Indiana Family and Social Services (FSSA) Office of Medicaid Policy and Planning (OMPP)

2021 Annual

External Quality Review Technical Report

Office of Medicaid Policy & Planning

Qsource

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List of Tables and Figures

Acknowledgements, Acronyms, and Initialisms[1]

AAP ..... American Academy of Pediatrics
ACA ..... Affordable Care Act
ANA ..... Annual Network Adequacy
Anthem ..... Blue Cross Blue Shield Anthem, a Managed Care Entity in Indiana
AON ..... Area of Noncompliance
CA ..... Compliance Assessment
CareSource ..... CareSource Indiana a Managed Care Entity in Indiana
CFR ..... *Code of Federal Regulations*
CHIP ..... Children's Health Insurance Program
CM ..... Case Manager
CMHC ..... Community Mental Health Center
CMS ..... Centers for Medicare & Medicaid Services
DMHA ..... Division of Mental Health and Addiction
ED ..... Emergency Department
EDI ..... Electronic Data Interchange
EPSDT ..... Early and Periodic Screening, Diagnostic and Treatment
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
ER ..... Emergency Room
FFS ..... Fee-For-Service
FORHP ..... Federal Office of Rural Health Policy
FPL ..... Federal Poverty Level
FQHC ..... Federally Qualified Health Center
FSSA ..... Indiana Family and Social Services Administration
FUA ..... Follow-up After Emergency Department Visit for Drug Abuse or Dependence
FUH ..... Follow-up After Hospitalization for Mental Illness
HCC ..... Hoosier Care Connect
HEDIS® ..... Healthcare Effectiveness Data and Information Set, a registered trademark of the NCQA
HHS ..... U.S. Department of Health and Human Services
HIP ..... Healthy Indiana Plan
HHW ..... Hoosier Healthwise
HNS ..... Health Needs Screening
IDOH ..... Indiana Department of Health
IHCP ..... Indiana Health Coverage Programs
IHIE ..... Indiana Health Information Exchange
IMD ..... Institution for Mental Disease
IOP ..... Intensive Outpatient
IS ..... Information System(s)
ISCA ..... Information Systems Capability Assessment
ISCAT ..... Information Systems Capability Assessment Tool

[1] *Other company and product names may be trademarks of the respective companies with which they are associated. The mention of such companies and product names is with due recognition and without intent to misappropriate such names or marks.*

IT .....Information Technology
MCE.....Managed Care Entity
MDwise ..... Managed Care Entity in Indiana
MHS..... Managed Health Services, a Managed Care Entity in Indiana
MMR .....Measles Mumps Rubella
MOU .....Memorandum of Understanding
MRO .....Medication Rehabilitation Option
MY .....Measurement Year
N .....No/Number
NA.....Not Applicable (CA)
NA..... Not Applicable: Denominator Too Small (PMV)
NA.....Not Assessed (PIP)
NB..... No Benefit (PMV)
NCQA ..... National Committee for Quality Assurance
NCQA HEDIS Compliance Audit™.....a trademark of NCQA
NQ .....Not Required (PMV)
NQF.....National Quality Forum
NR .....Not Reported (PMV)
OMPP ..... Office of Medicaid Policy and Planning
OTP .....Opiate Treatment Program
P&P.....Policy and Procedure
PCP..... Primary Care Provider/Physician
PDSA .....Plan Do Study Act
PHP..... Partial Hospitalization
PIP .....Performance Improvement Project
PMP .....Primary Medical Provider
PMV .....Performance Measure Validation
PPC..... Postpartum Timeliness
PRS.....Peer Recovery Specialist
QAPI .....Quality Assessment and Performance Improