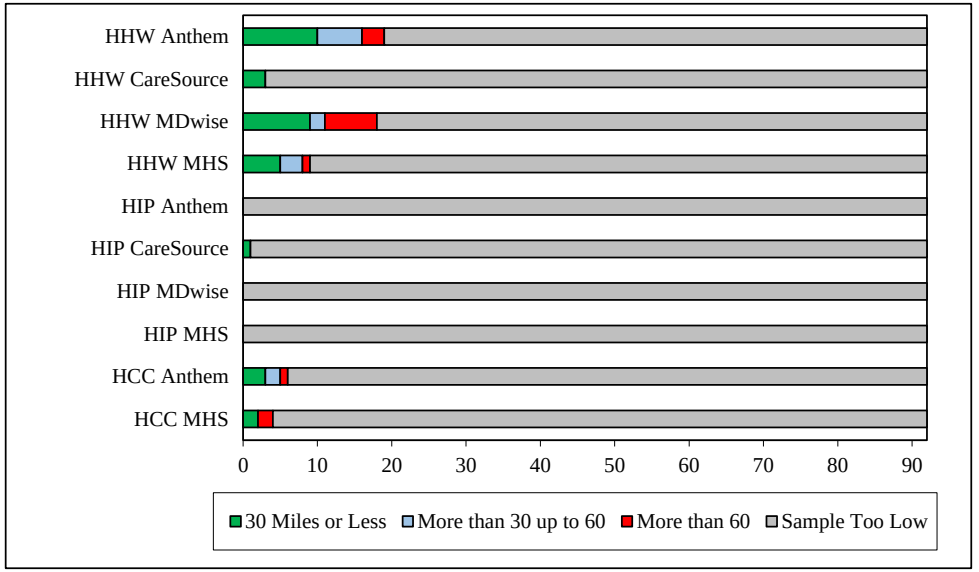
Appendix D.6
Orthodontists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

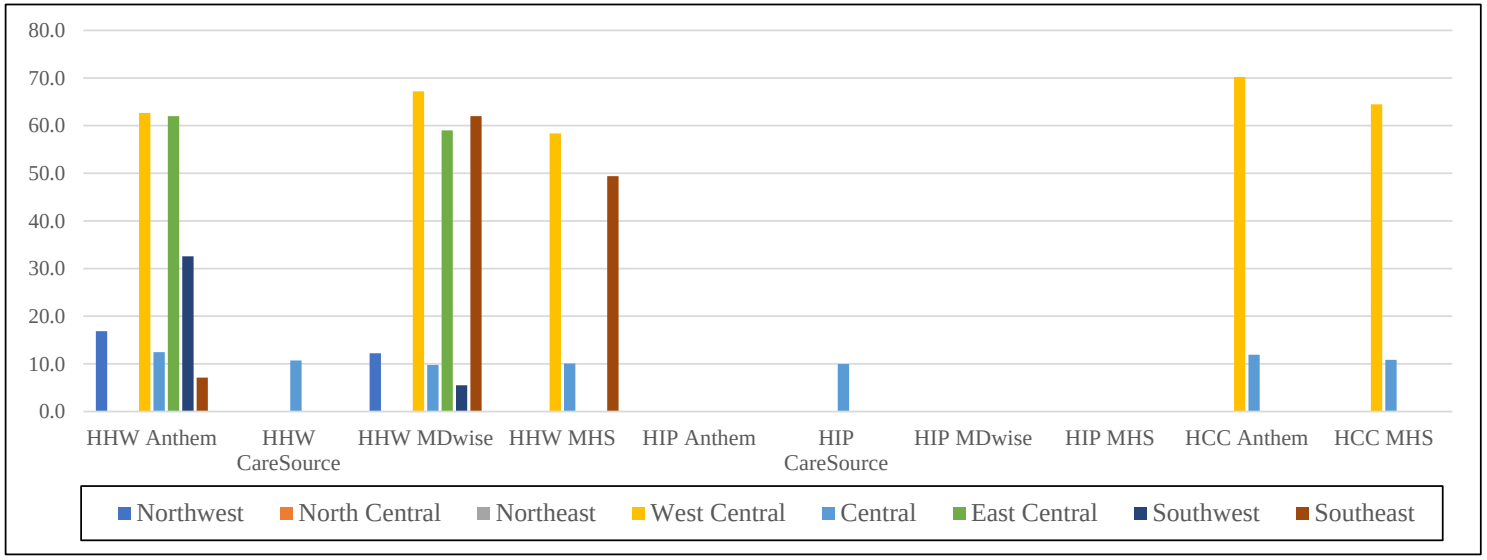


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

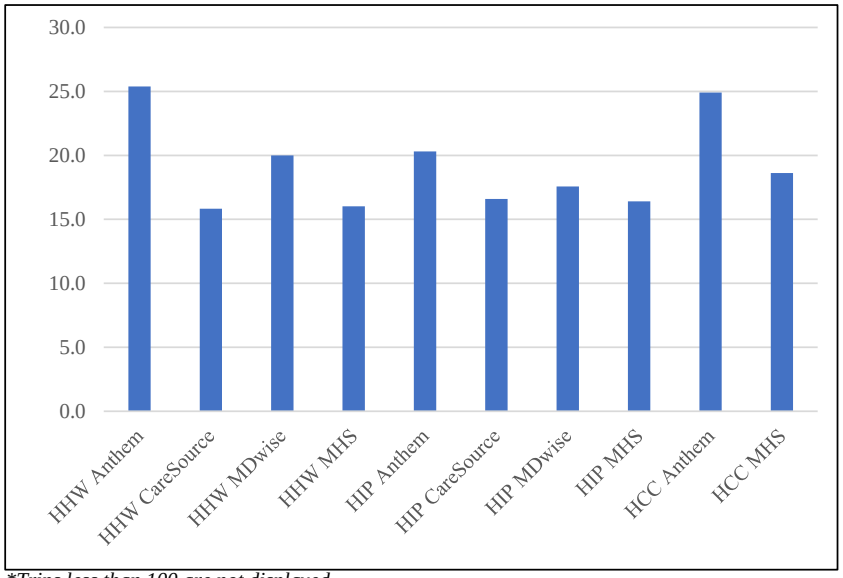


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	2,523
HHW CareSource	360
HHW MDwise	3,422
HHW MHS	961
HIP Anthem	20
HIP CareSource	167
HIP MDwise	8
HIP MHS	1
HCC Anthem	524
HCC MHS	351

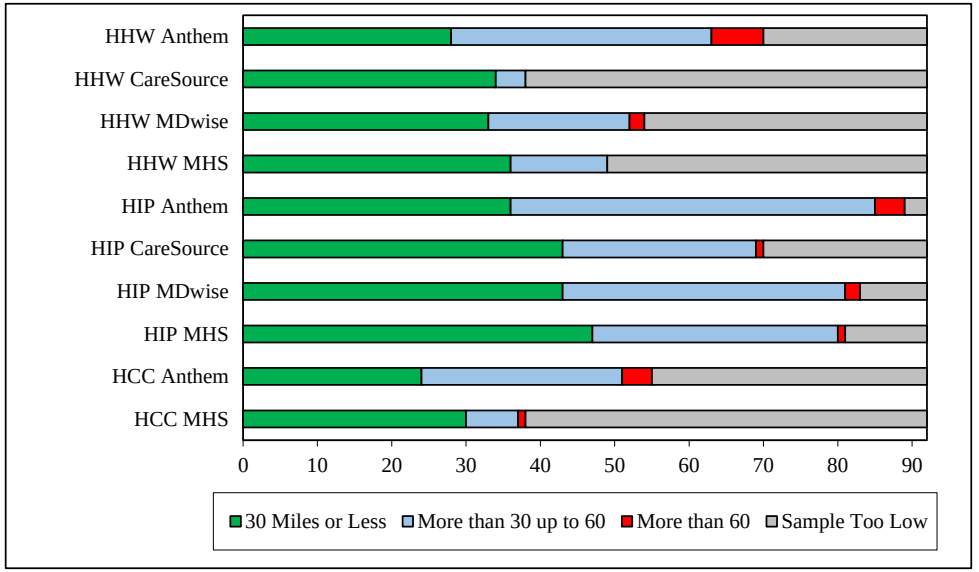
Appendix D.7
OB/GYN Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

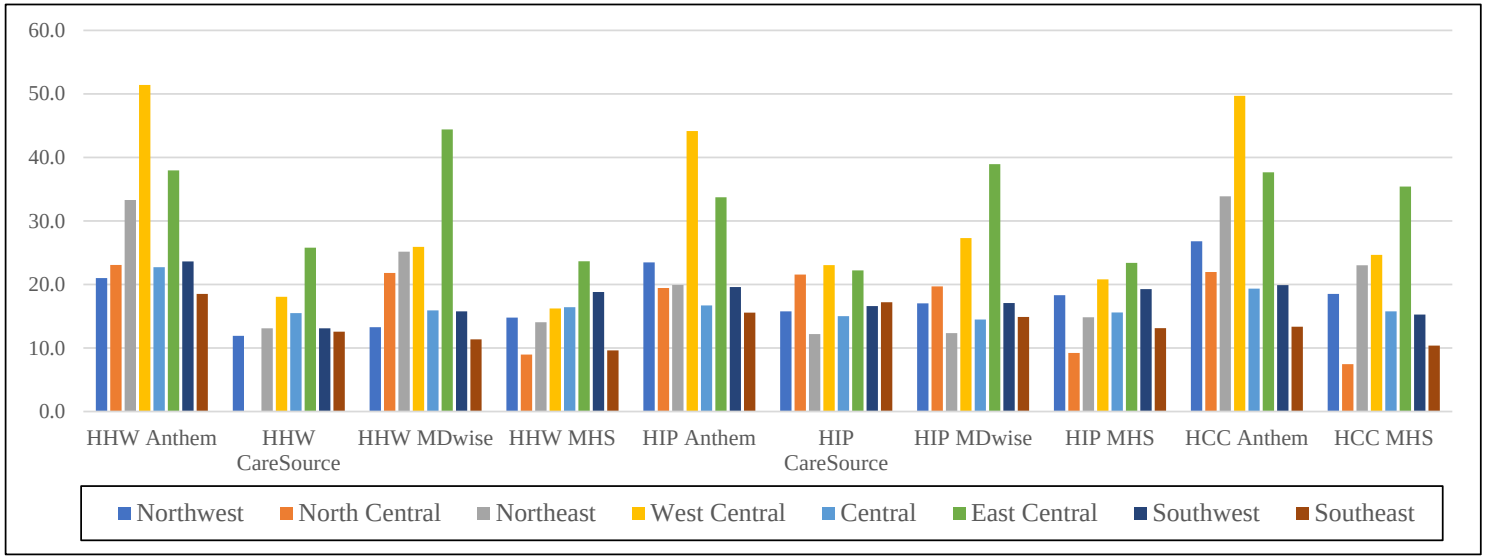


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

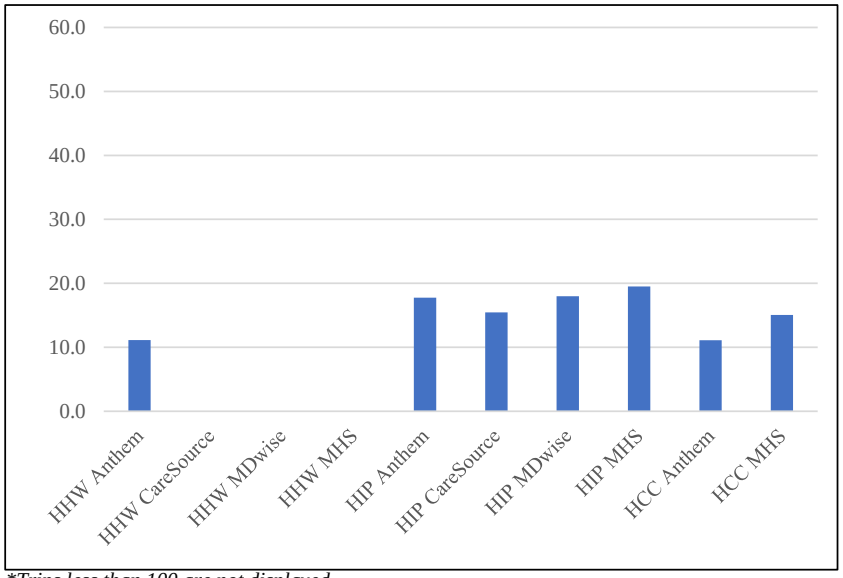


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	10,724
HHW CareSource	2,047
HHW MDwise	7,564
HHW MHS	4,576
HIP Anthem	31,339
HIP CareSource	6,694
HIP MDwise	16,759
HIP MHS	15,206
HCC Anthem	5,053
HCC MHS	2,740

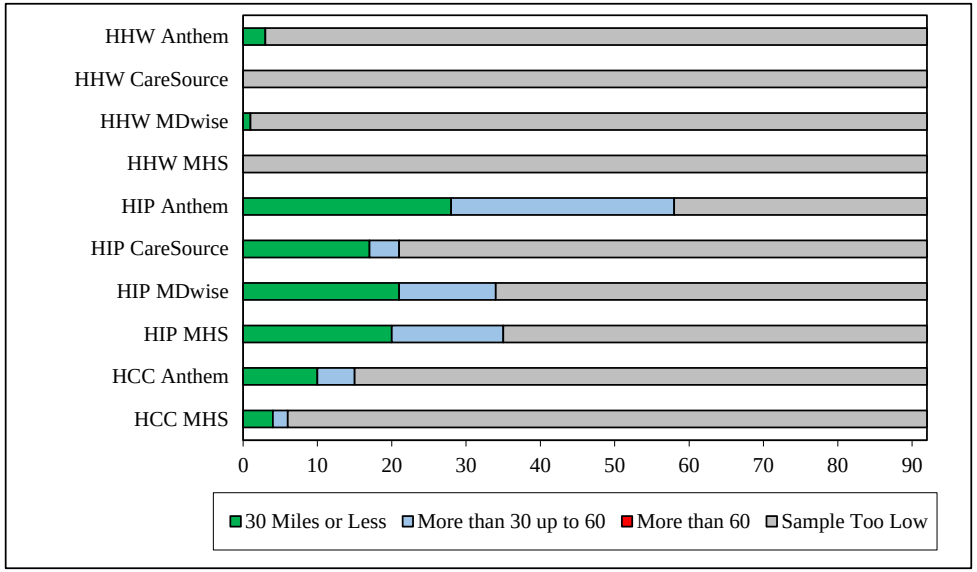
Appendix D.8
Addiction Services Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

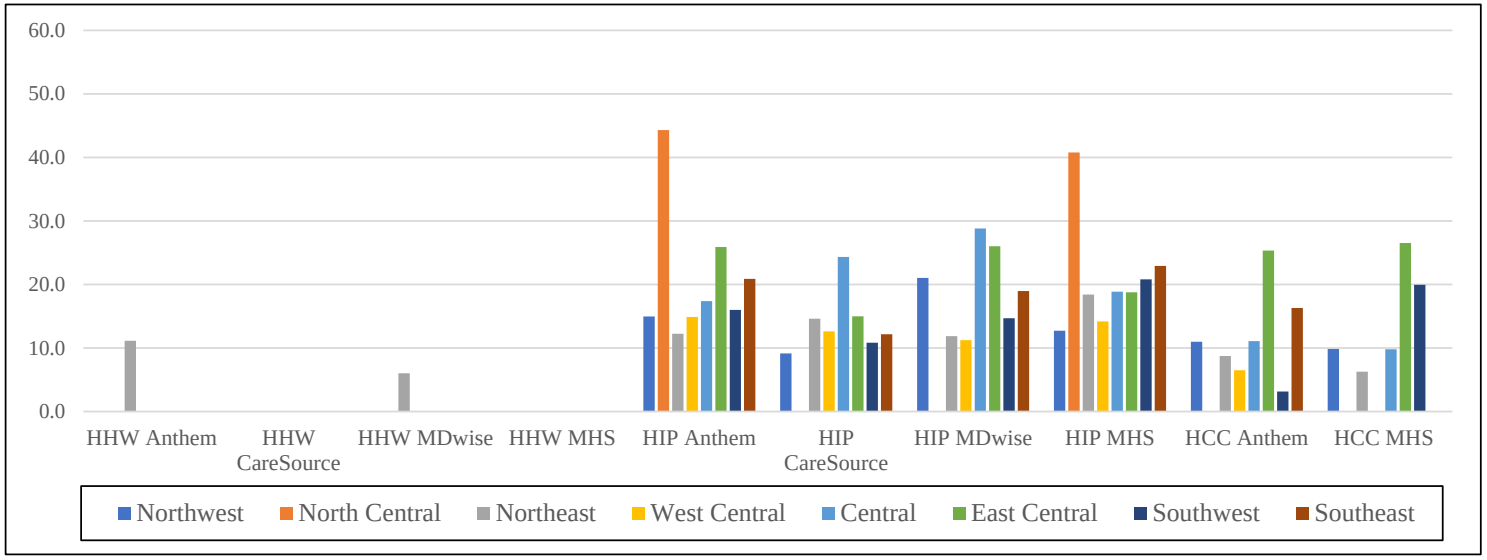


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

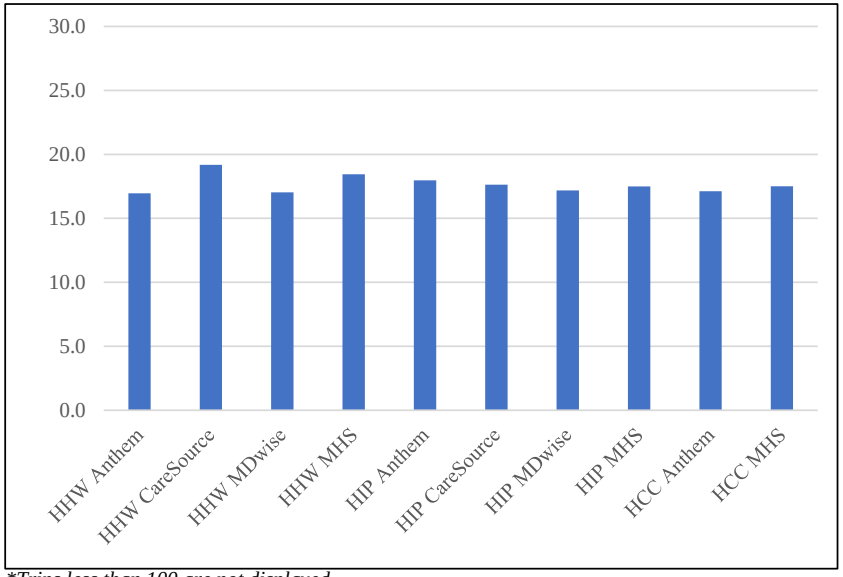


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	222
HHW CareSource	0
HHW MDwise	36
HHW MHS	0
HIP Anthem	4,702
HIP CareSource	527
HIP MDwise	2,023
HIP MHS	1,305
HCC Anthem	776
HCC MHS	185

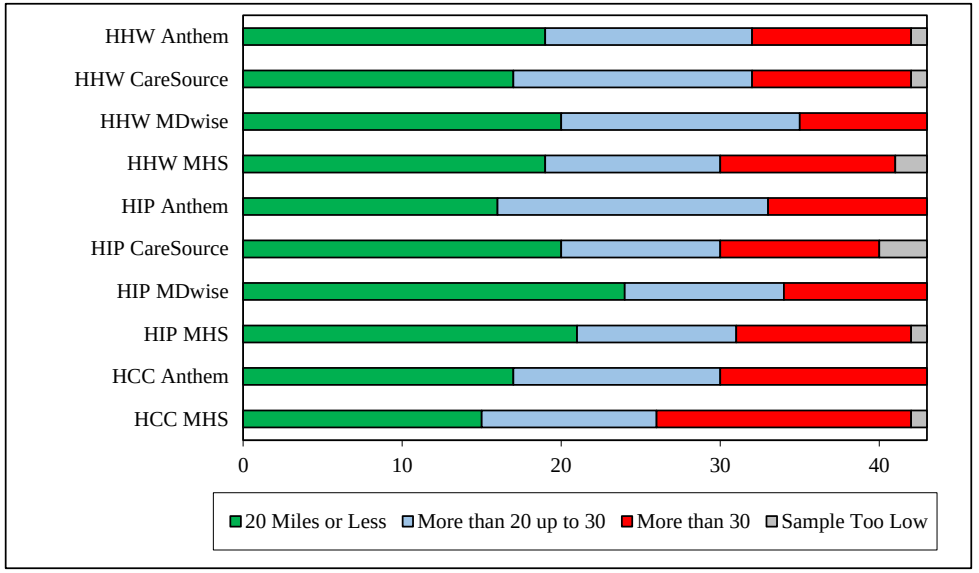
Appendix D.9
Behavioral Health Providers Unique Member Provider Trips - URBAN
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

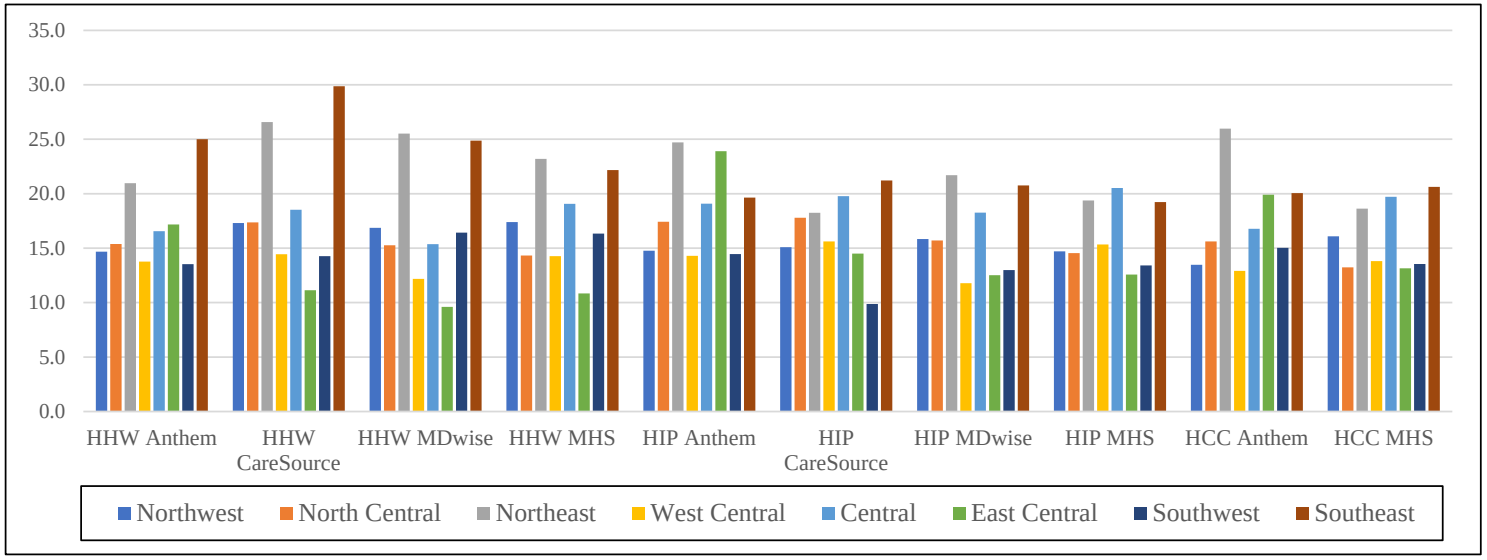


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 43 Urban) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

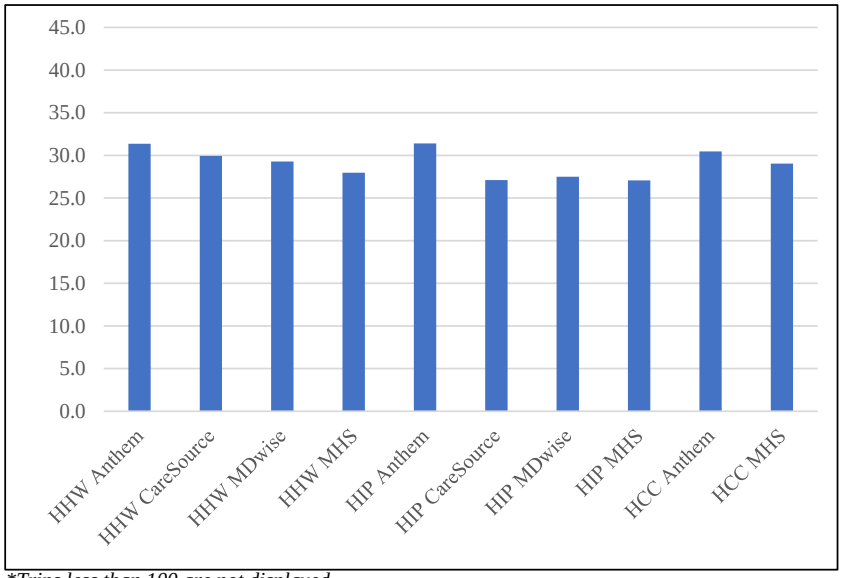


*Trips less than 10 at region level are not displayed

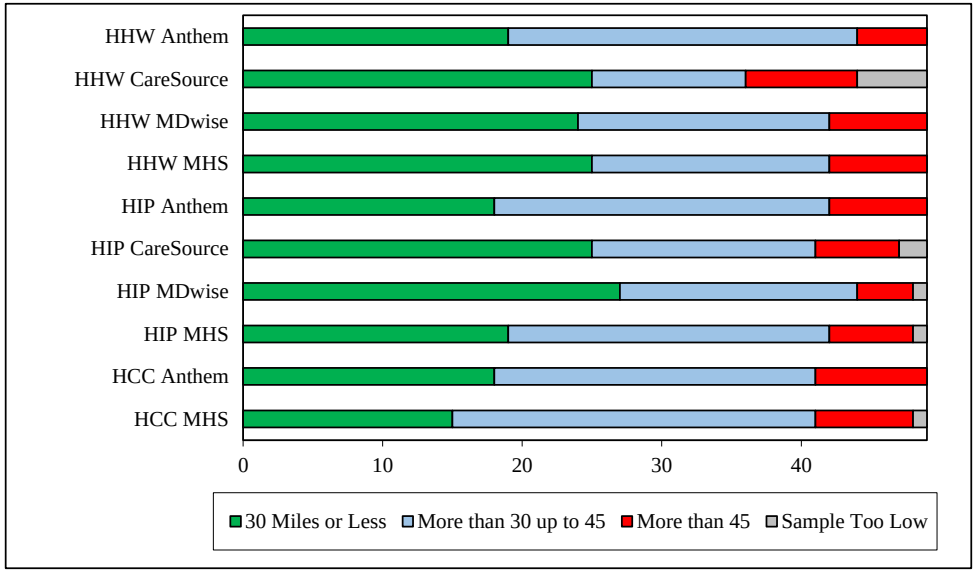
Unique Trips in Study	
HHW Anthem	27,685
HHW CareSource	5,241
HHW MDwise	24,642
HHW MHS	17,293
HIP Anthem	35,220
HIP CareSource	6,196
HIP MDwise	17,504
HIP MHS	12,366
HCC Anthem	20,475
HCC MHS	12,544

Appendix D.10
Behavioral Health Providers Unique Member Provider Trips - RURAL
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

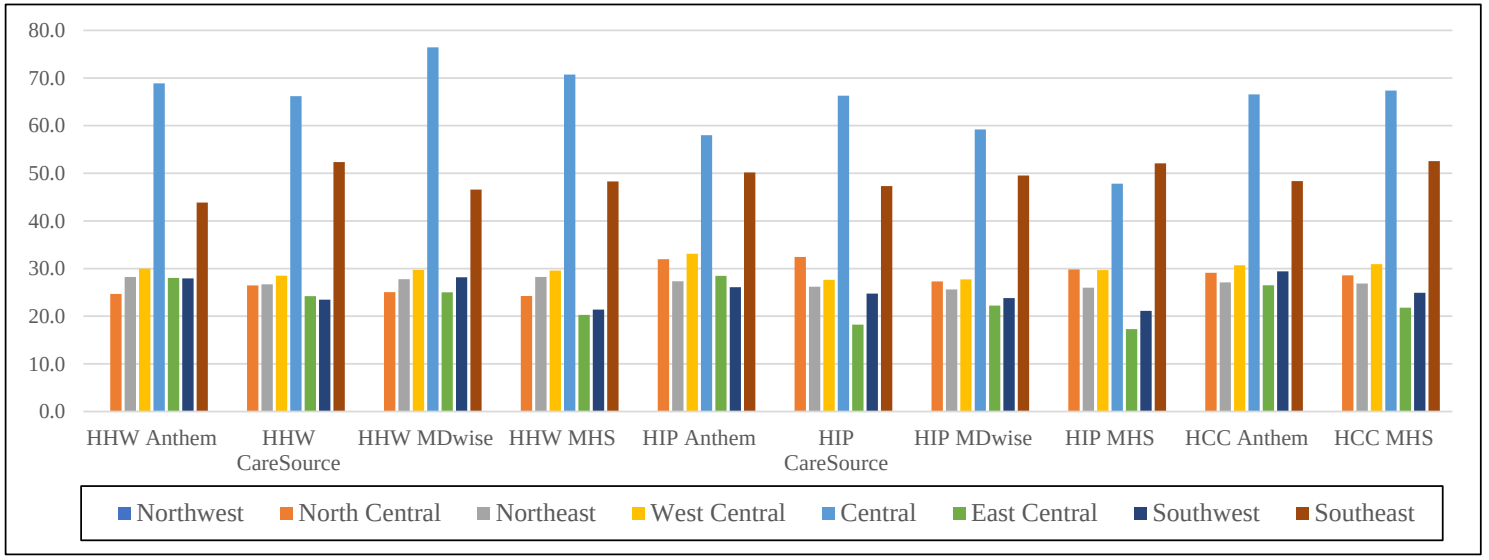


CY 2019 Colored Bars Plot # Counties (out of 49 Rural) in Each Distance Range



**Trips less than 100 are not displayed*

Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

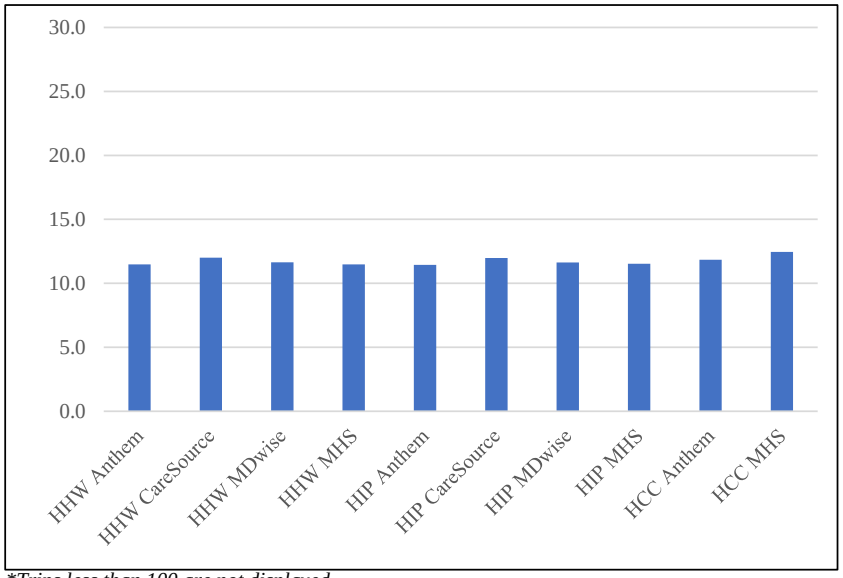


Unique Trips in Study	
HHW Anthem	7,142
HHW CareSource	1,960
HHW MDwise	9,736
HHW MHS	6,556
HIP Anthem	11,273
HIP CareSource	2,409
HIP MDwise	8,327
HIP MHS	5,069
HCC Anthem	6,207
HCC MHS	4,585

**Trips less than 10 at region level are not displayed*

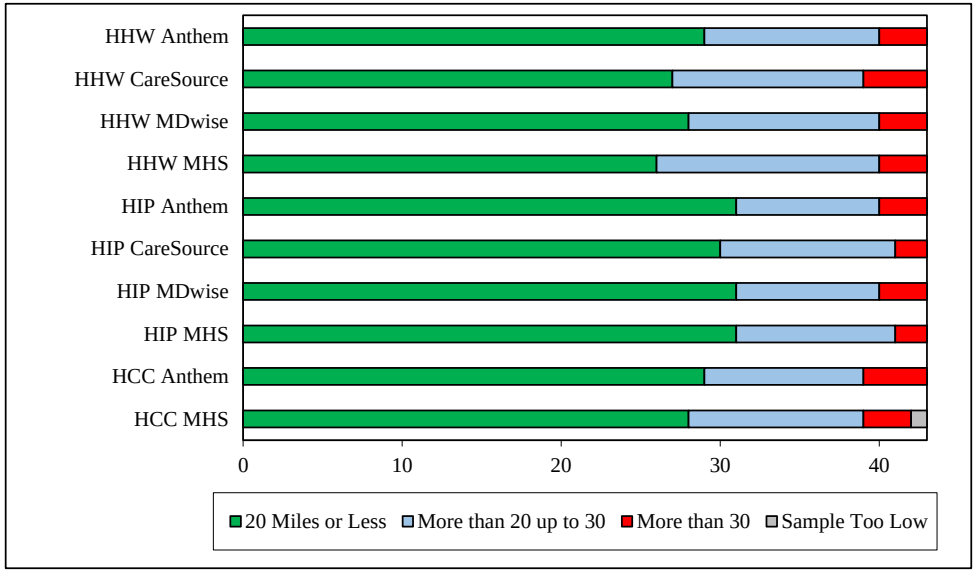
Appendix D.11
Acute Care Hospitals Unique Member Provider Trips - URBAN
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

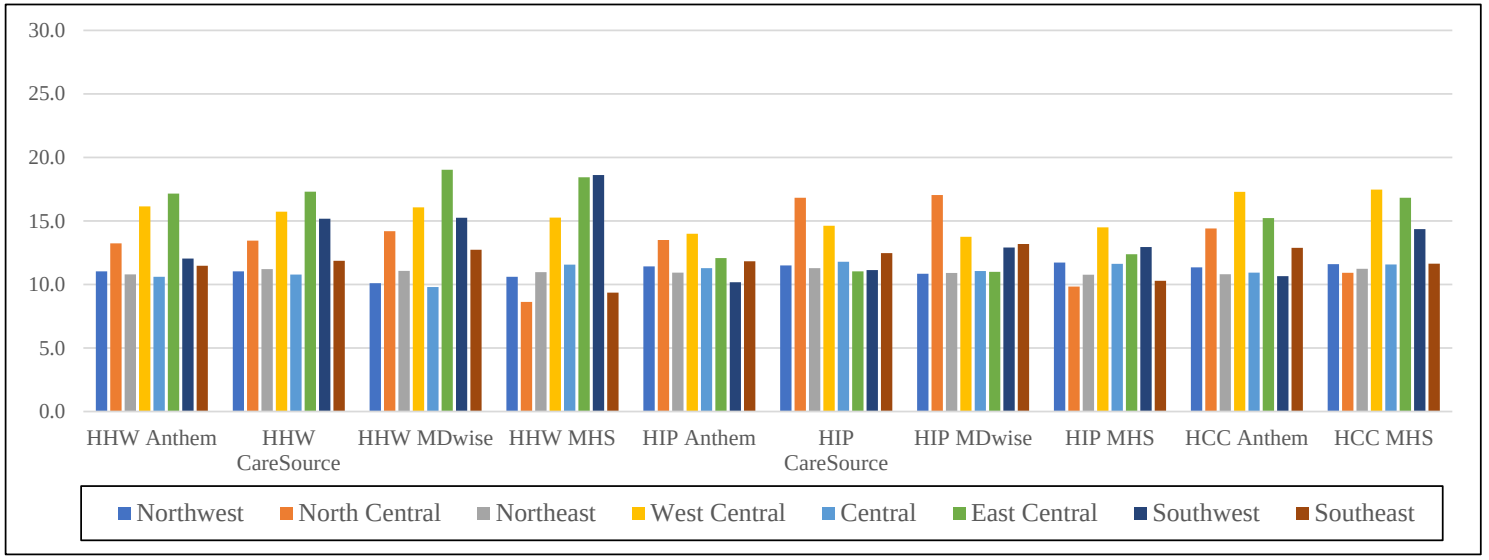


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 43 Urban) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

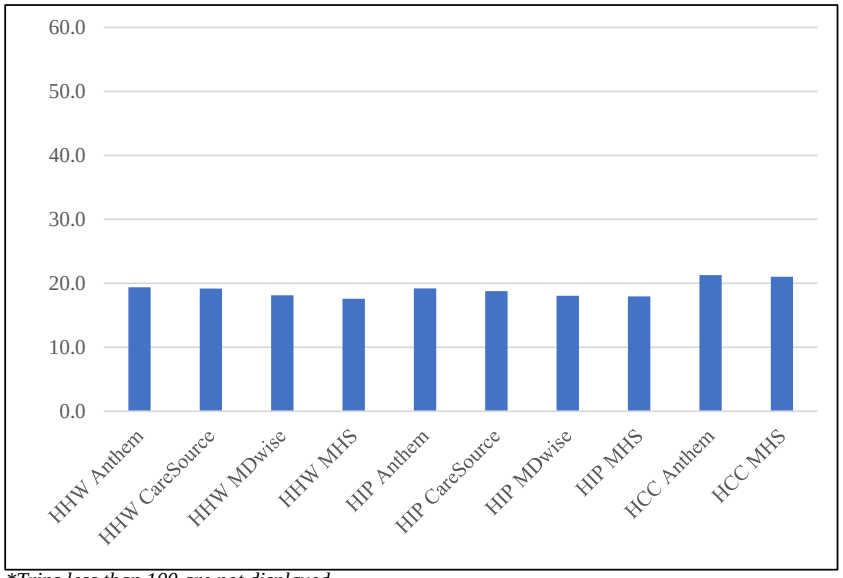


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	100,050
HHW CareSource	23,614
HHW MDwise	83,779
HHW MHS	58,077
HIP Anthem	161,127
HIP CareSource	27,683
HIP MDwise	84,585
HIP MHS	56,729
HCC Anthem	54,352
HCC MHS	27,826

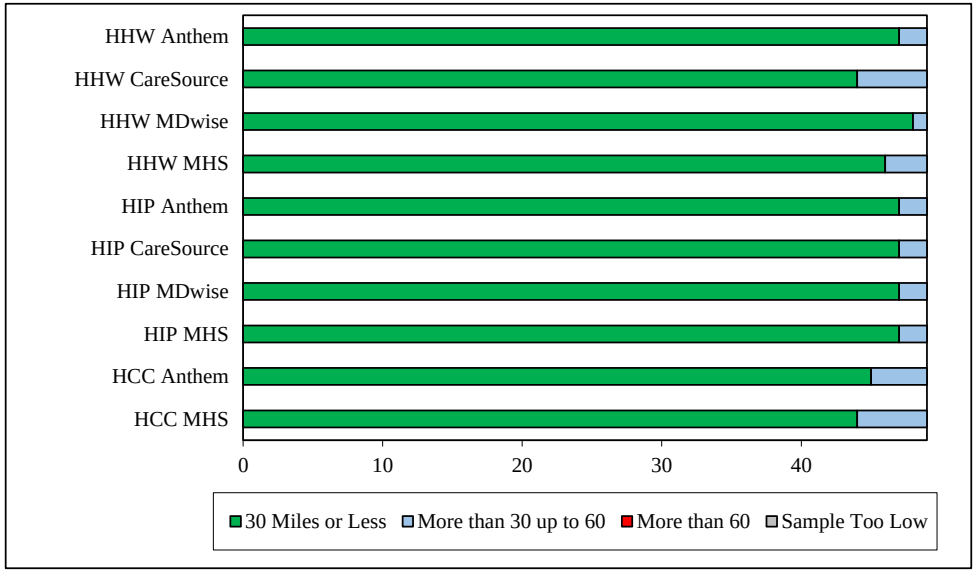
Appendix D.12
Acute Care Hospitals Unique Member Provider Trips - RURAL
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

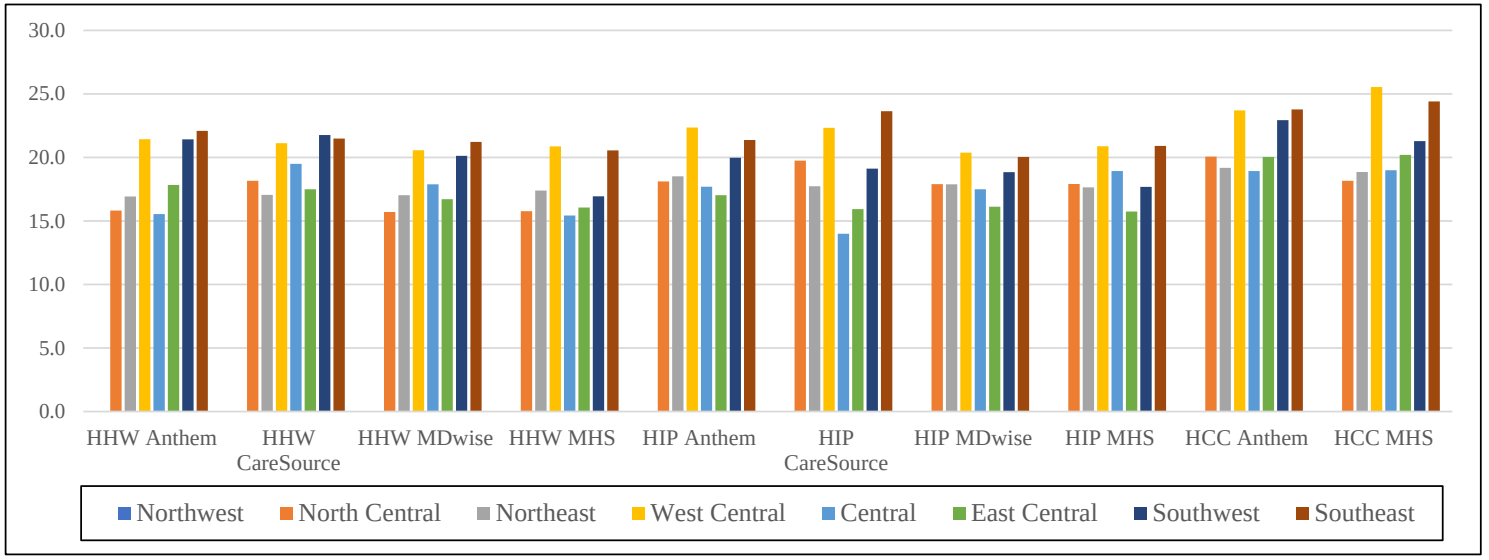


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 49 Rural) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

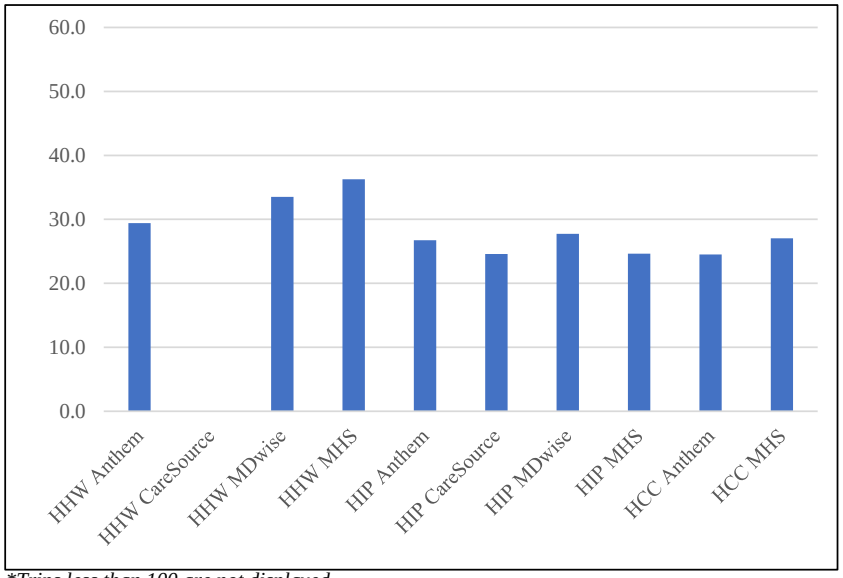


*Trips less than 10 at region level are not displayed

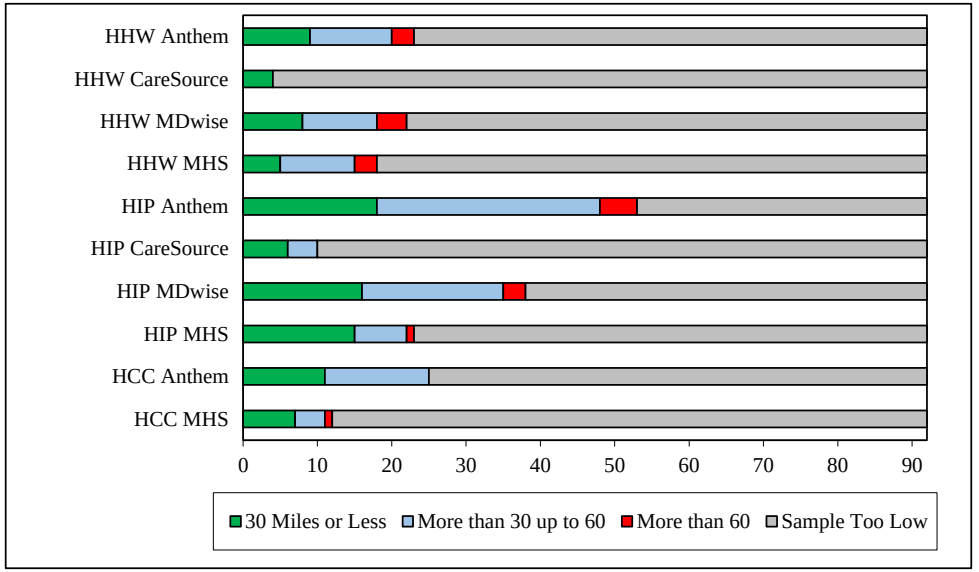
Unique Trips in Study	
HHW Anthem	29,127
HHW CareSource	8,538
HHW MDwise	27,777
HHW MHS	23,940
HIP Anthem	47,135
HIP CareSource	9,492
HIP MDwise	29,163
HIP MHS	21,466
HCC Anthem	15,571
HCC MHS	9,699

Appendix D.13
Inpatient Psychiatric Facilities Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

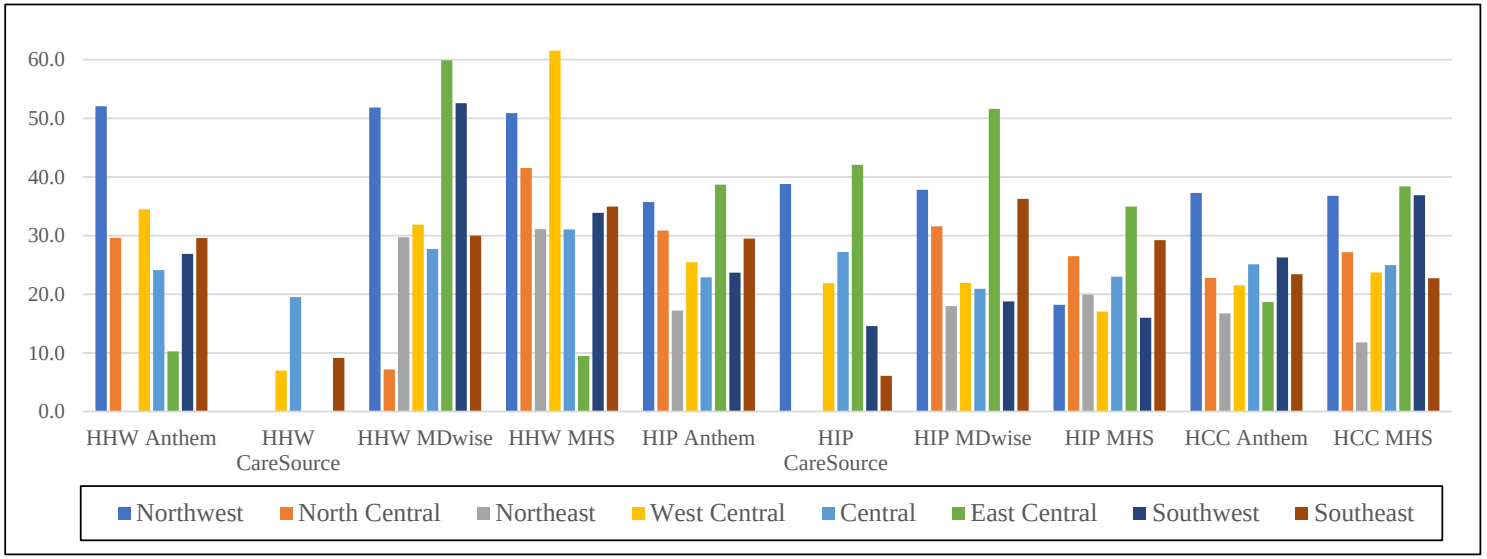


CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



**Trips less than 100 are not displayed*

Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

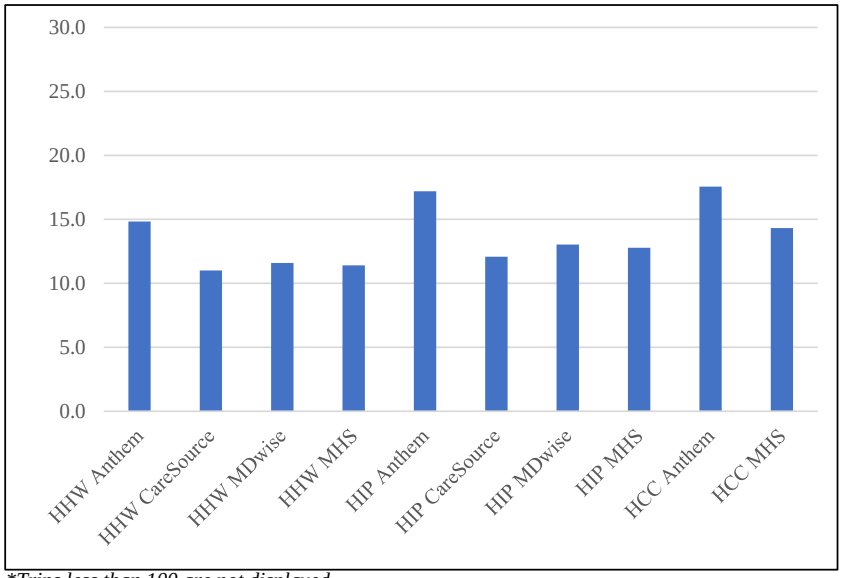


**Trips less than 10 at region level are not displayed*

Unique Trips in Study	
HHW Anthem	574
HHW CareSource	54
HHW MDwise	511
HHW MHS	328
HIP Anthem	2,028
HIP CareSource	204
HIP MDwise	1,049
HIP MHS	539
HCC Anthem	660
HCC MHS	310

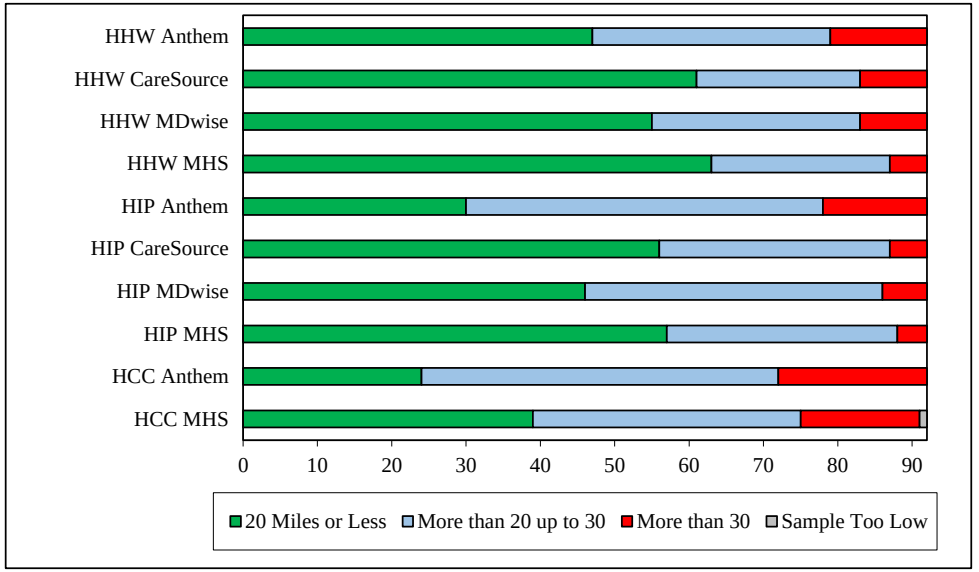
Appendix D.14
Clinic Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

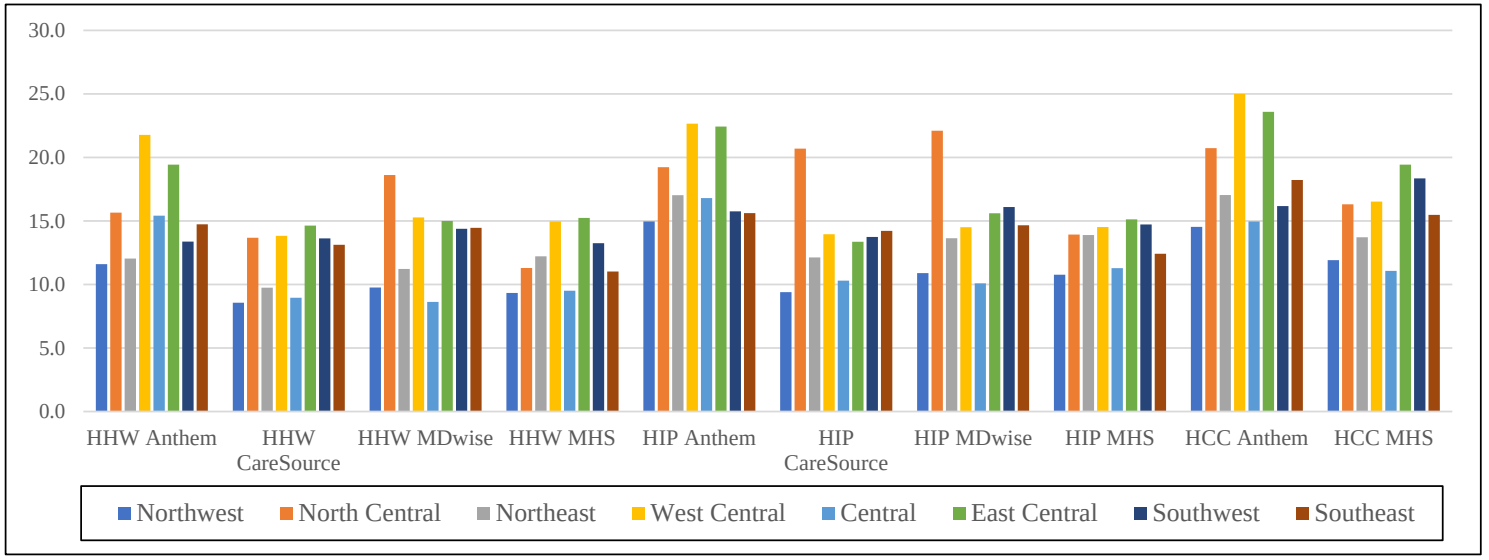


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

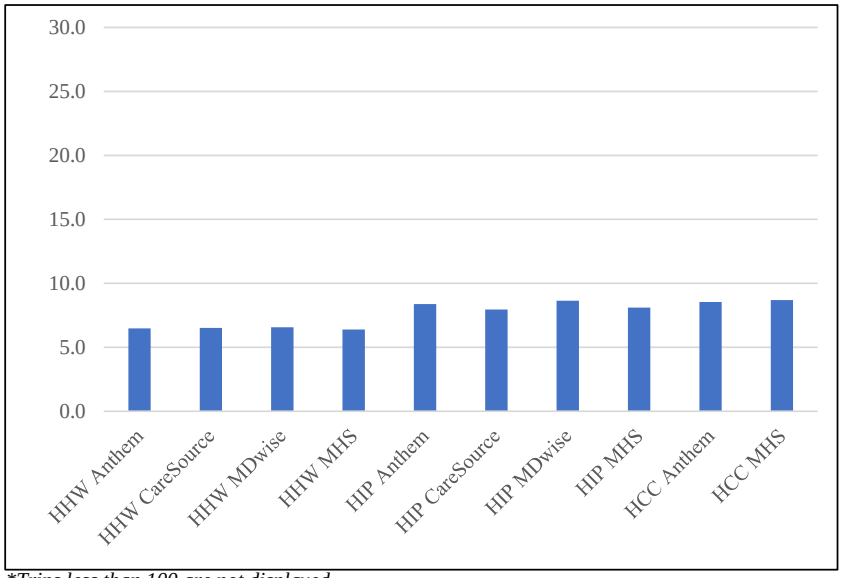


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	168,169
HHW CareSource	43,698
HHW MDwise	175,669
HHW MHS	110,867
HIP Anthem	201,508
HIP CareSource	34,271
HIP MDwise	126,814
HIP MHS	76,093
HCC Anthem	76,620
HCC MHS	43,576

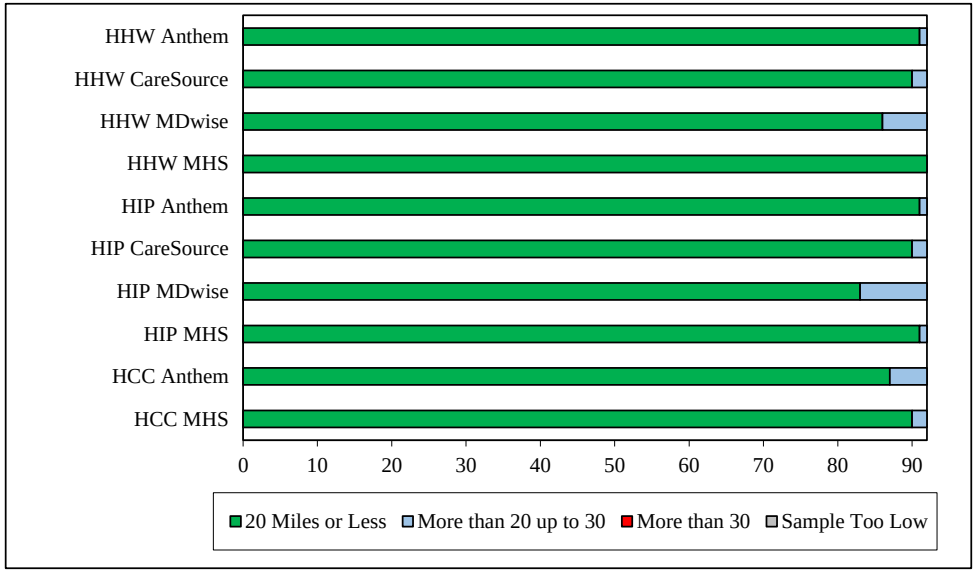
Appendix D.15
Pharmacy Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

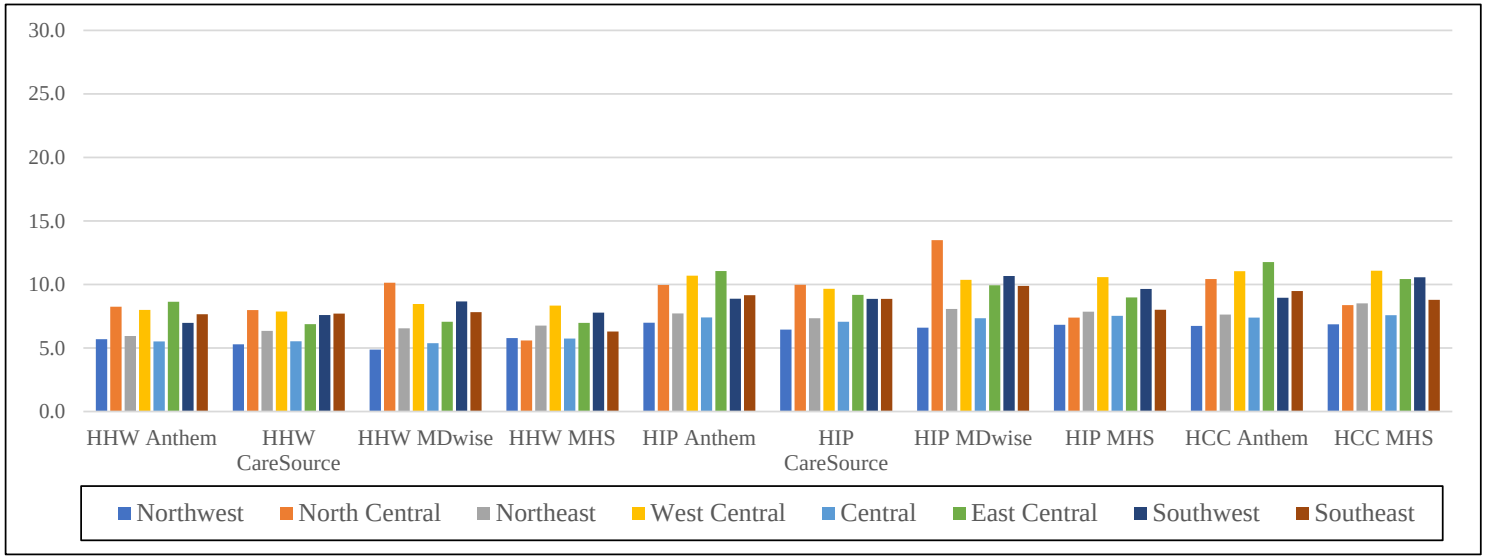


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

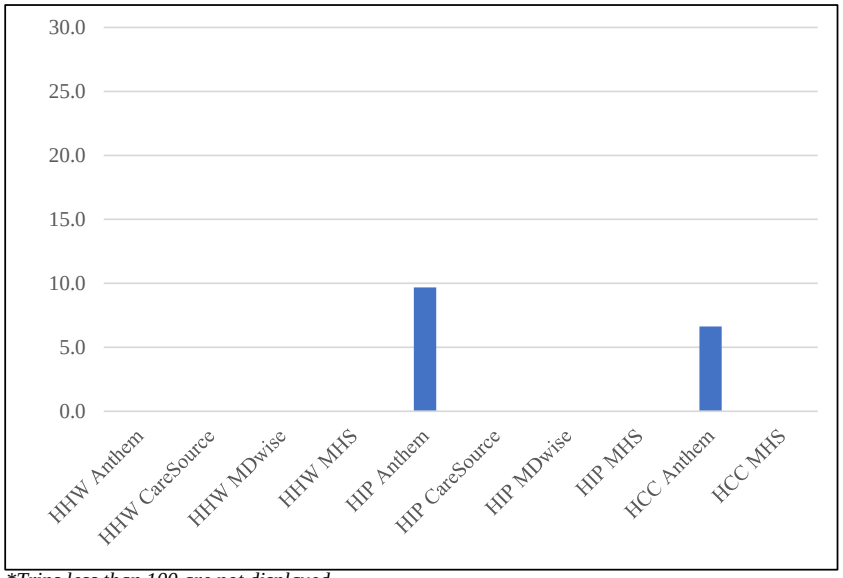


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	209,673
HHW CareSource	34,960
HHW MDwise	173,805
HHW MHS	136,070
HIP Anthem	297,413
HIP CareSource	85,474
HIP MDwise	153,318
HIP MHS	111,184
HCC Anthem	96,434
HCC MHS	52,906

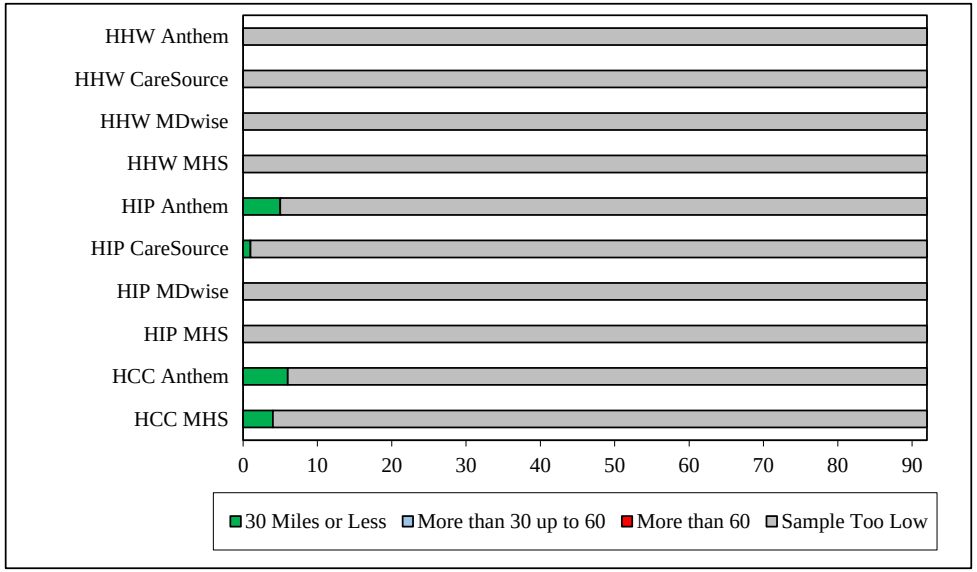
Appendix D.16
ESRD Clinic Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

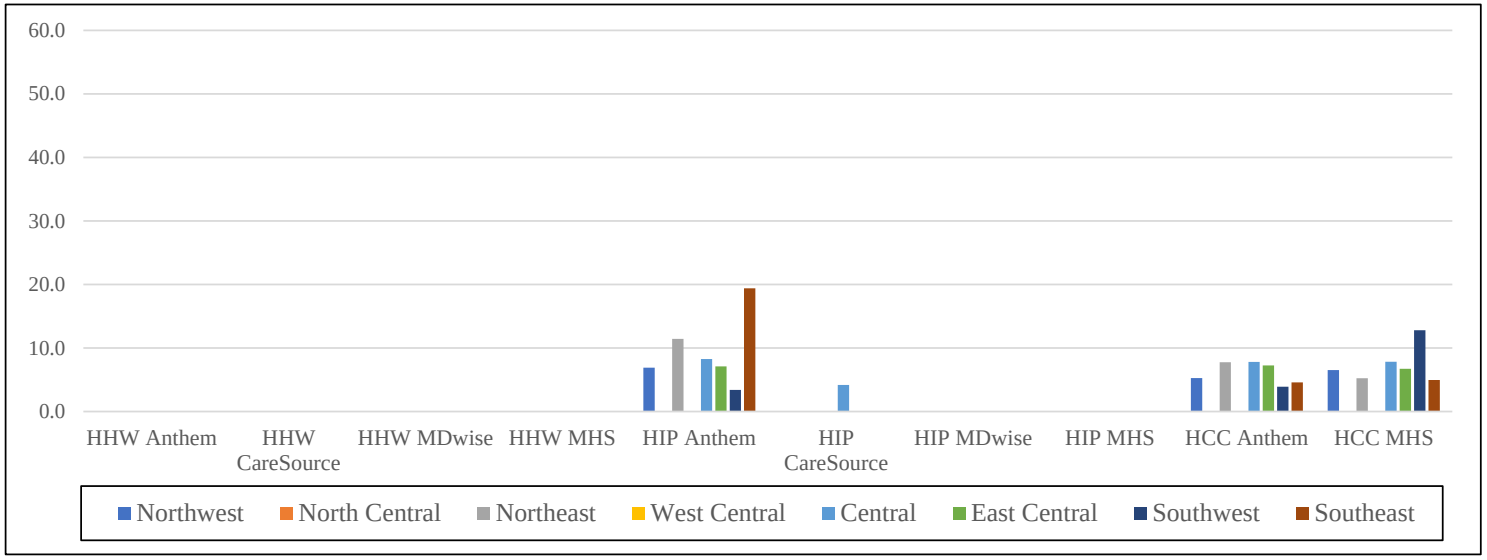


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

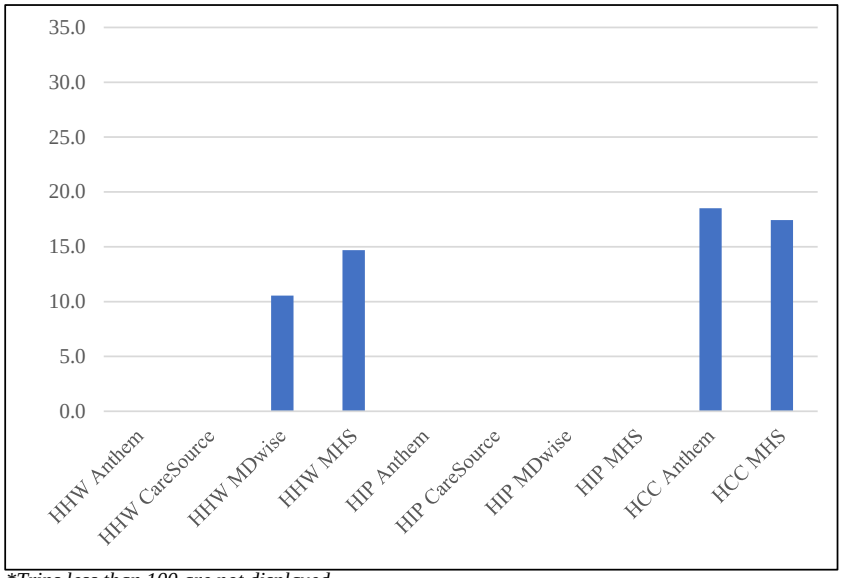


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	0
HHW CareSource	0
HHW MDwise	0
HHW MHS	0
HIP Anthem	112
HIP CareSource	13
HIP MDwise	0
HIP MHS	0
HCC Anthem	237
HCC MHS	98

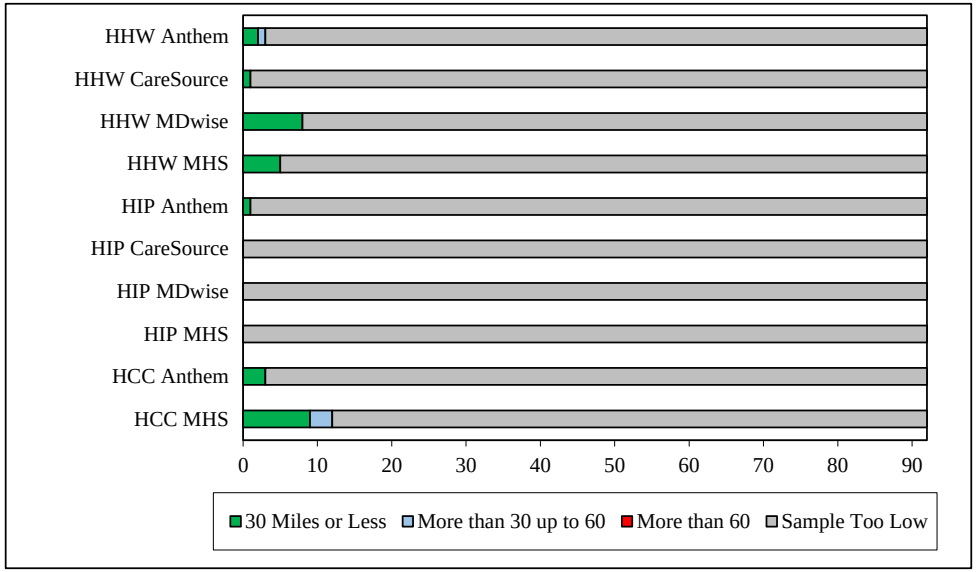
Appendix D.17
ABA Providers Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

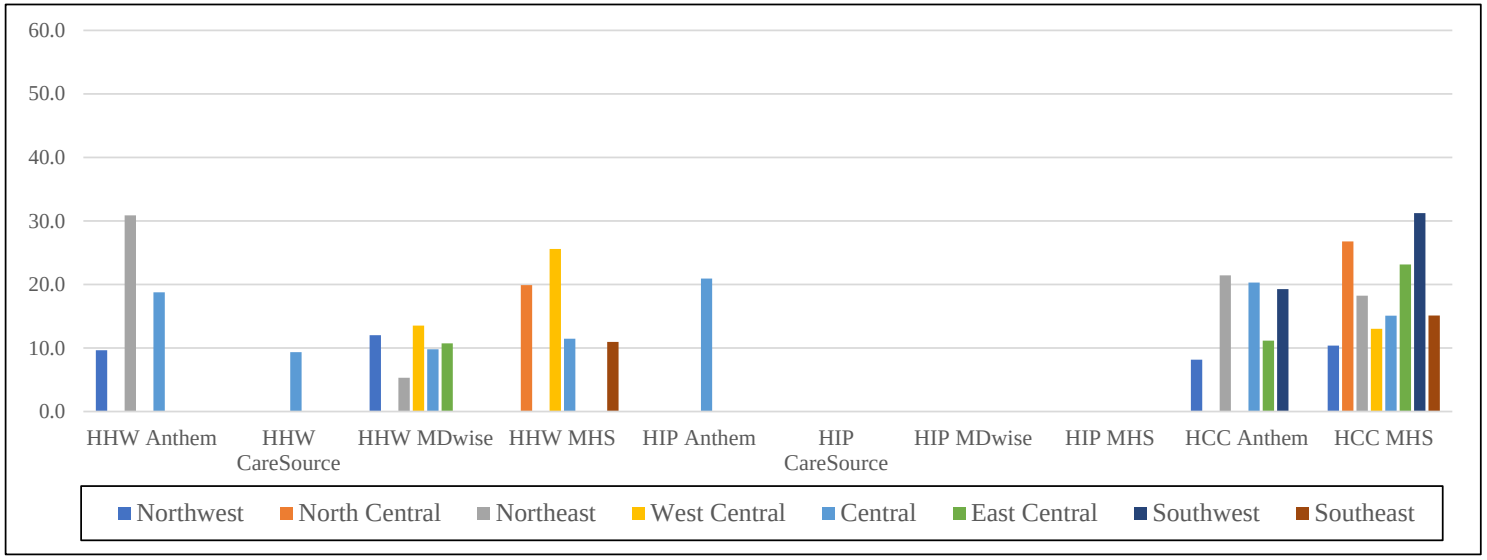


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

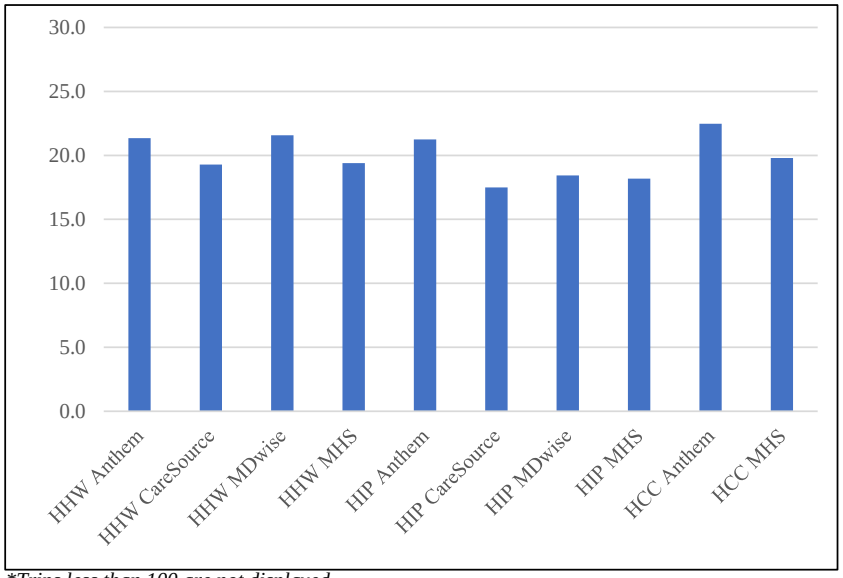


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	143
HHW CareSource	93
HHW MDwise	275
HHW MHS	264
HIP Anthem	32
HIP CareSource	0
HIP MDwise	0
HIP MHS	6
HCC Anthem	231
HCC MHS	463

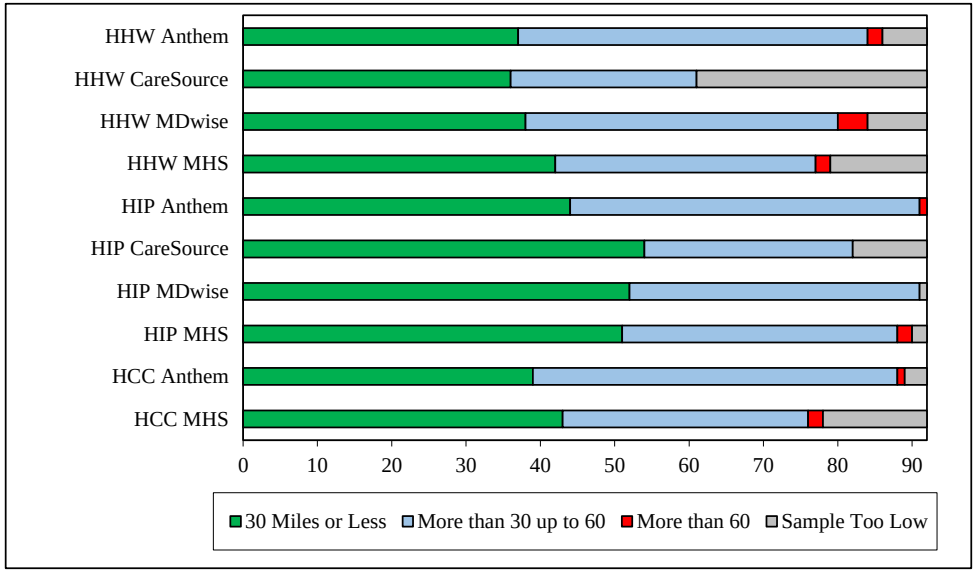
Appendix D.18
Anesthesiologists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

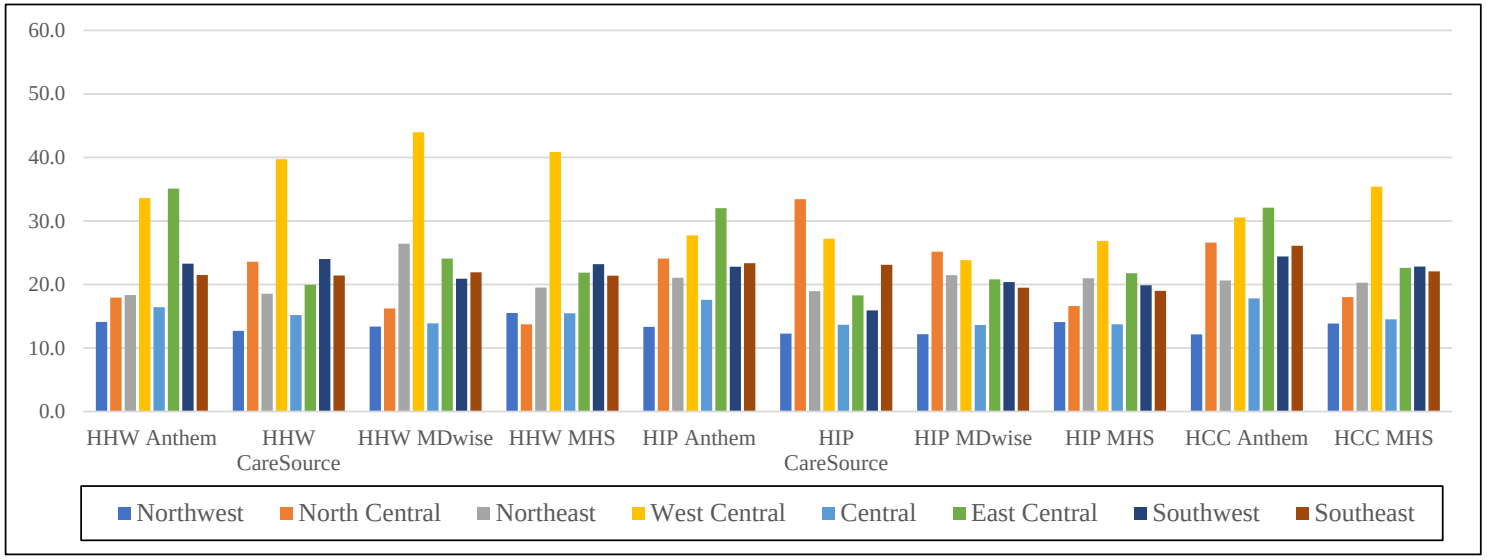


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

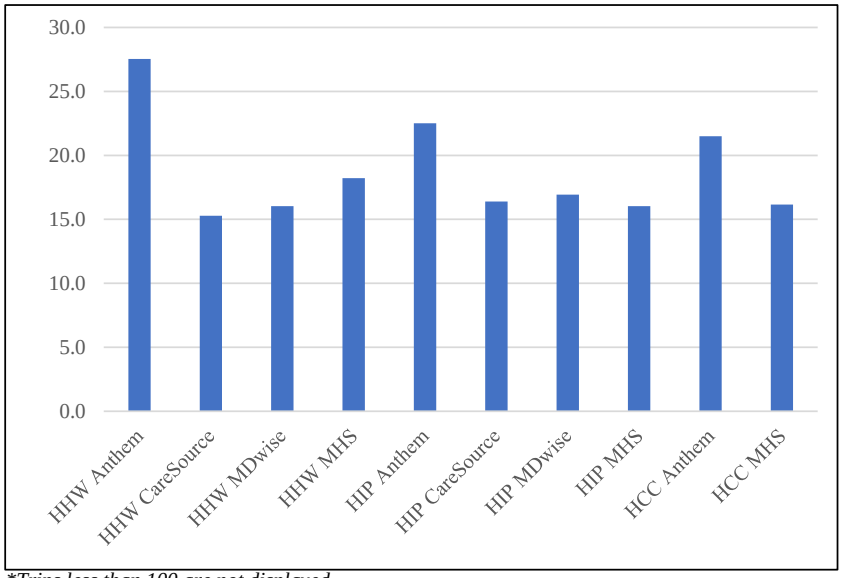


*Trips less than 10 at region level are not displayed

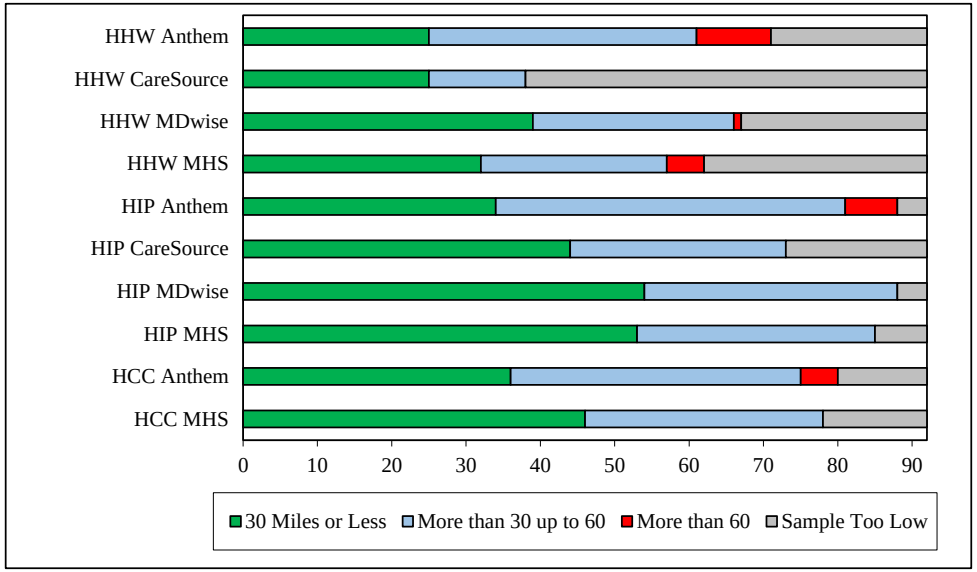
Unique Trips in Study	
HHW Anthem	14,740
HHW CareSource	3,417
HHW MDwise	11,531
HHW MHS	10,235
HIP Anthem	38,483
HIP CareSource	6,630
HIP MDwise	20,911
HIP MHS	15,151
HCC Anthem	12,852
HCC MHS	6,937

Appendix D.19
Cardiologists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

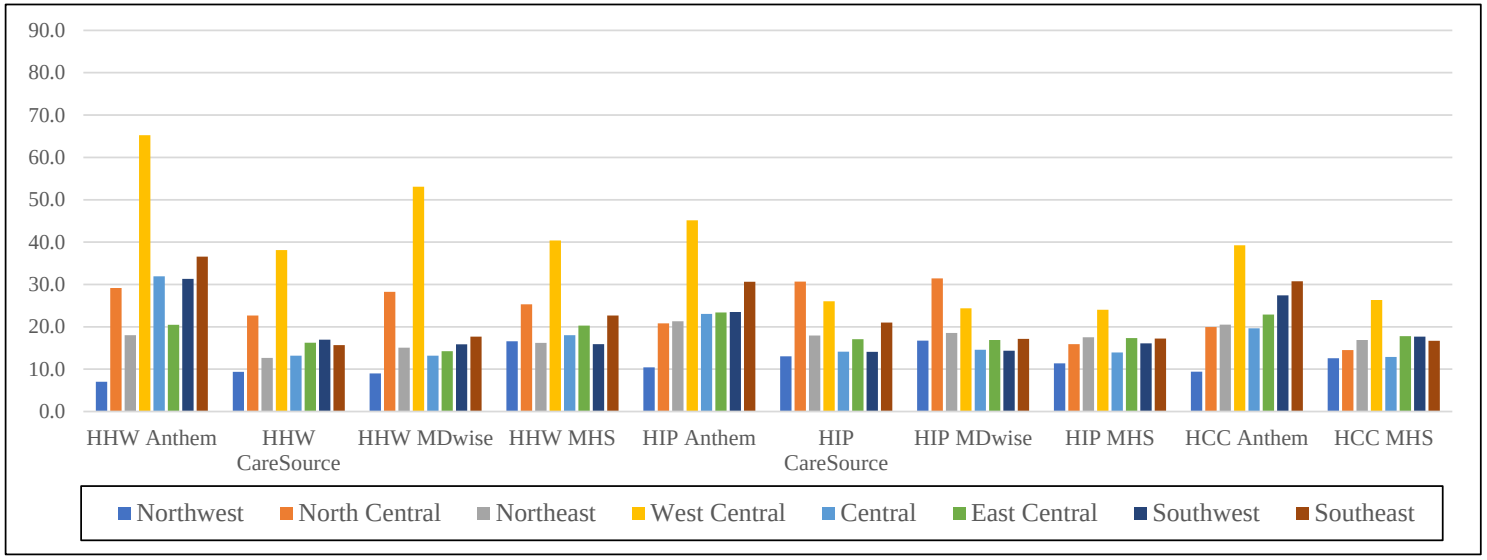


CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



**Trips less than 100 are not displayed*

Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

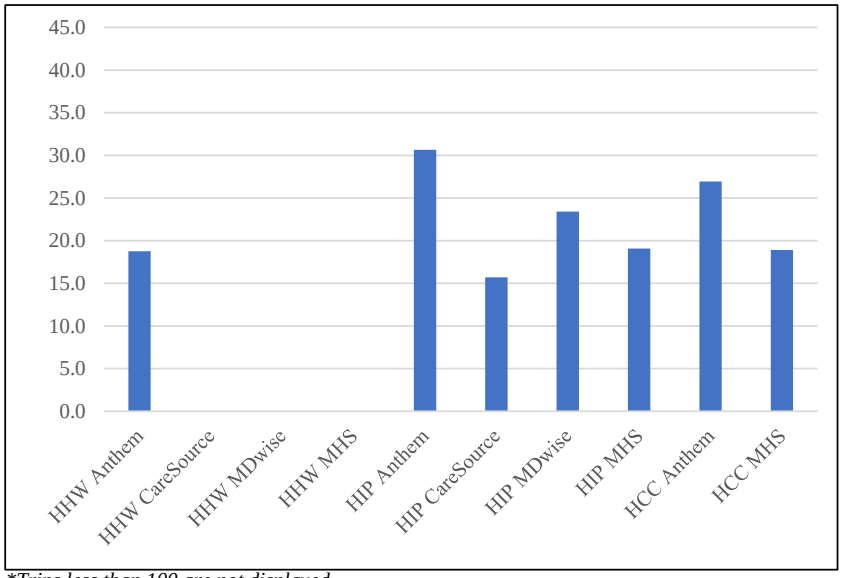


**Trips less than 10 at region level are not displayed*

Unique Trips in Study	
HHW Anthem	8,600
HHW CareSource	1,955
HHW MDwise	6,239
HHW MHS	5,483
HIP Anthem	24,052
HIP CareSource	5,807
HIP MDwise	13,328
HIP MHS	12,993
HCC Anthem	11,049
HCC MHS	7,405

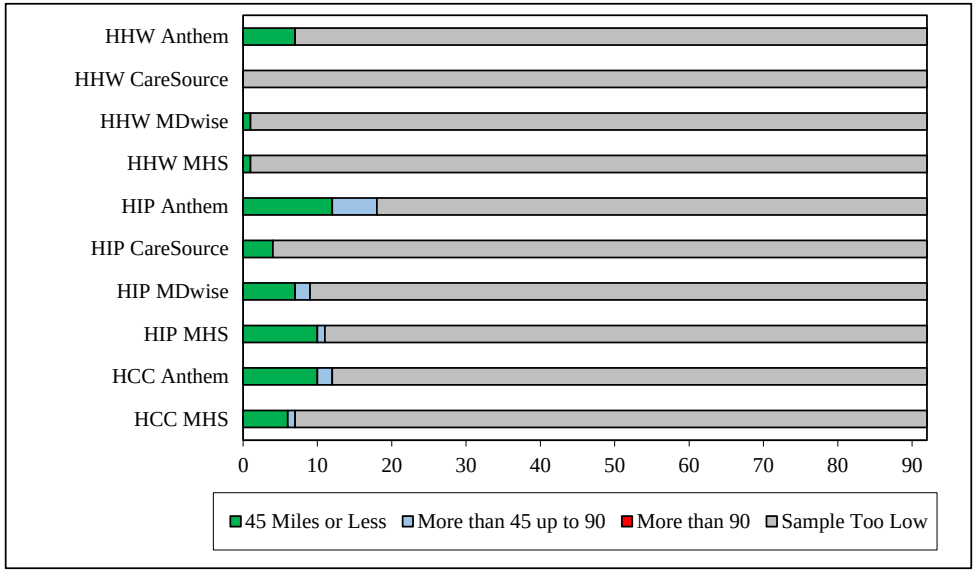
Appendix D.20
Cardiovascular Surgeons Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

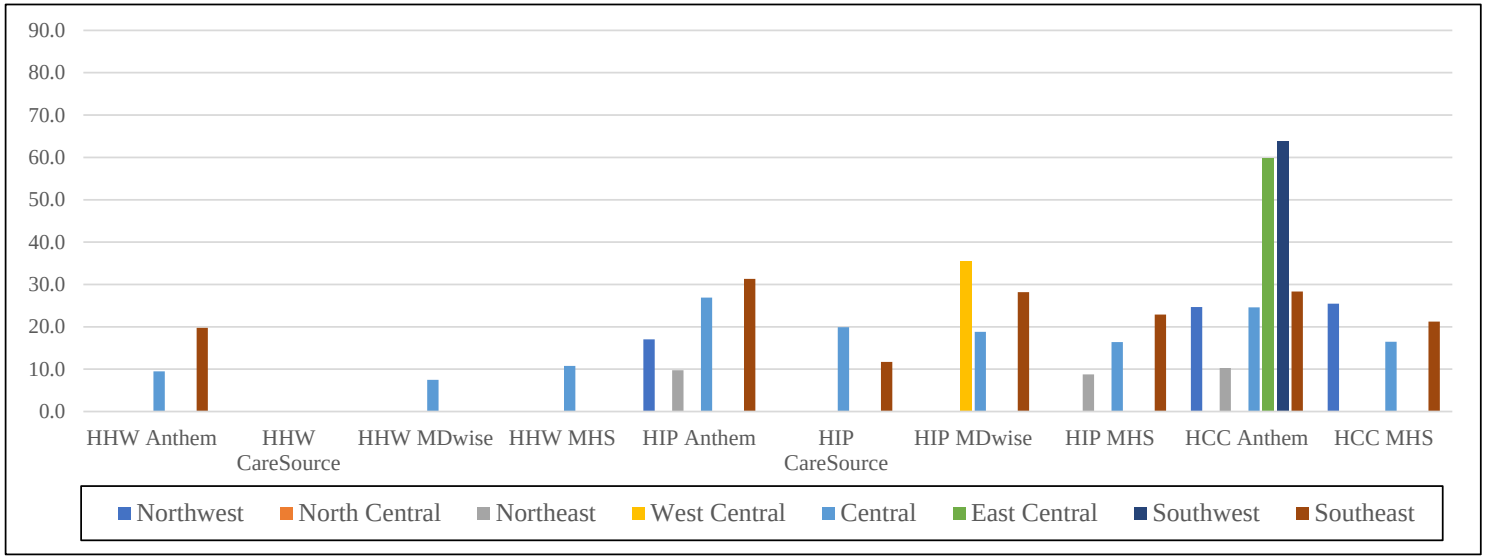


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

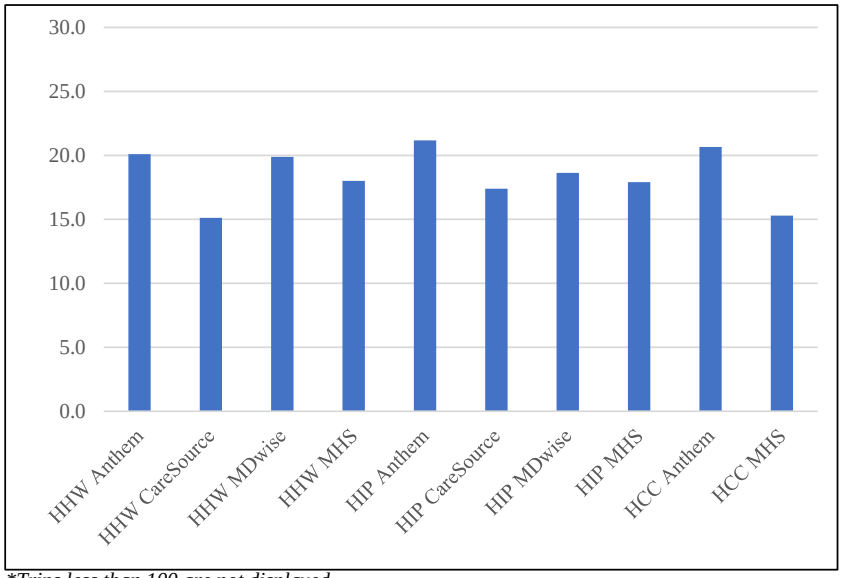


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	414
HHW CareSource	21
HHW MDwise	95
HHW MHS	35
HIP Anthem	2,445
HIP CareSource	224
HIP MDwise	513
HIP MHS	558
HCC Anthem	993
HCC MHS	348

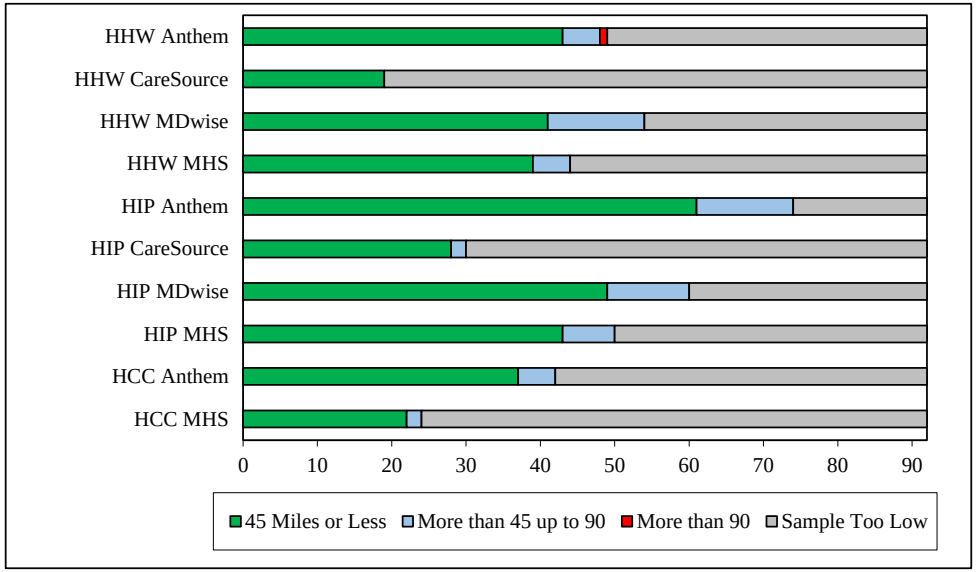
Appendix D.21
Dermatologists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

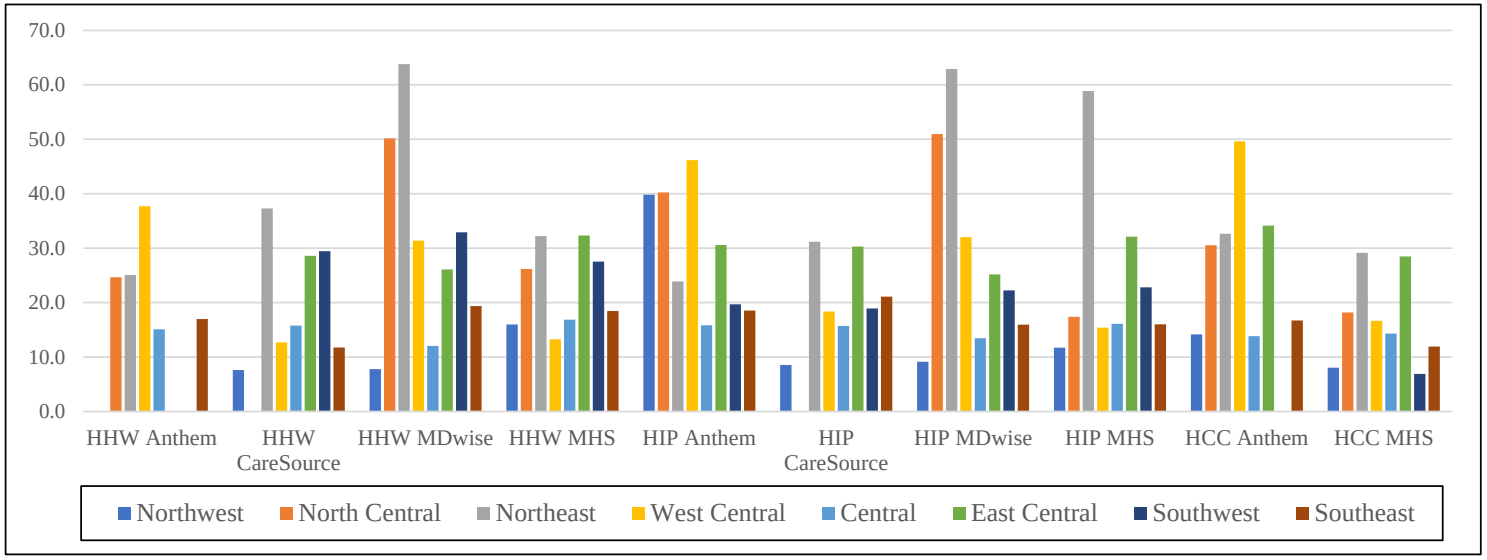


Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

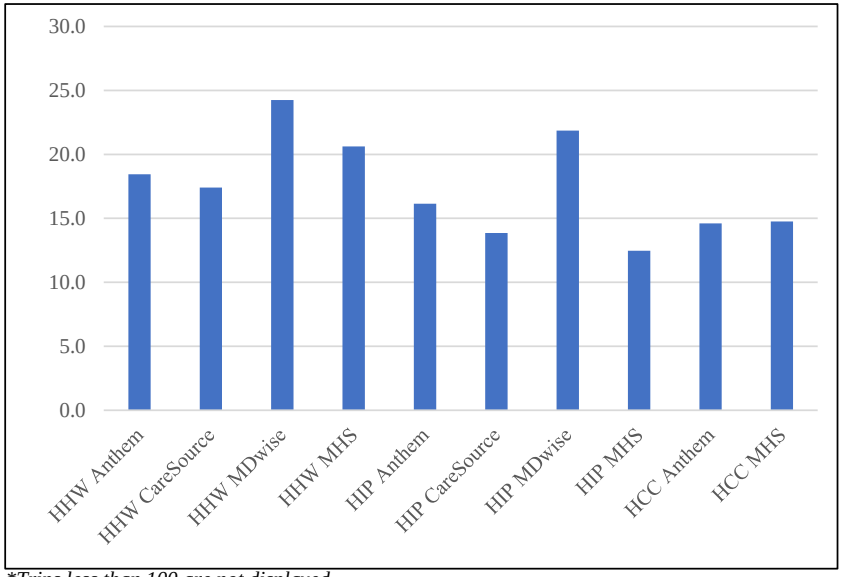


Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	3,497
HHW CareSource	1,161
HHW MDwise	3,524
HHW MHS	3,338
HIP Anthem	6,423
HIP CareSource	1,328
HIP MDwise	3,989
HIP MHS	2,727
HCC Anthem	1,686
HCC MHS	1,082

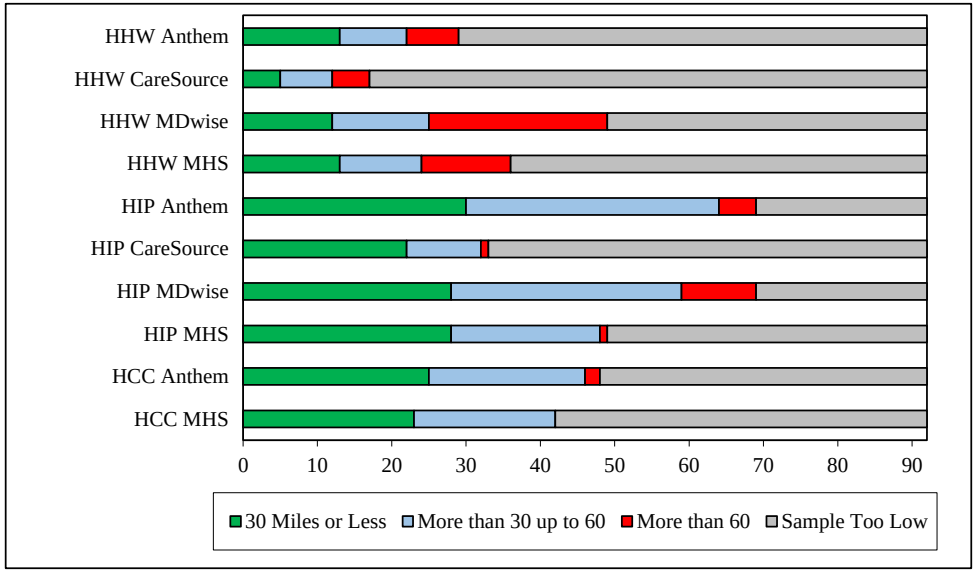
Appendix D.22
Gastroenterologists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

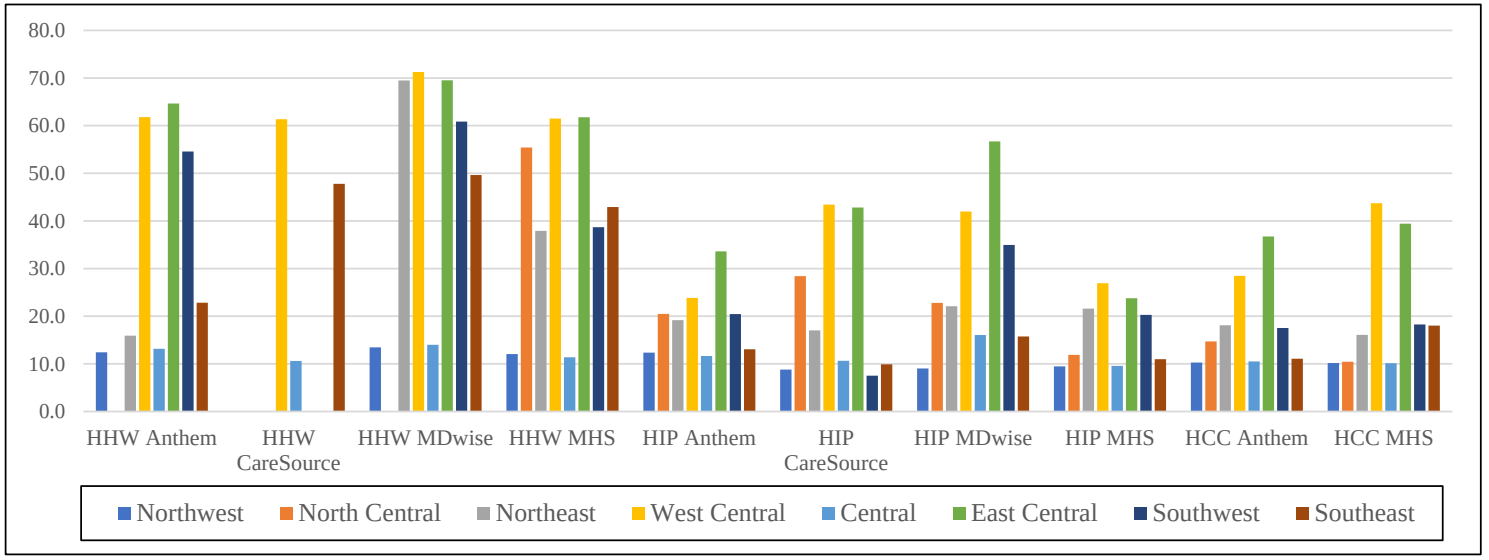


Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

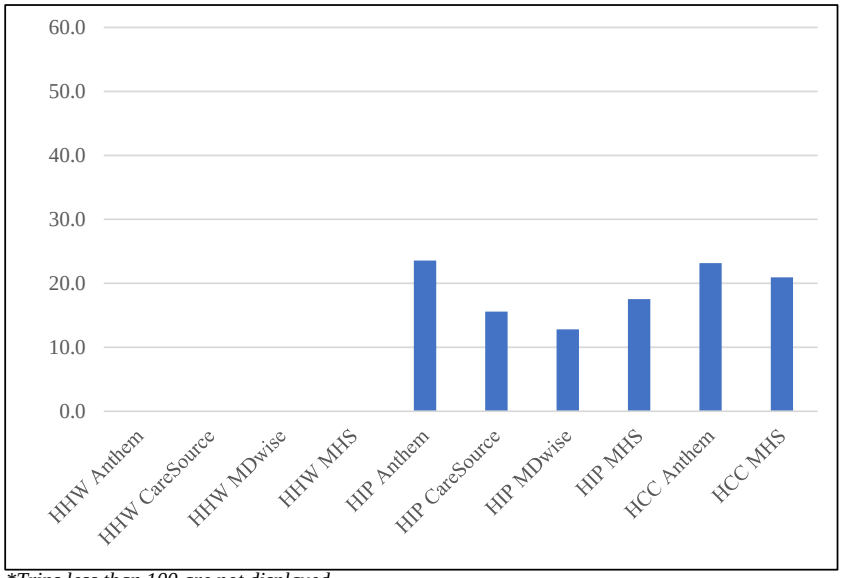


Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	1,906
HHW CareSource	1,685
HHW MDwise	9,721
HHW MHS	3,406
HIP Anthem	8,583
HIP CareSource	2,367
HIP MDwise	12,817
HIP MHS	4,738
HCC Anthem	3,522
HCC MHS	3,440

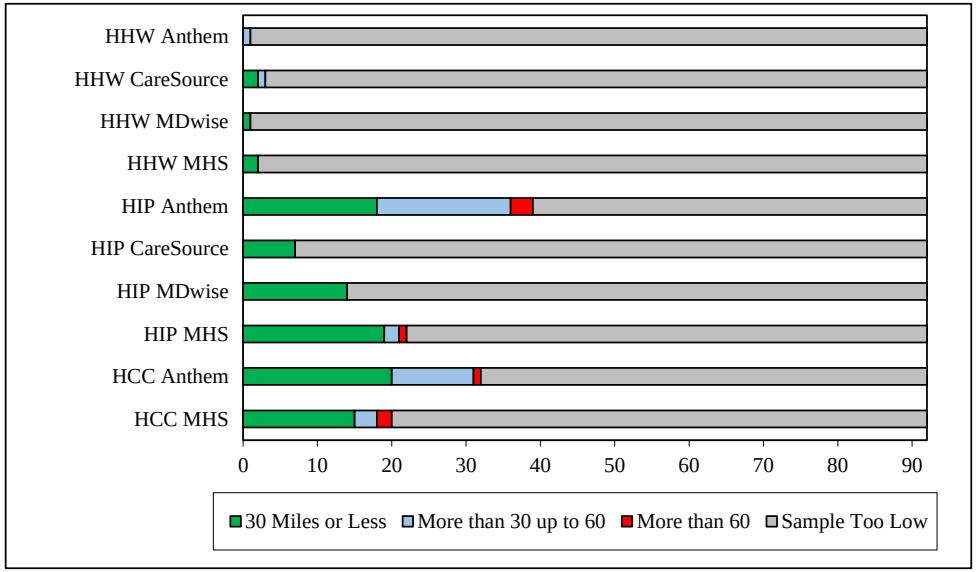
Appendix D.23
Nephrologists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

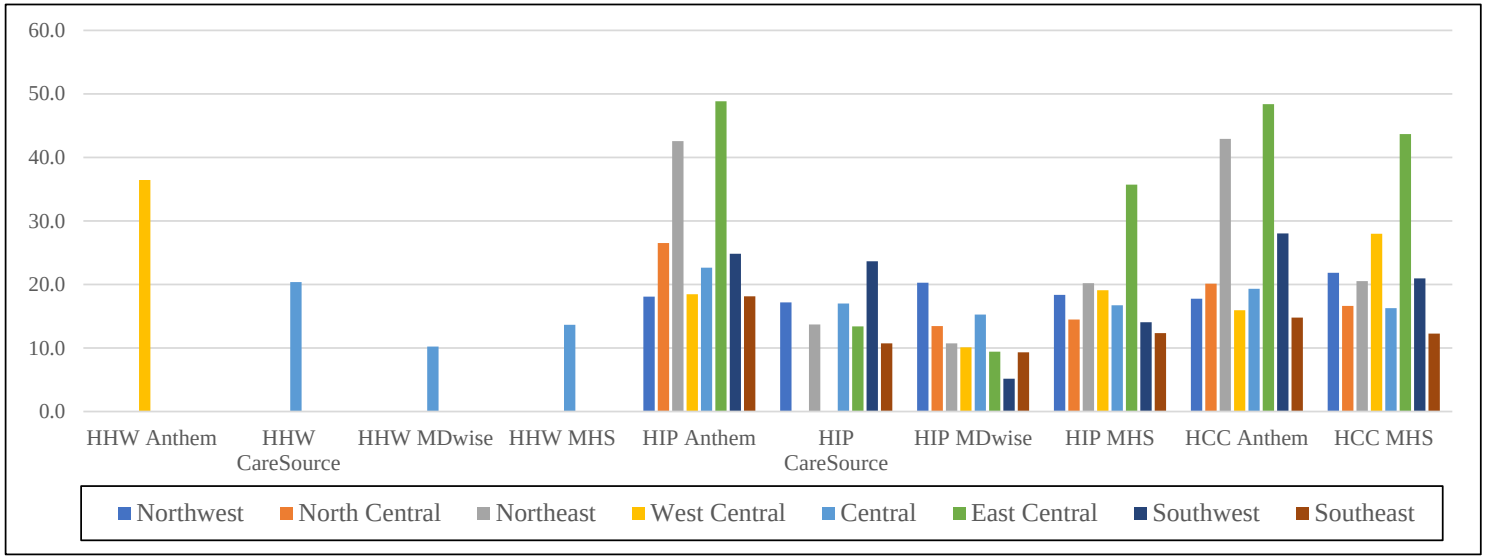


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

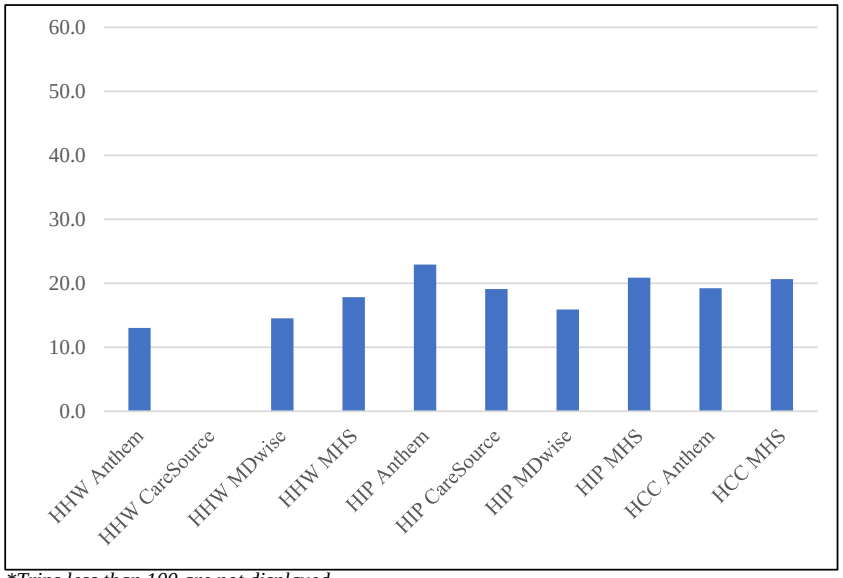


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	79
HHW CareSource	69
HHW MDwise	109
HHW MHS	117
HIP Anthem	2,293
HIP CareSource	319
HIP MDwise	587
HIP MHS	868
HCC Anthem	1,609
HCC MHS	884

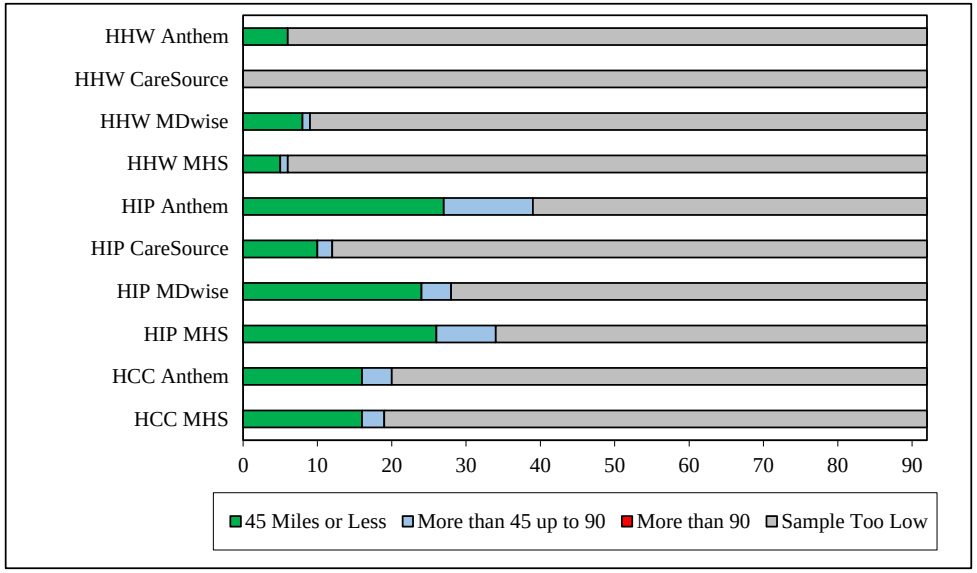
Appendix D.24
Neurological Surgeons Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

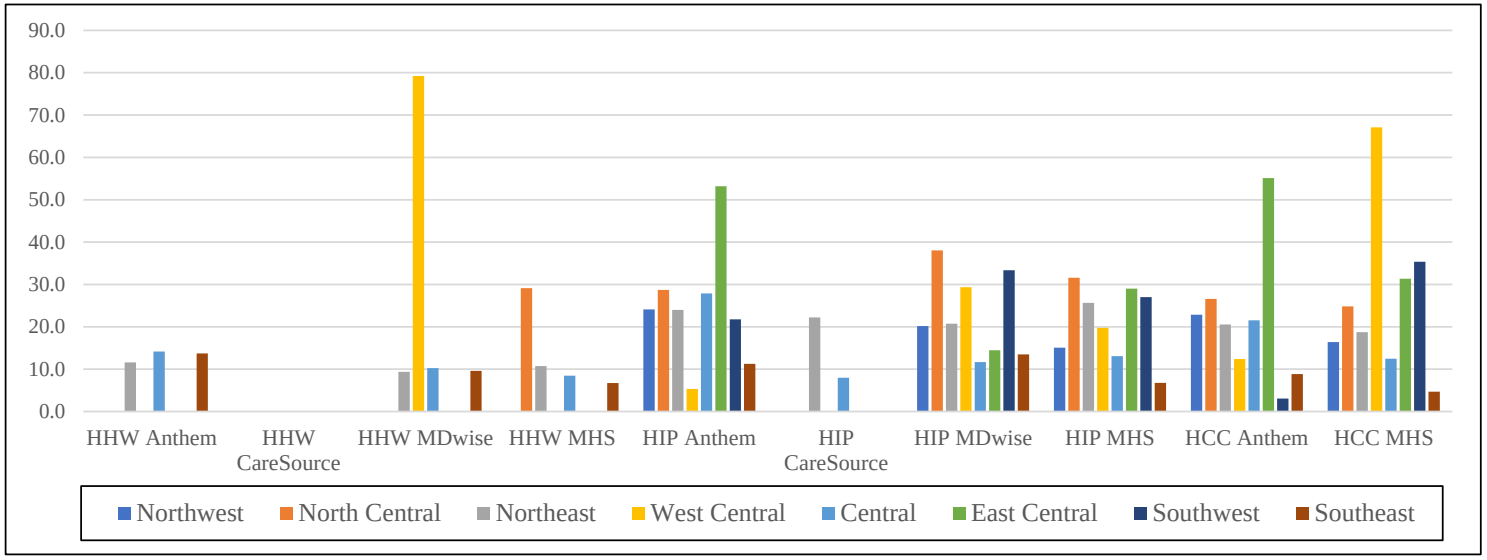


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

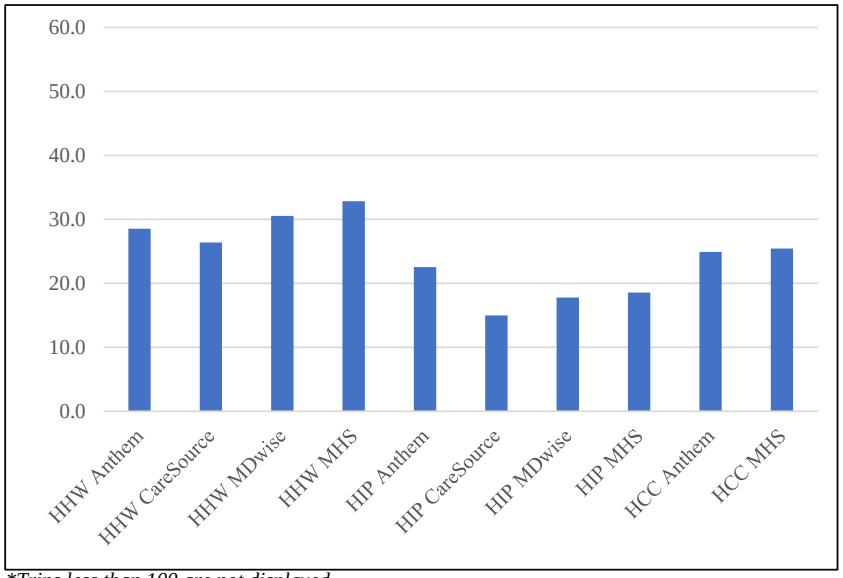


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	216
HHW CareSource	48
HHW MDwise	419
HHW MHS	331
HIP Anthem	2,156
HIP CareSource	443
HIP MDwise	1,775
HIP MHS	1,224
HCC Anthem	913
HCC MHS	739

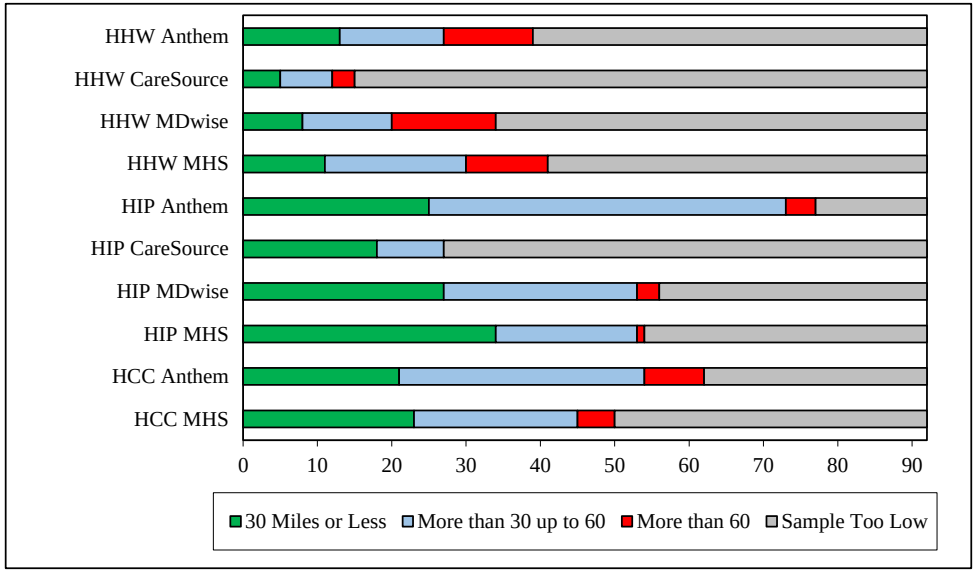
Appendix D.25
Neurologists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

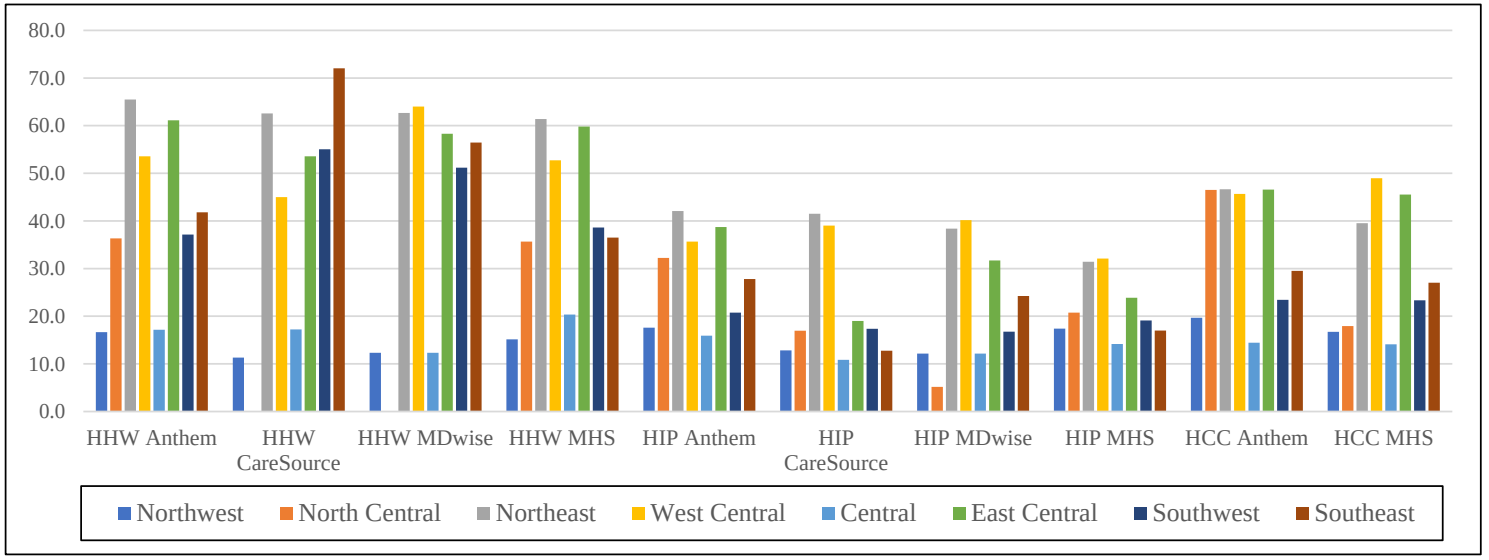


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

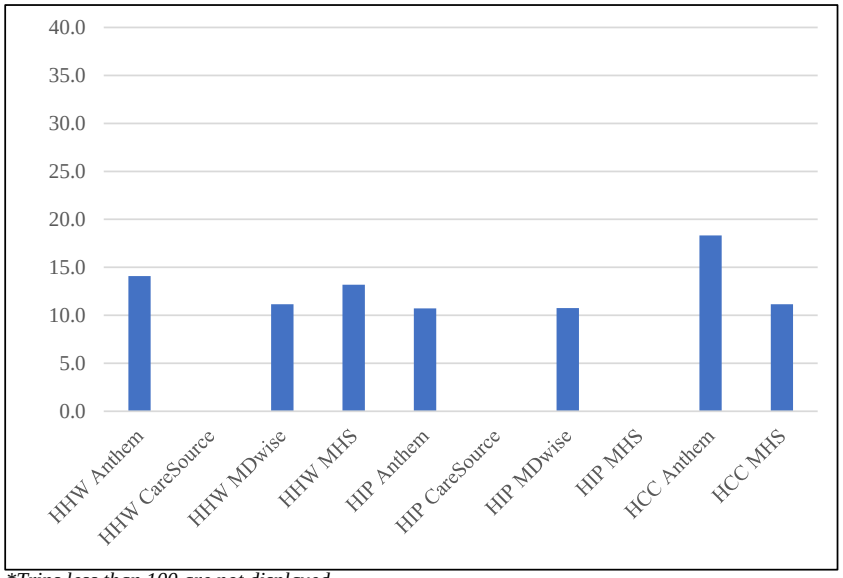


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	1,870
HHW CareSource	708
HHW MDwise	2,216
HHW MHS	1,941
HIP Anthem	7,684
HIP CareSource	946
HIP MDwise	3,881
HIP MHS	2,776
HCC Anthem	4,640
HCC MHS	2,459

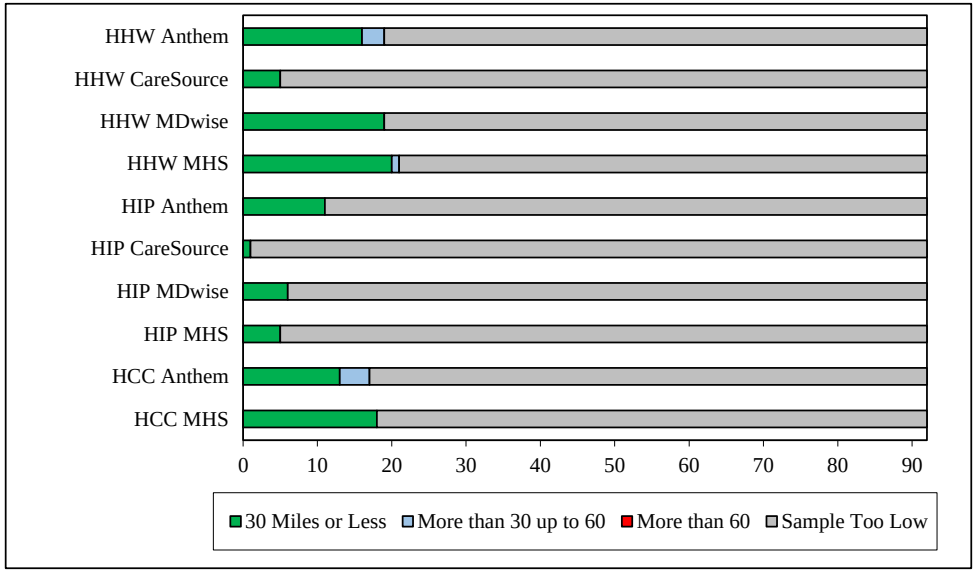
Appendix D.26
Occupational Therapists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

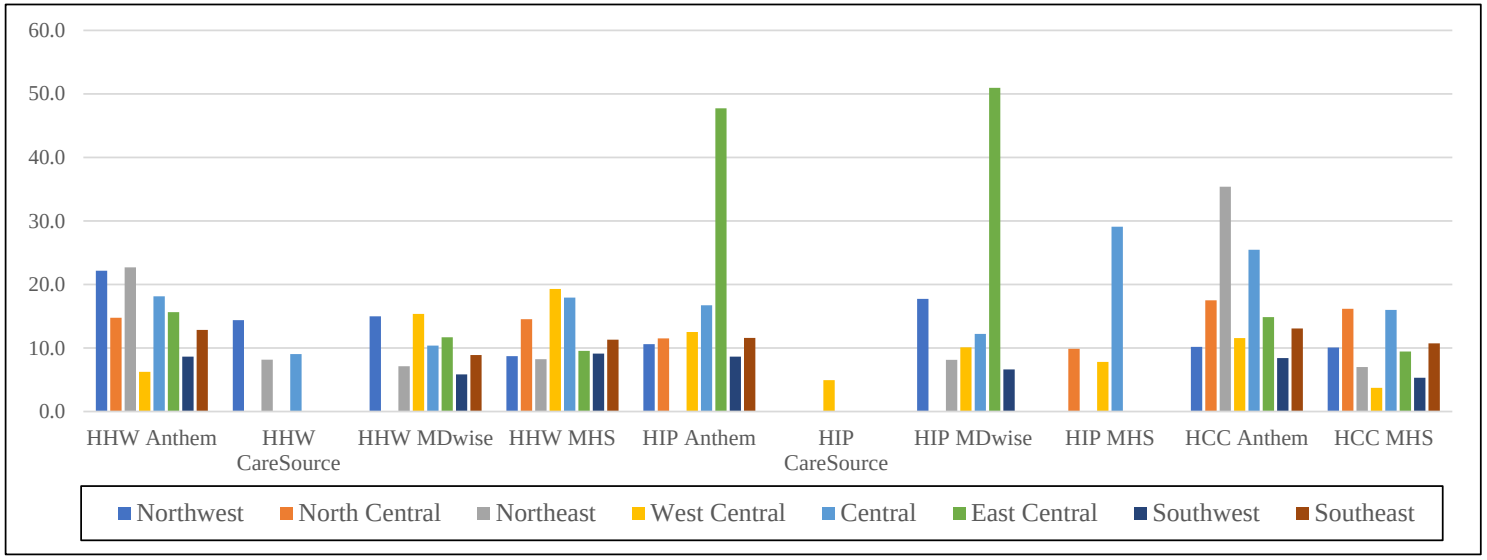


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

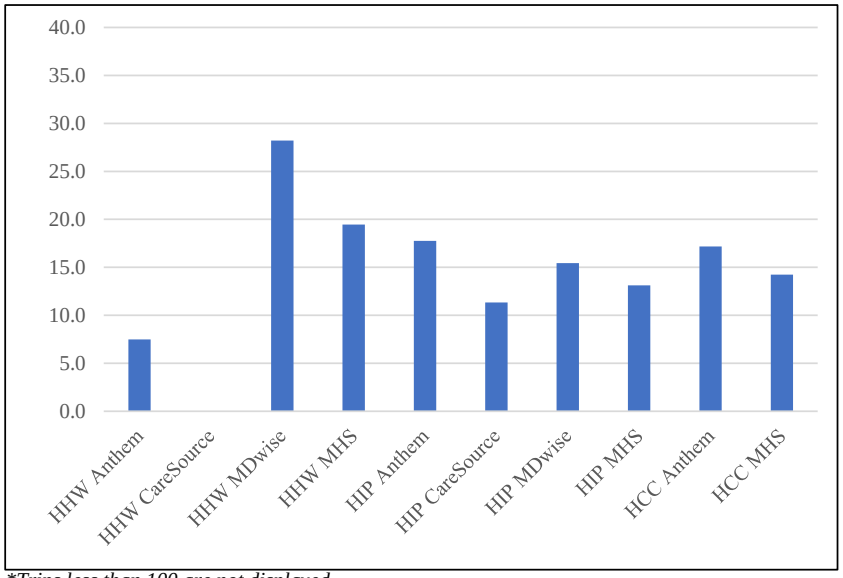


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	854
HHW CareSource	165
HHW MDwise	735
HHW MHS	672
HIP Anthem	578
HIP CareSource	88
HIP MDwise	294
HIP MHS	221
HCC Anthem	716
HCC MHS	710

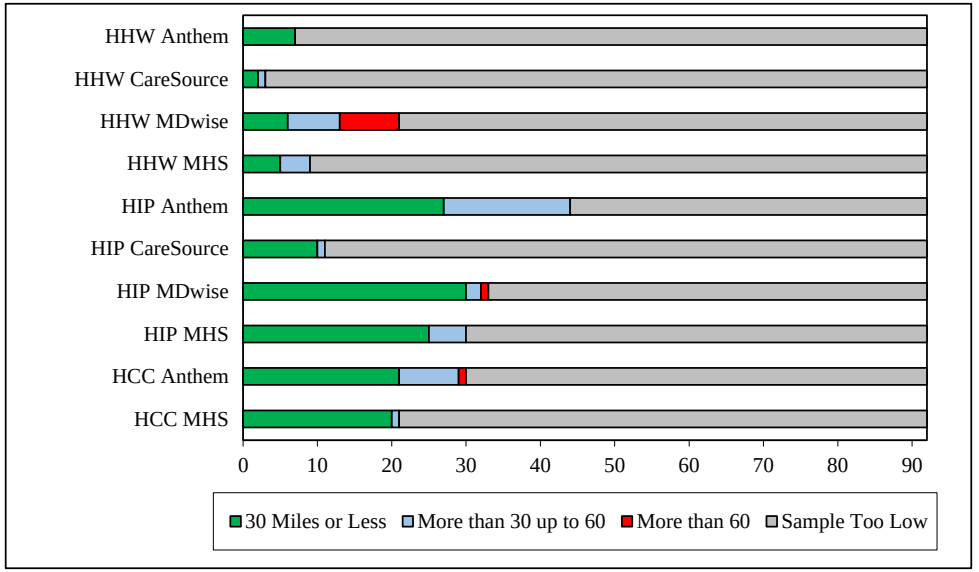
Appendix D.27
Oncologists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

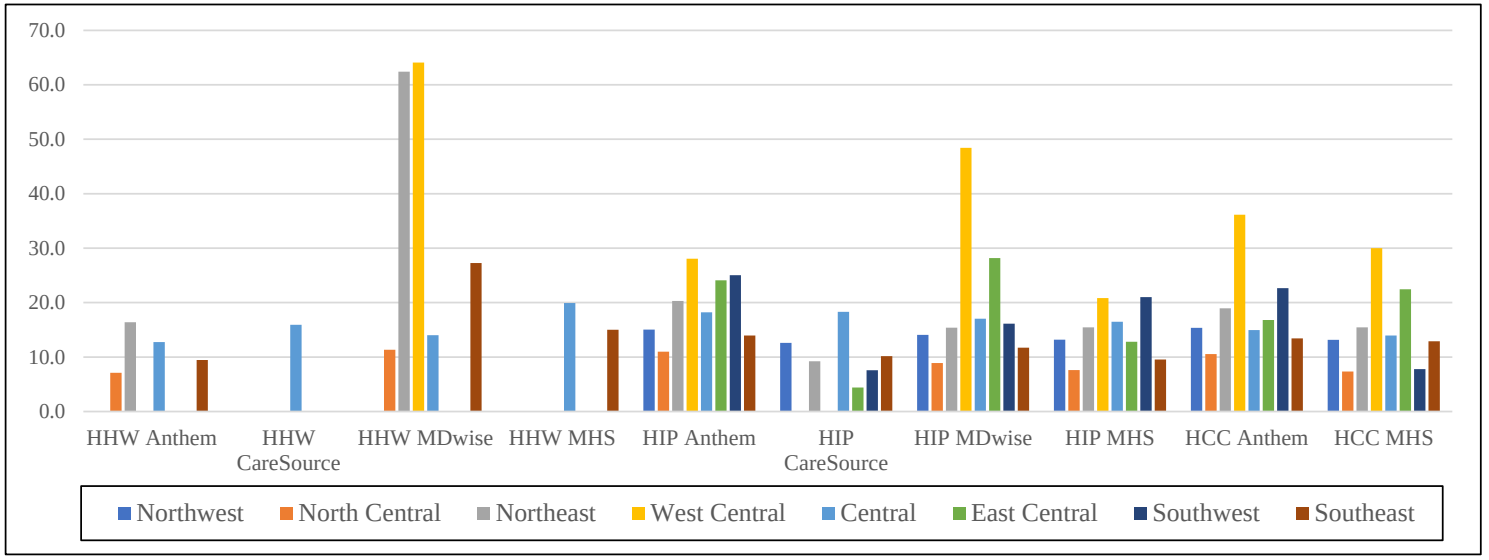


**Trips less than 100 are not displayed*

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

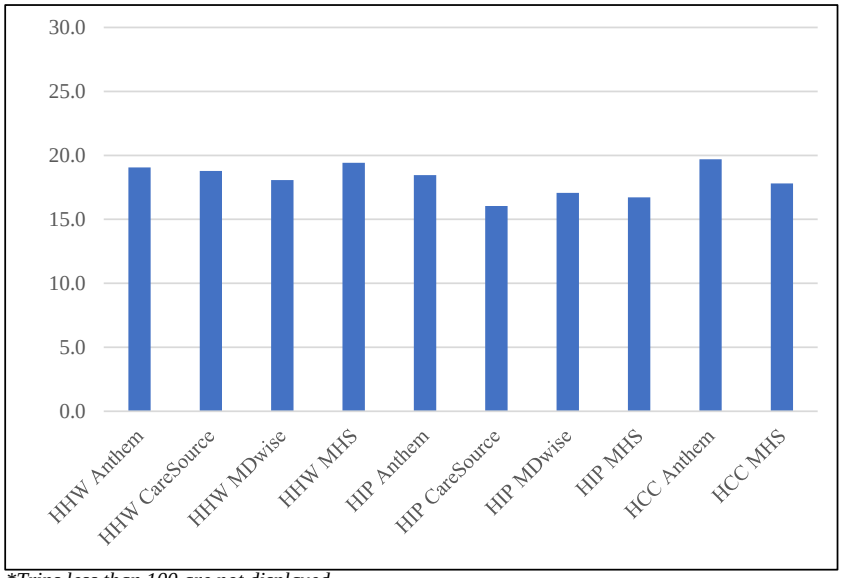


**Trips less than 10 at region level are not displayed*

Unique Trips in Study	
HHW Anthem	704
HHW CareSource	158
HHW MDwise	1,148
HHW MHS	429
HIP Anthem	2,516
HIP CareSource	393
HIP MDwise	1,439
HIP MHS	1,411
HCC Anthem	1,517
HCC MHS	965

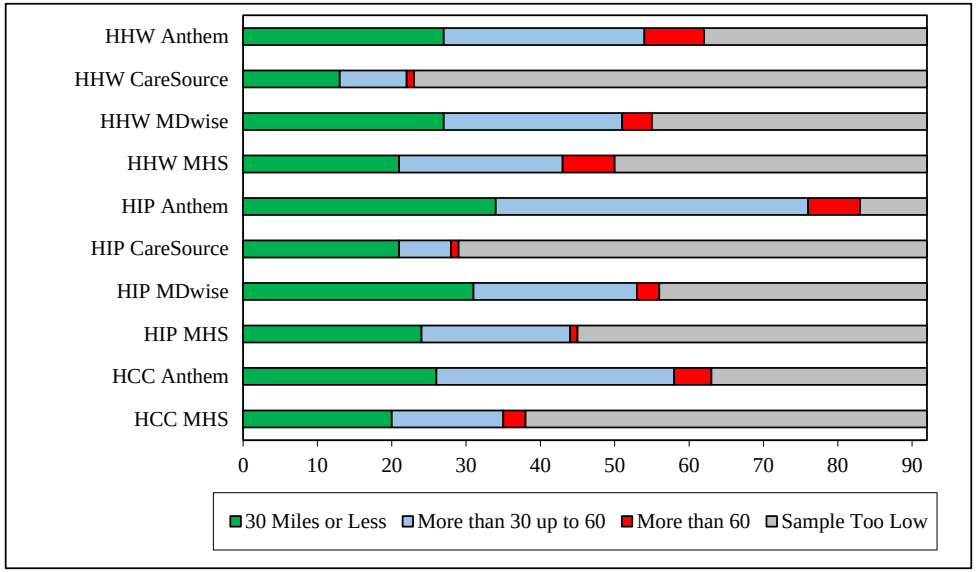
Appendix D.28
Ophthalmologists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

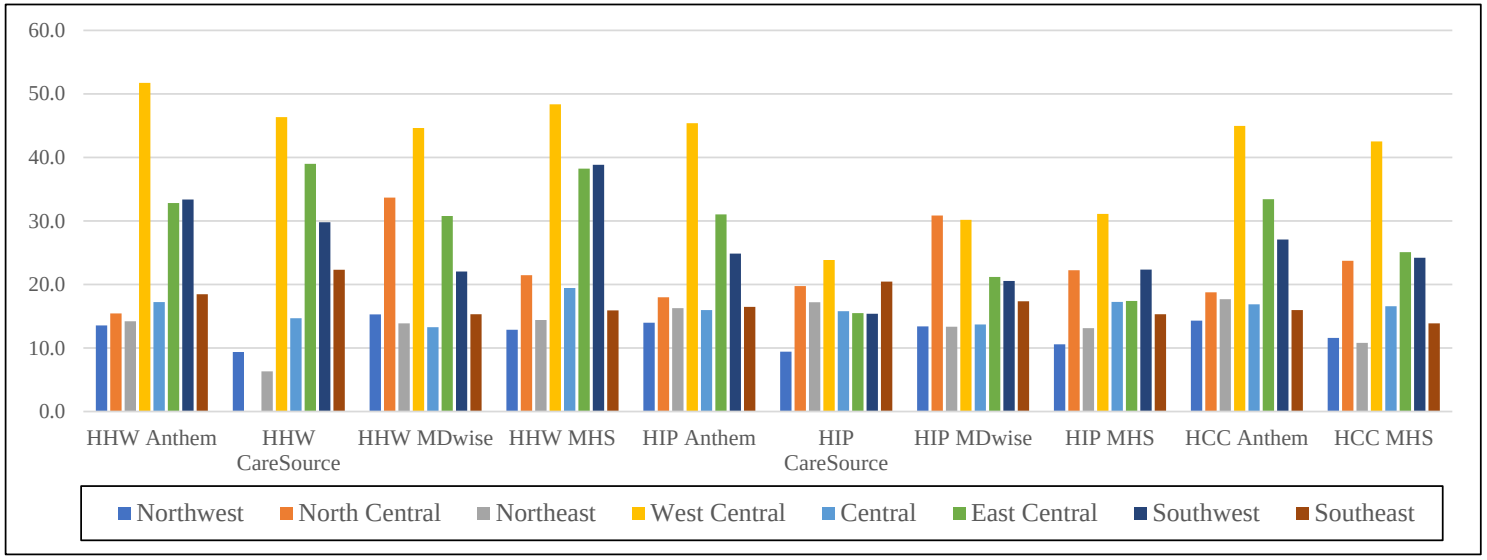


Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

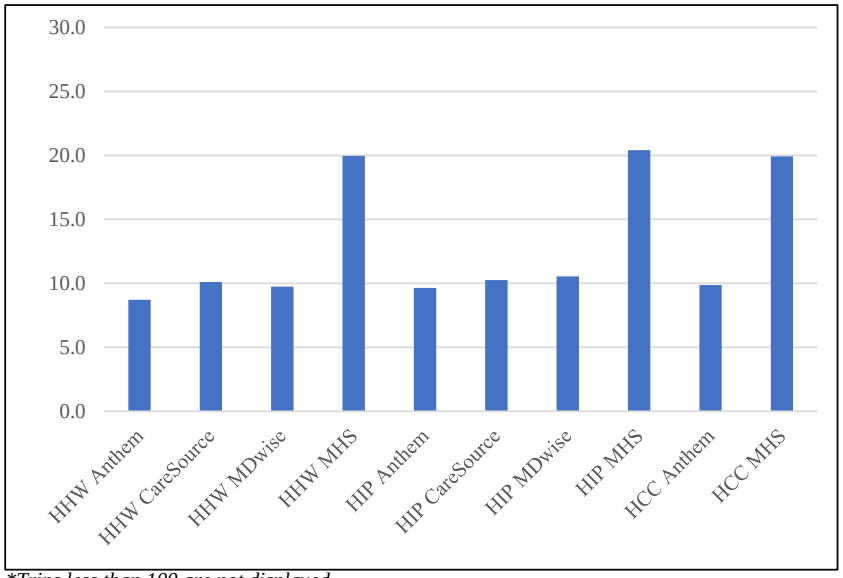


Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	8,907
HHW CareSource	1,128
HHW MDwise	5,812
HHW MHS	5,651
HIP Anthem	13,769
HIP CareSource	1,221
HIP MDwise	4,091
HIP MHS	3,447
HCC Anthem	6,961
HCC MHS	2,659

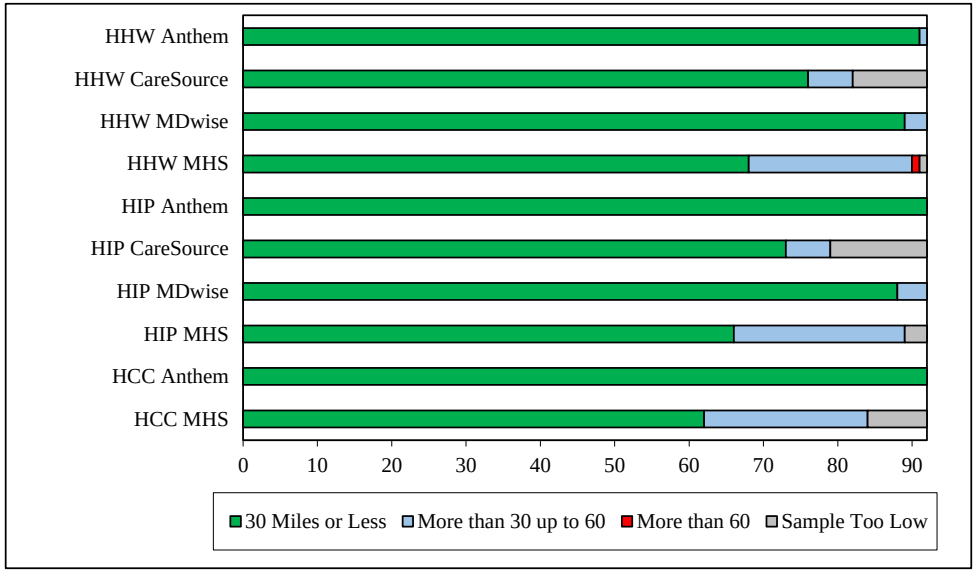
Appendix D.29
Optometrists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

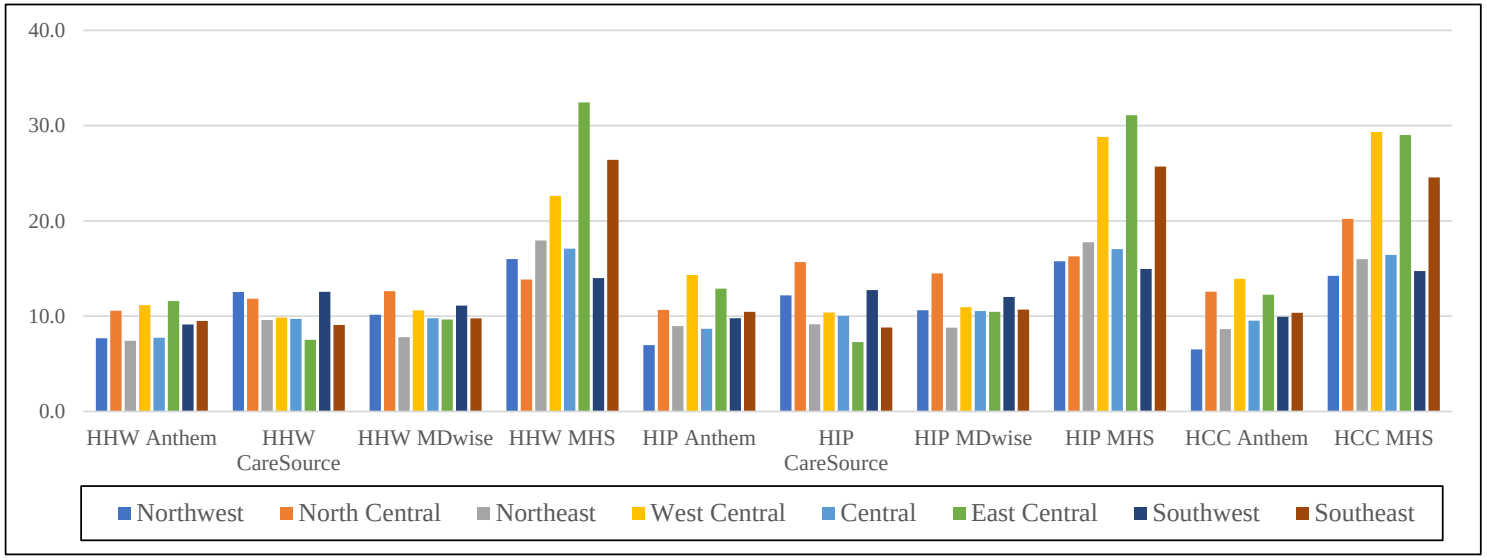


Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

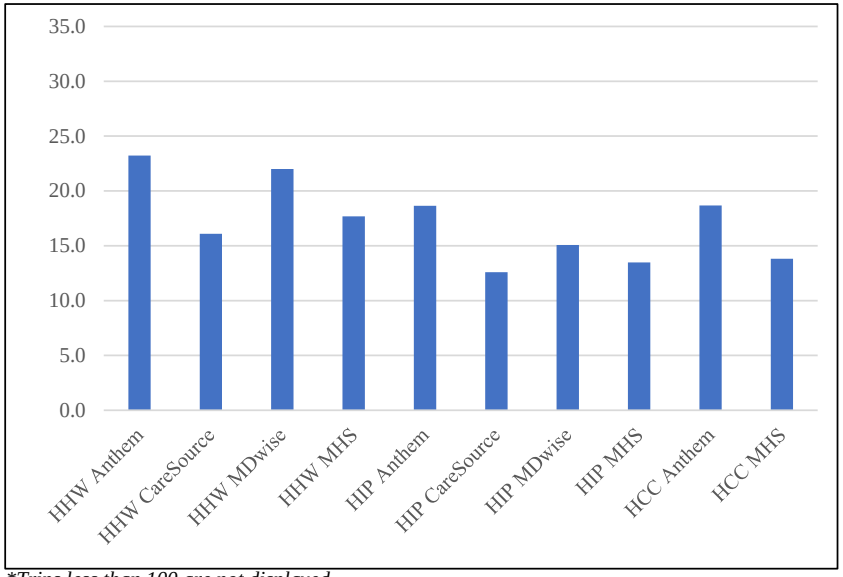


Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	39,317
HHW CareSource	6,532
HHW MDwise	36,999
HHW MHS	26,921
HIP Anthem	41,939
HIP CareSource	5,458
HIP MDwise	21,349
HIP MHS	14,196
HCC Anthem	13,685
HCC MHS	7,401

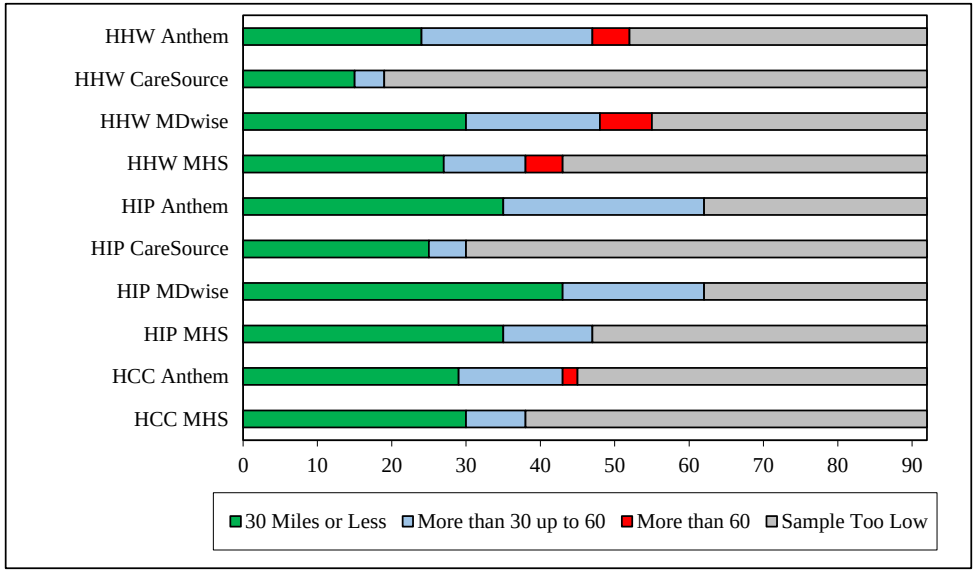
Appendix D.30
Orthopedic Surgeons Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

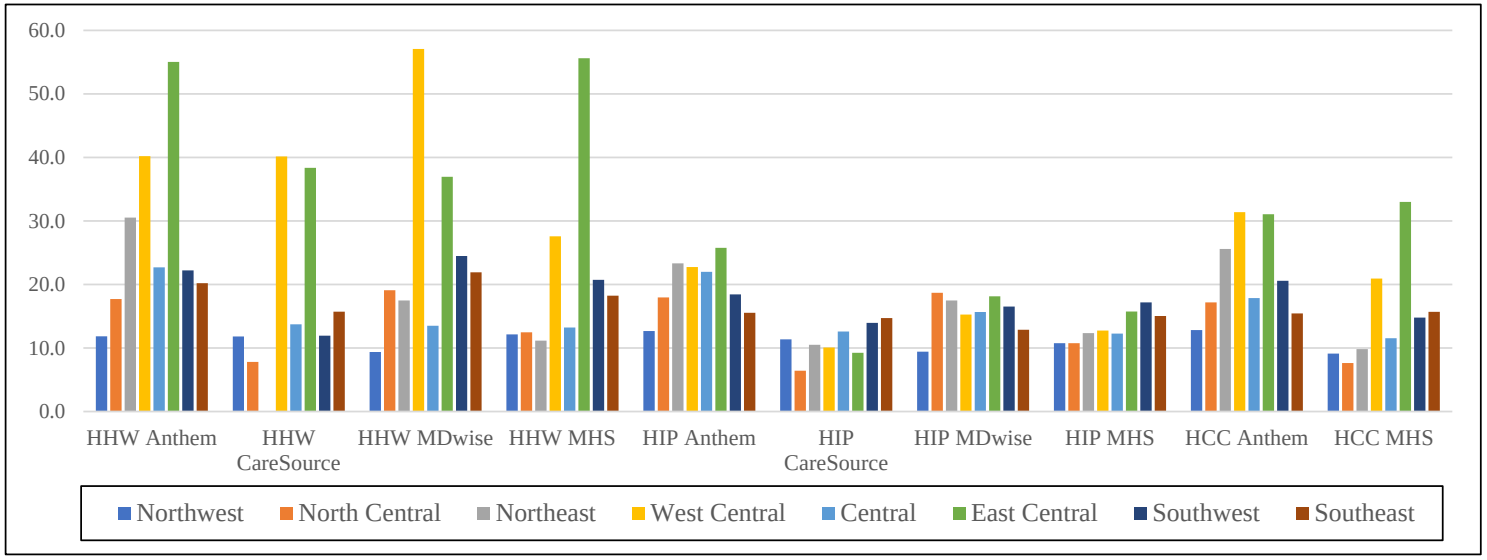


Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

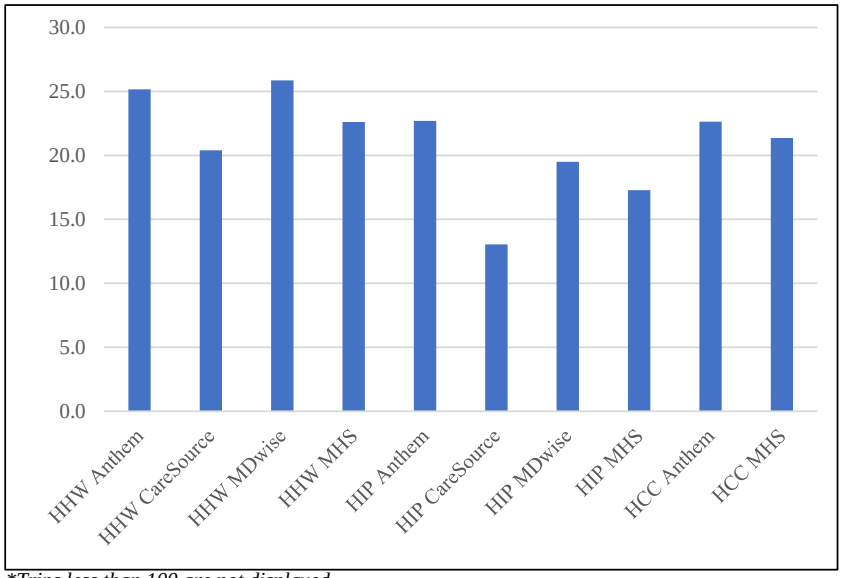


Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	2,972
HHW CareSource	713
HHW MDwise	3,000
HHW MHS	2,393
HIP Anthem	6,045
HIP CareSource	1,123
HIP MDwise	4,293
HIP MHS	2,814
HCC Anthem	2,387
HCC MHS	1,508

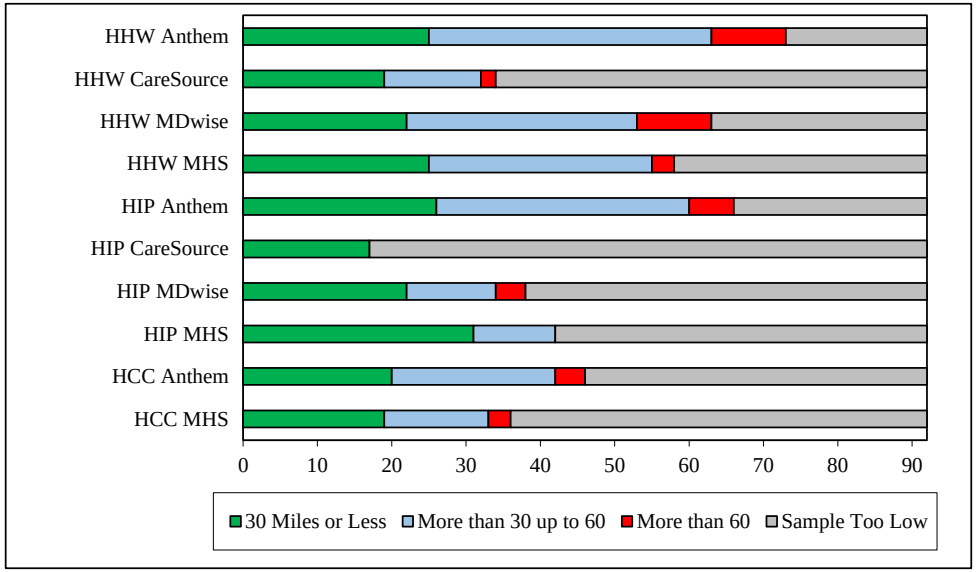
Appendix D.31
Otolaryngologists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

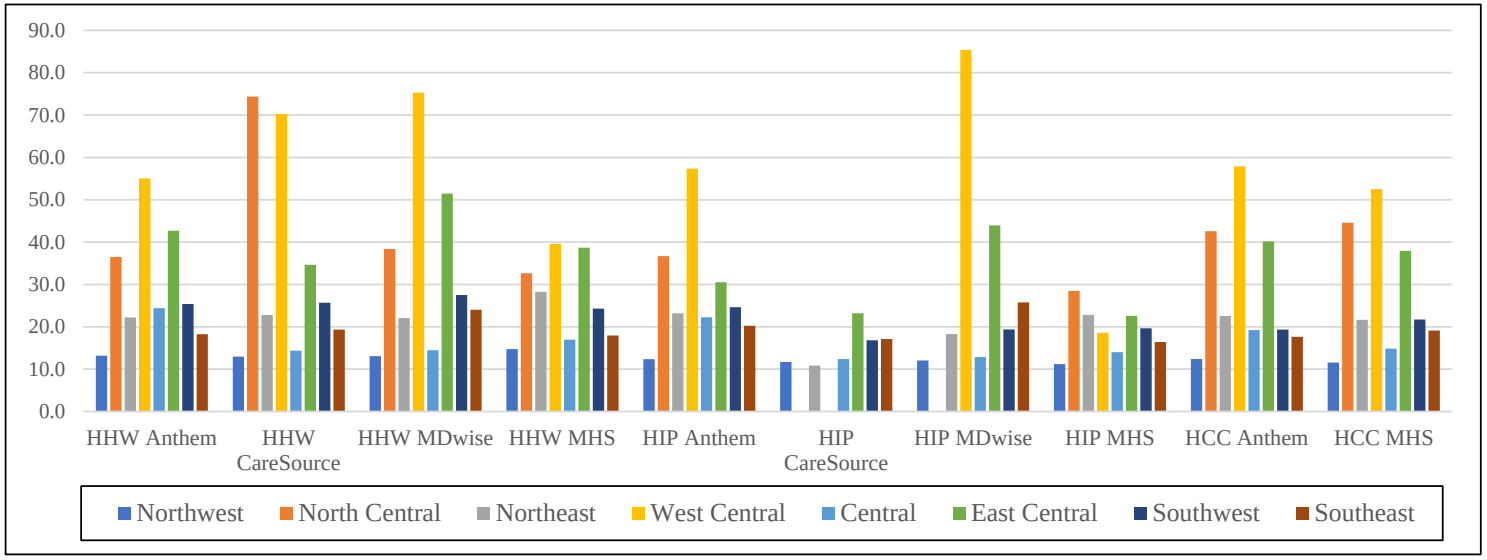


Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

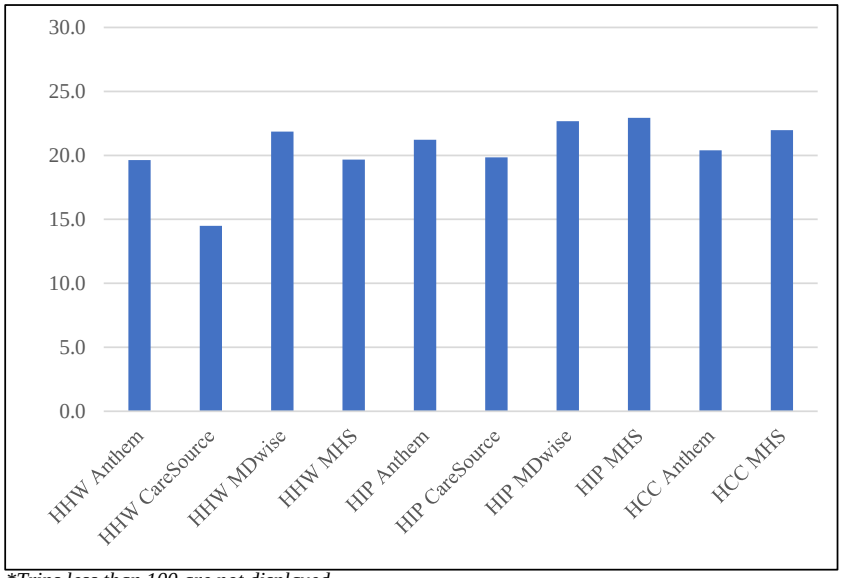


Trips less than 10 at region level are not displayed

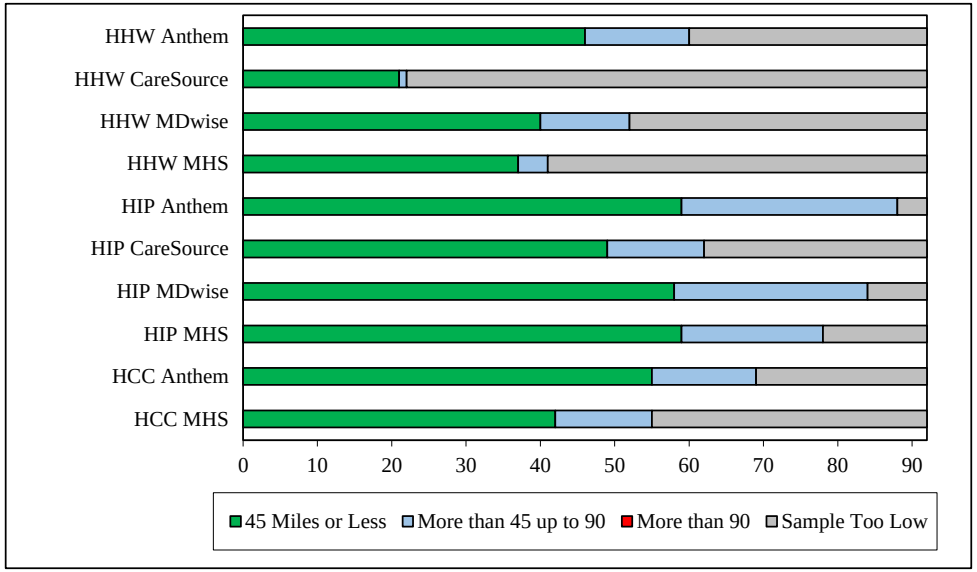
Unique Trips in Study	
HHW Anthem	7,326
HHW CareSource	1,460
HHW MDwise	4,132
HHW MHS	4,160
HIP Anthem	5,369
HIP CareSource	734
HIP MDwise	2,025
HIP MHS	1,902
HCC Anthem	2,573
HCC MHS	1,485

Appendix D.32
Pathologists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

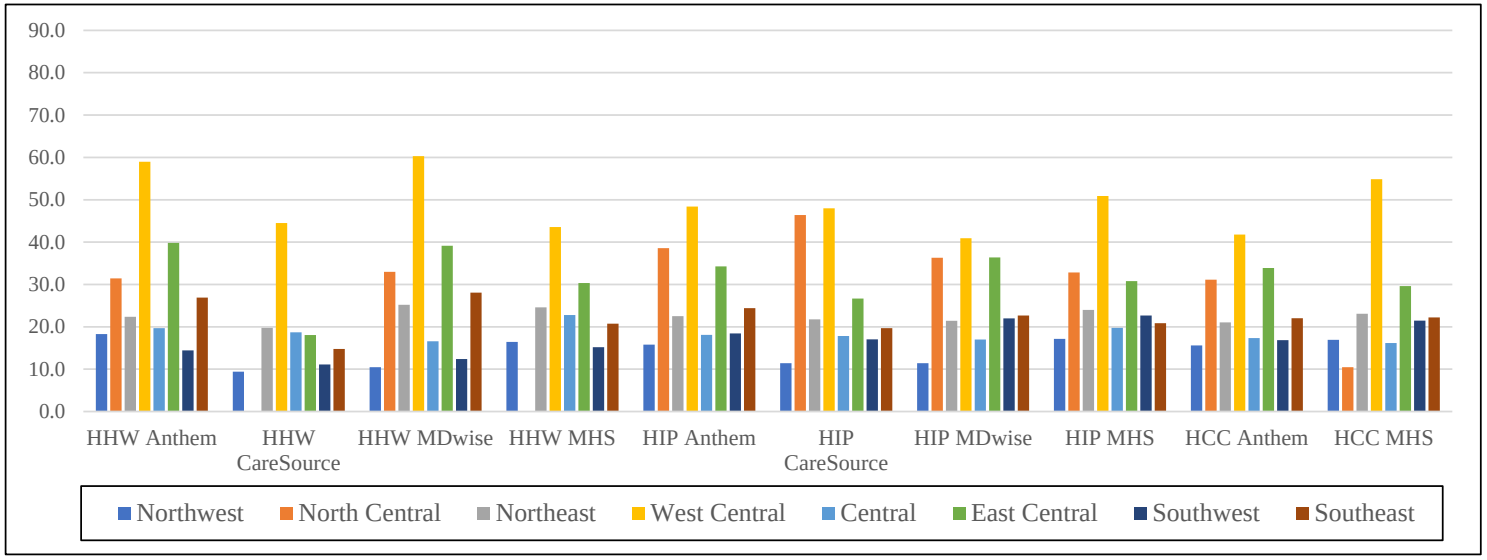


CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



**Trips less than 100 are not displayed*

Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

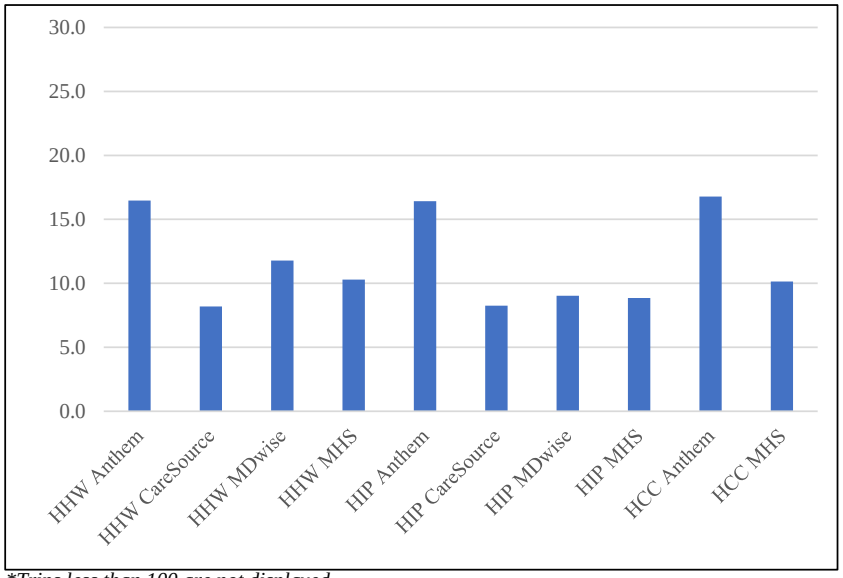


**Trips less than 10 at region level are not displayed*

Unique Trips in Study	
HHW Anthem	4,040
HHW CareSource	979
HHW MDwise	2,362
HHW MHS	2,133
HIP Anthem	19,921
HIP CareSource	3,171
HIP MDwise	9,481
HIP MHS	6,955
HCC Anthem	4,744
HCC MHS	2,554

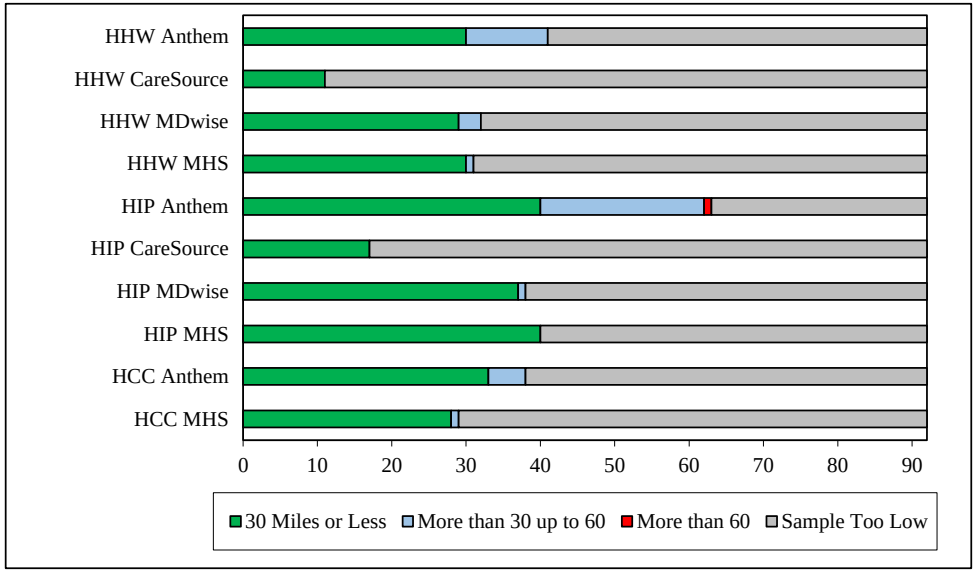
Appendix D.33
Physical Therapists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

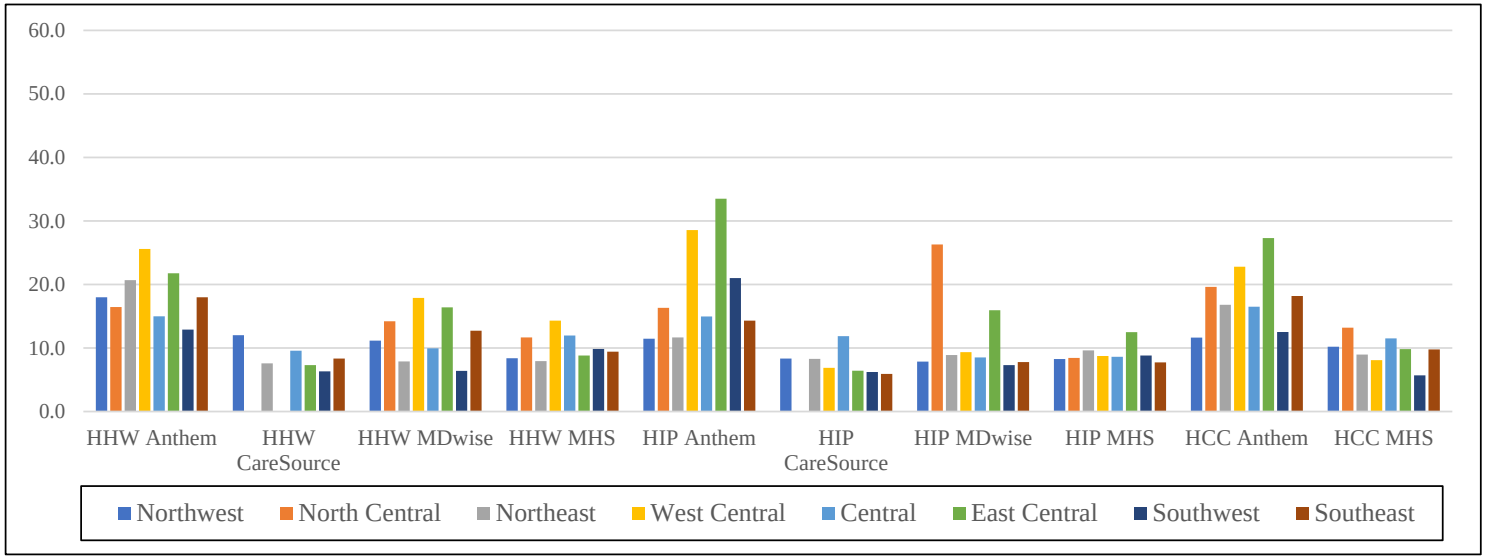


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

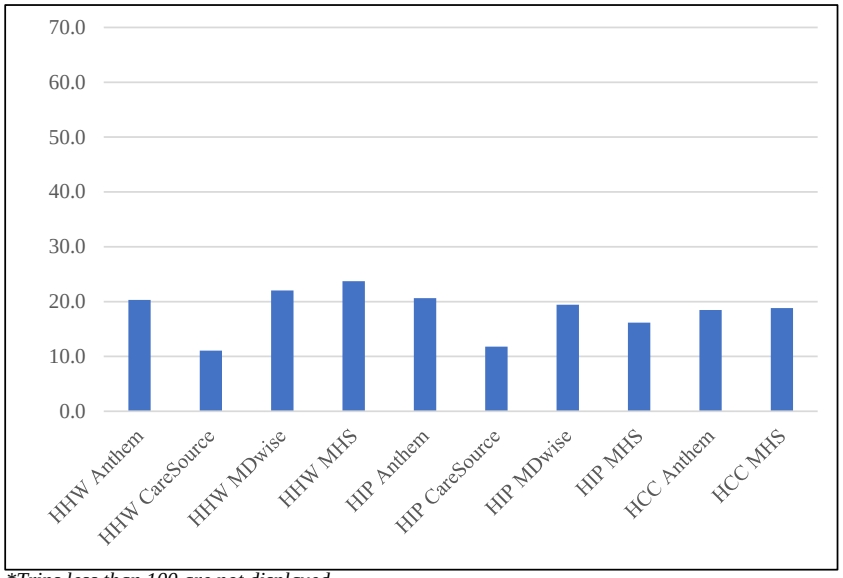


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	2,616
HHW CareSource	370
HHW MDwise	1,800
HHW MHS	1,595
HIP Anthem	6,962
HIP CareSource	652
HIP MDwise	2,392
HIP MHS	2,310
HCC Anthem	2,726
HCC MHS	1,462

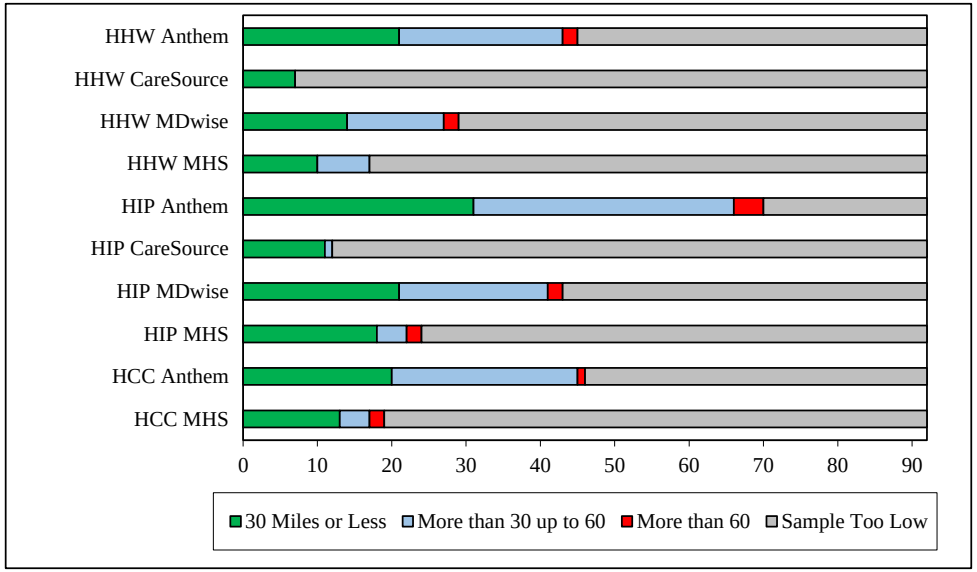
Appendix D.34
Psychiatrists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

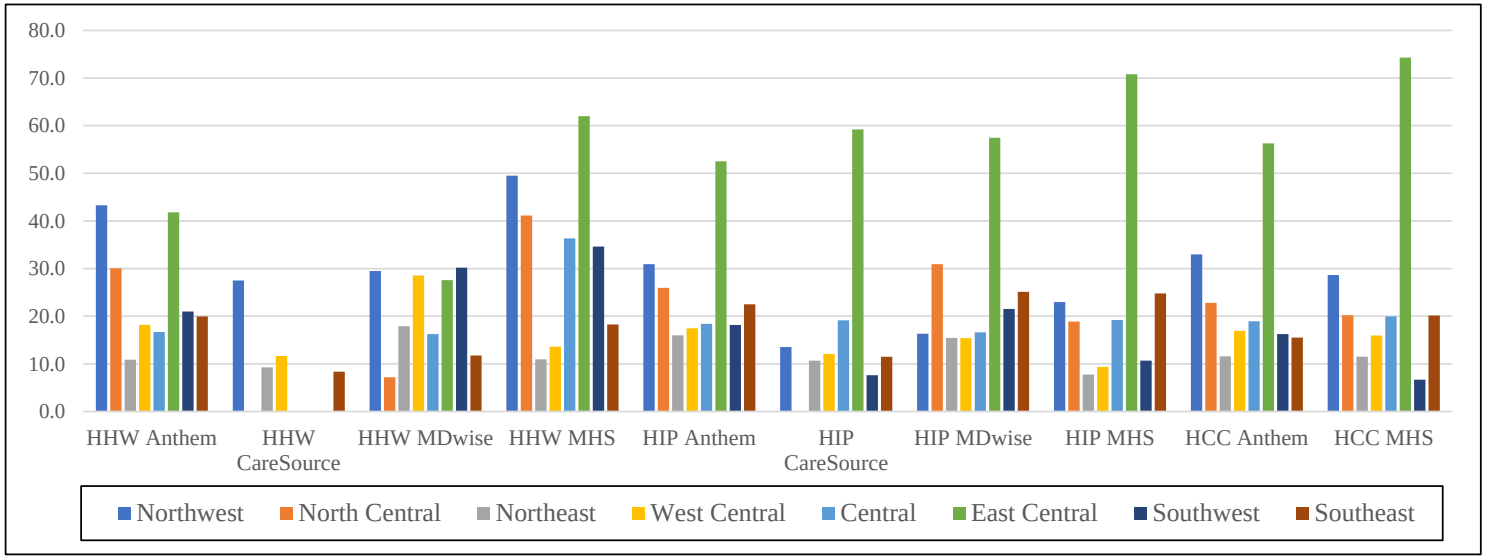


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

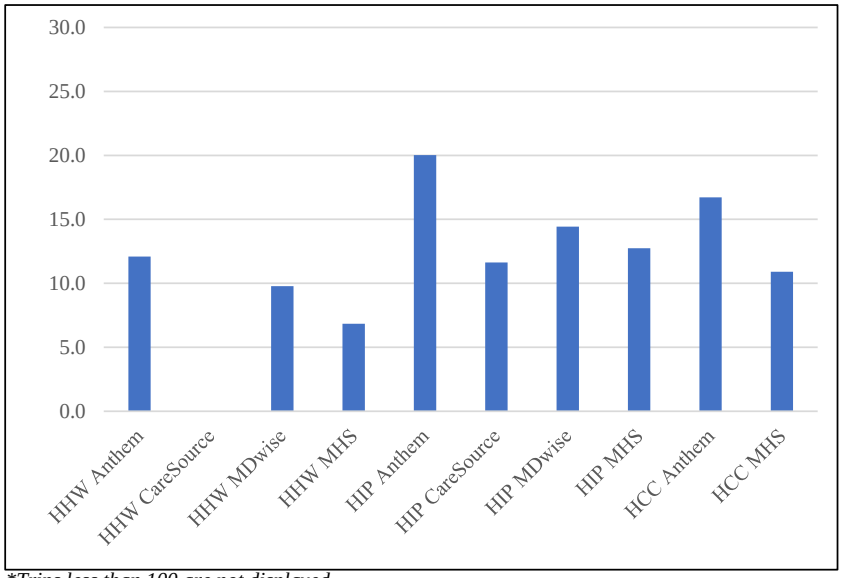


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	1,958
HHW CareSource	287
HHW MDwise	1,038
HHW MHS	644
HIP Anthem	4,975
HIP CareSource	637
HIP MDwise	2,220
HIP MHS	1,154
HCC Anthem	2,496
HCC MHS	935

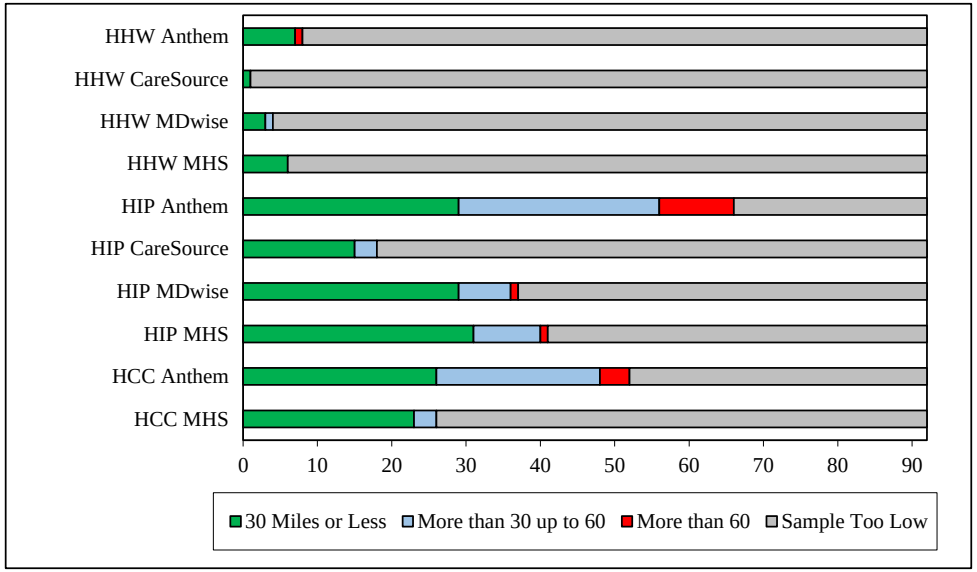
Appendix D.35
Pulmonologists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

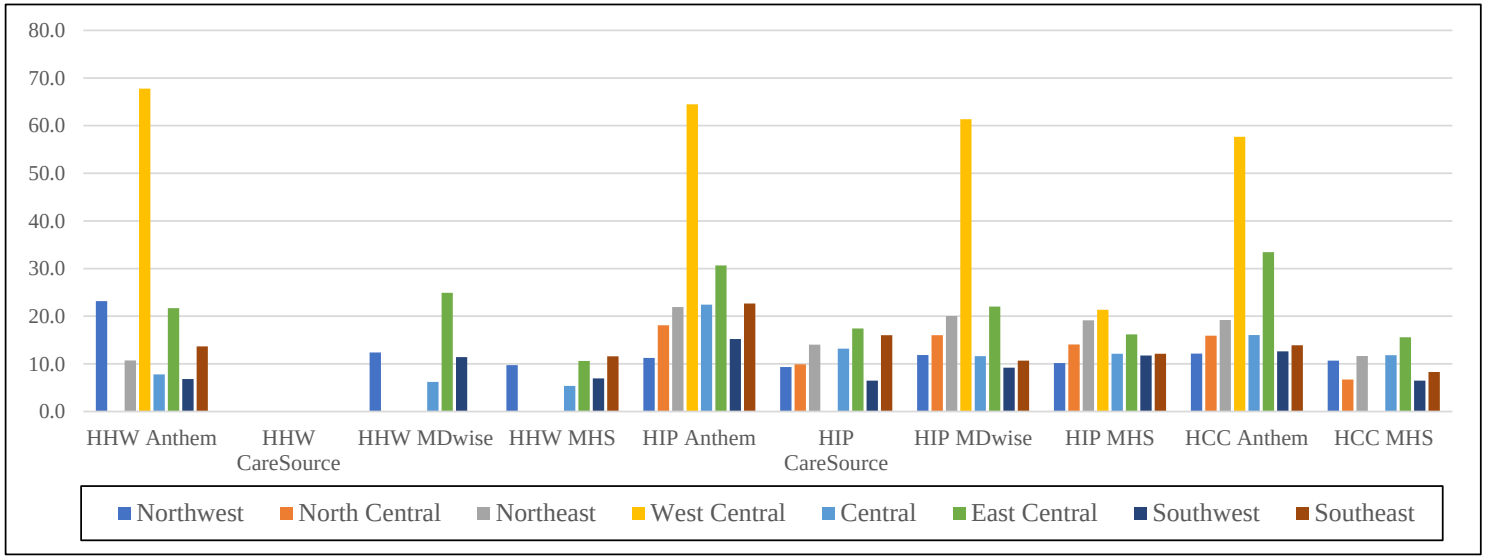


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

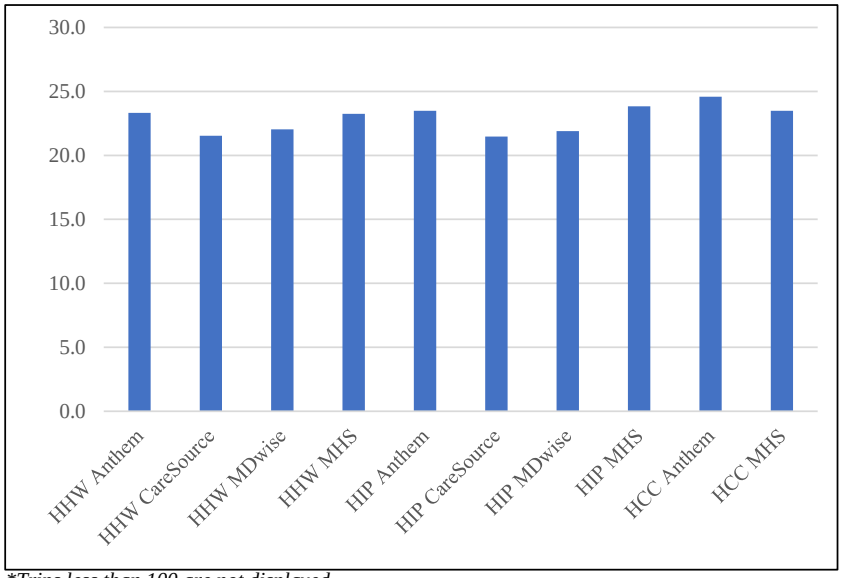


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	531
HHW CareSource	64
HHW MDwise	236
HHW MHS	288
HIP Anthem	7,578
HIP CareSource	728
HIP MDwise	2,302
HIP MHS	2,117
HCC Anthem	3,702
HCC MHS	1,432

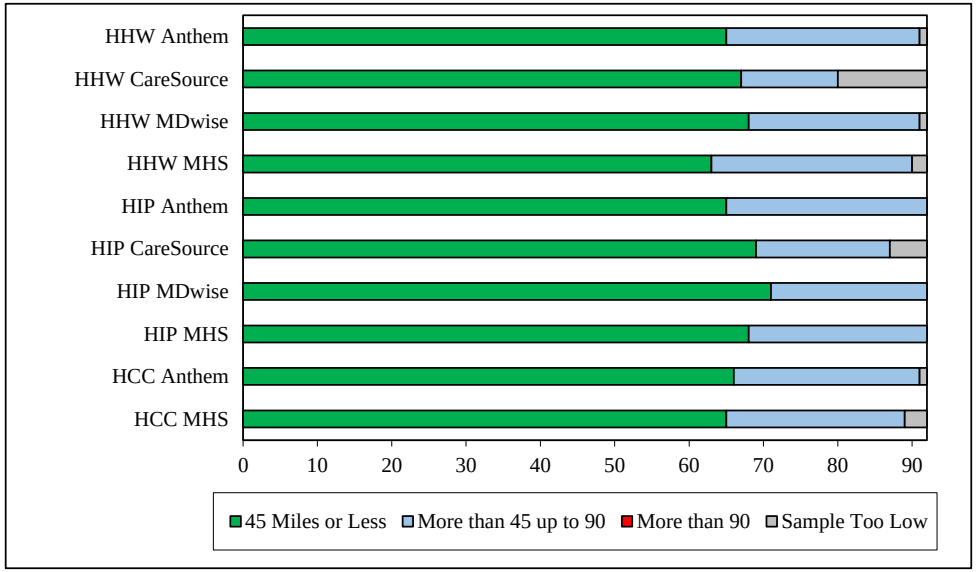
Appendix D.36
Radiologists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

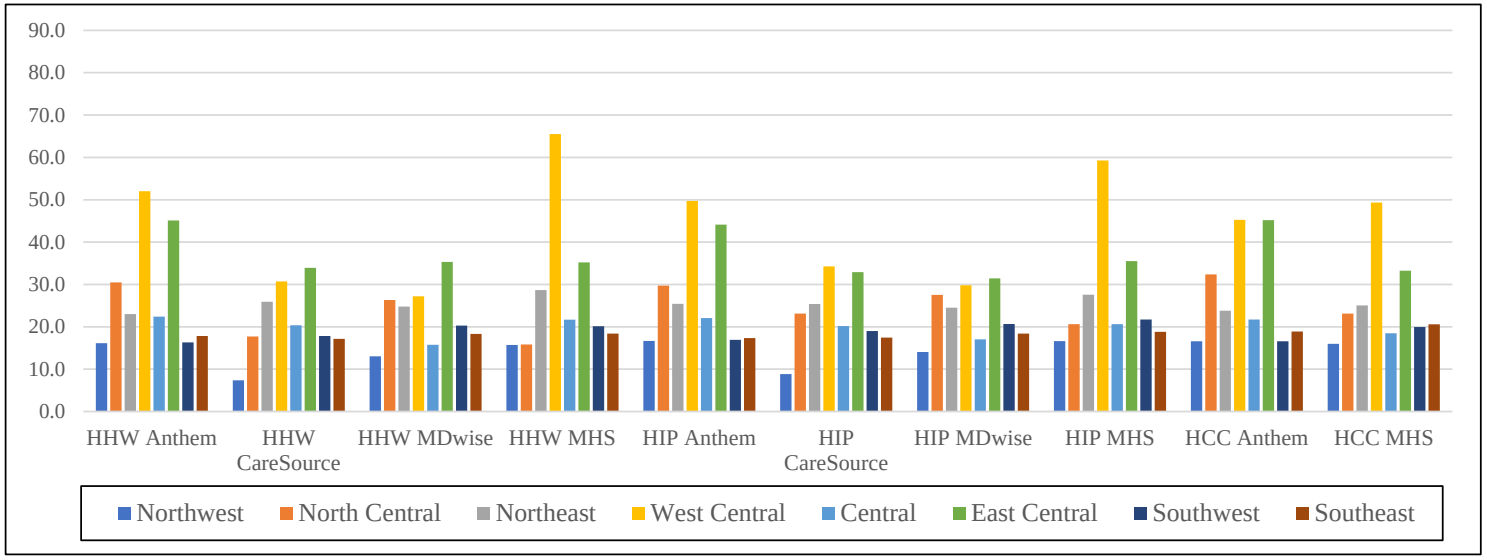


*Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

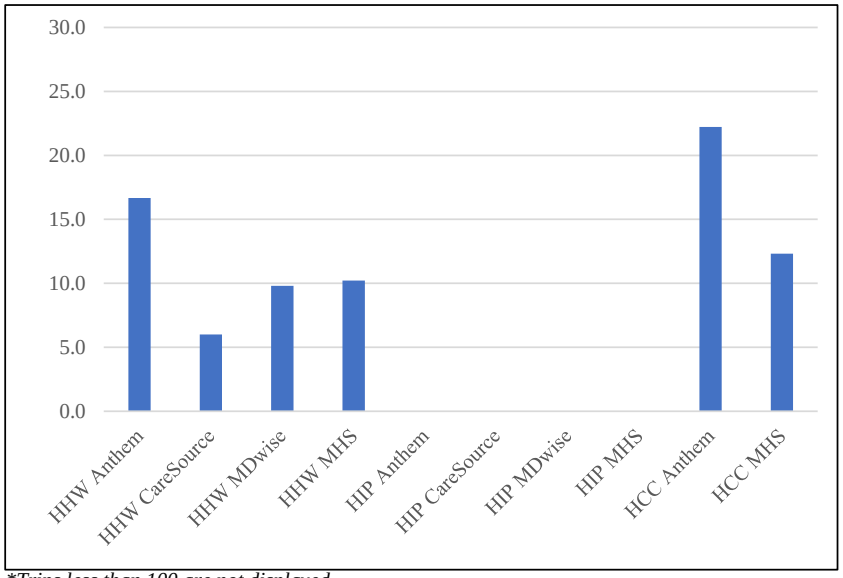


*Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	41,982
HHW CareSource	8,696
HHW MDwise	31,845
HHW MHS	29,465
HIP Anthem	101,715
HIP CareSource	15,809
HIP MDwise	47,237
HIP MHS	39,804
HCC Anthem	33,429
HCC MHS	18,118

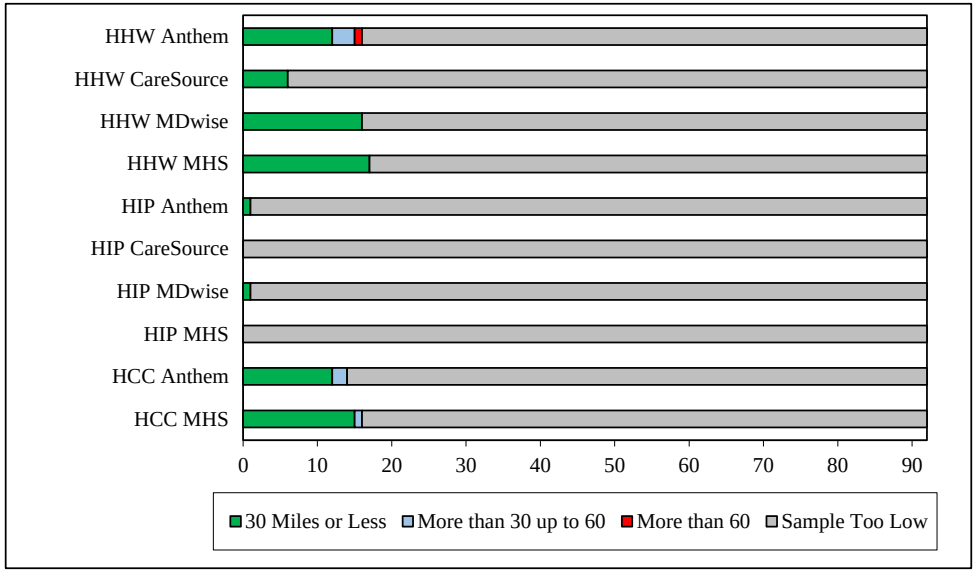
Appendix D.37
Speech Therapists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

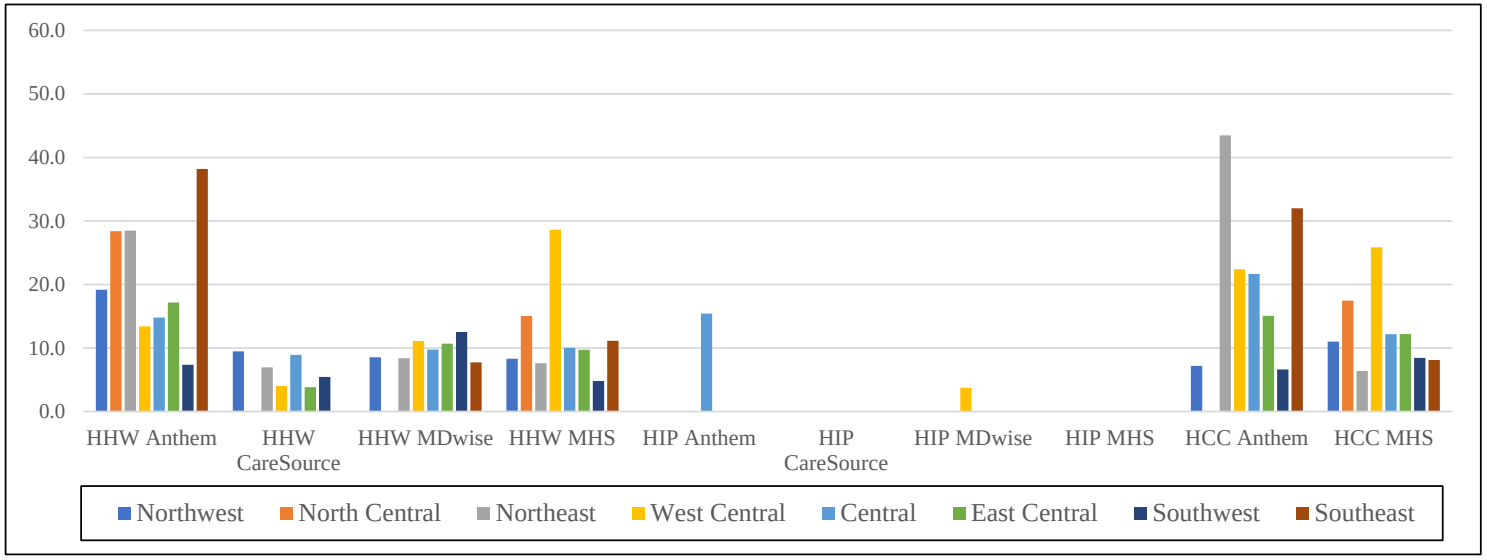


Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

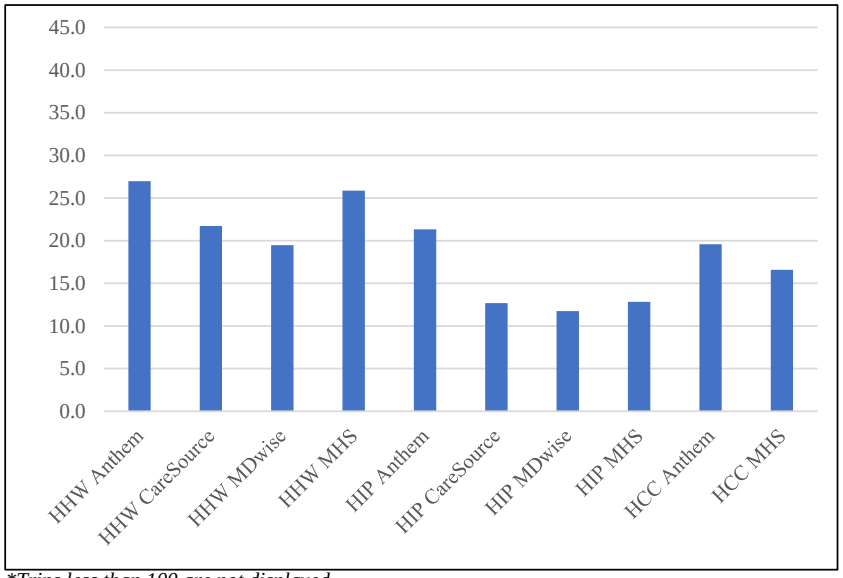


Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	1,008
HHW CareSource	222
HHW MDwise	779
HHW MHS	646
HIP Anthem	39
HIP CareSource	7
HIP MDwise	30
HIP MHS	11
HCC Anthem	697
HCC MHS	564

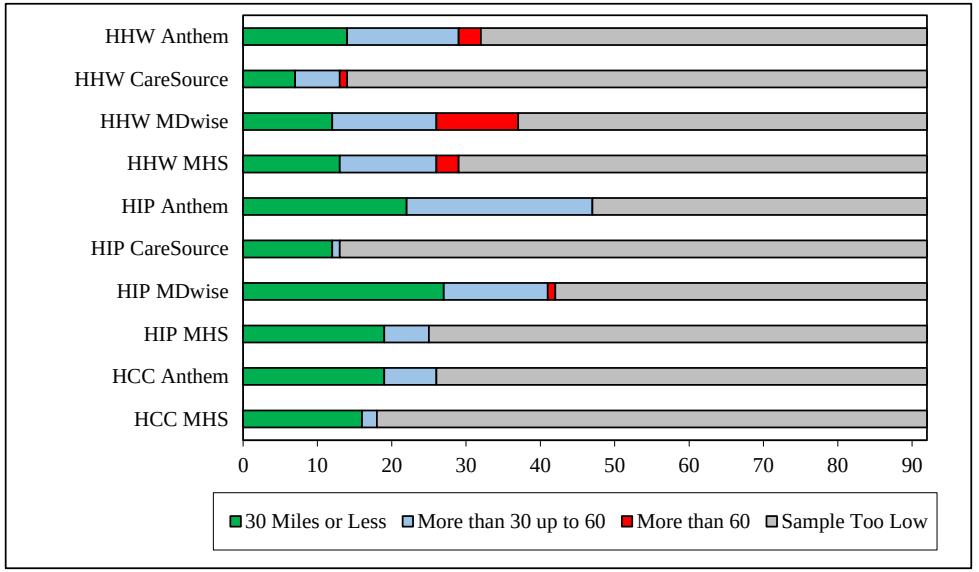
Appendix D.38
Urologists Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Average Driving Distance by Program/MCE, CY 2019 Trips

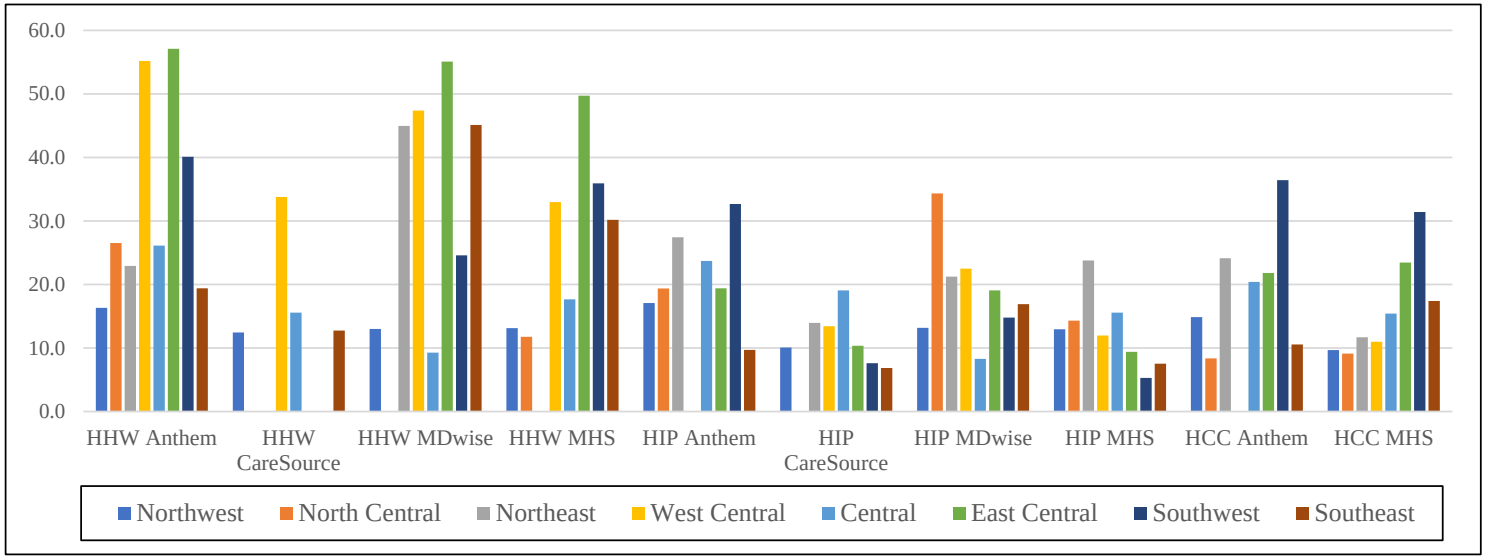


Trips less than 100 are not displayed

CY 2019 Colored Bars Plot # Counties (out of 92) in Each Distance Range



Average Driving Distance by Program/MCE at the Region Level, CY 2019 Trips

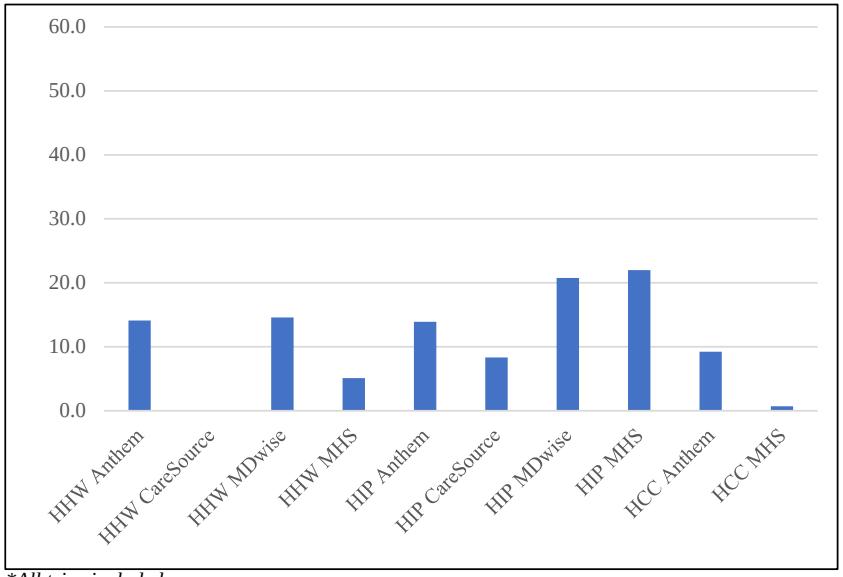


Trips less than 10 at region level are not displayed

Unique Trips in Study	
HHW Anthem	1,376
HHW CareSource	475
HHW MDwise	2,965
HHW MHS	1,006
HIP Anthem	2,497
HIP CareSource	407
HIP MDwise	4,056
HIP MHS	918
HCC Anthem	1,209
HCC MHS	658

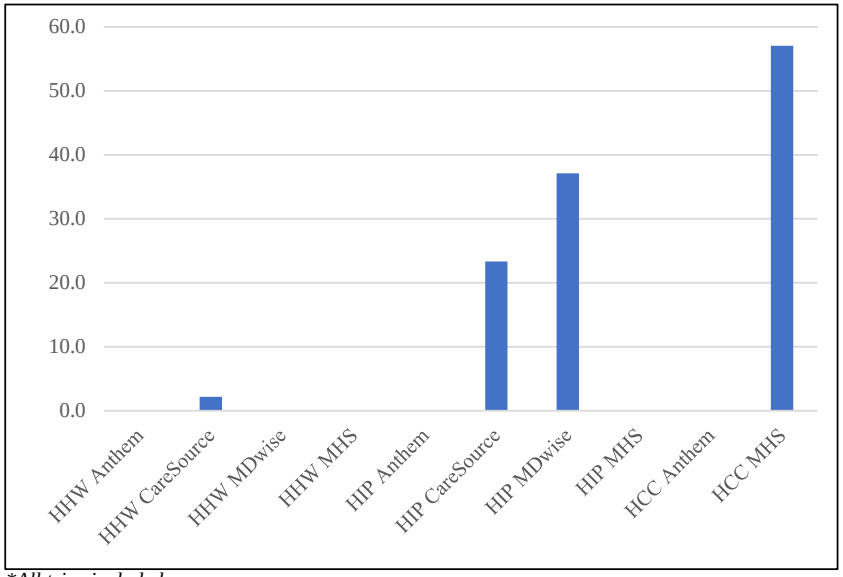
Appendix D.39
Low Volume Specialty Providers Unique Member Provider Trips
Average Driving Distance for Members, CY 2019, by MCE/Program

Endocrinologists



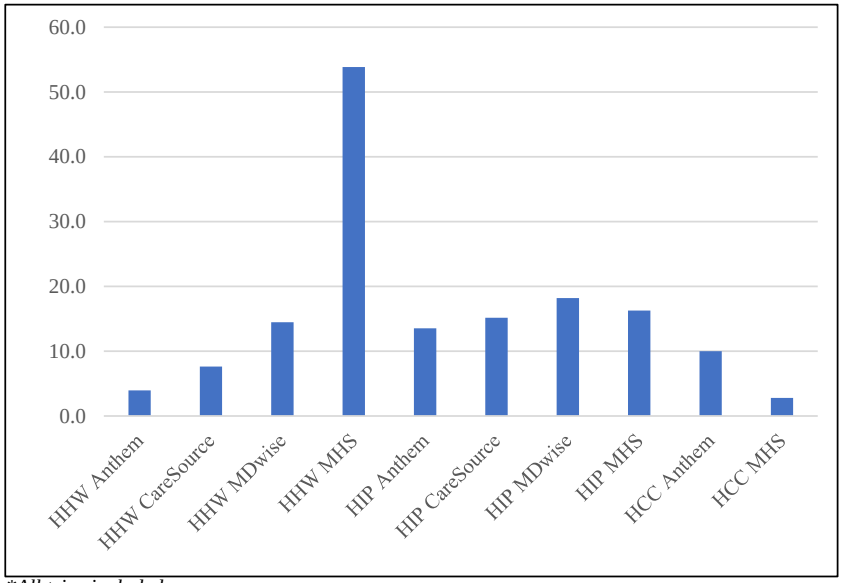
**All trips included*

Hematologists



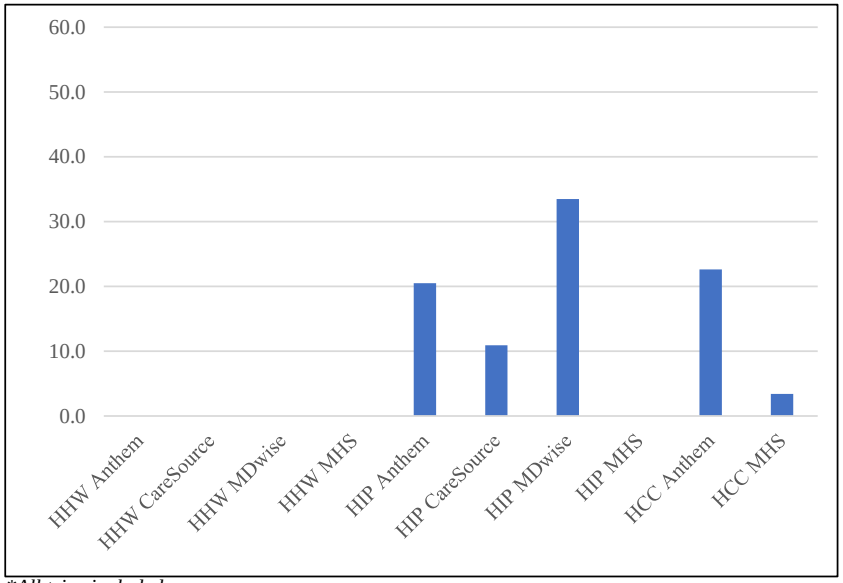
**All trips included*

Infectious Disease Specialists



**All trips included*

Rheumatologists



**All trips included*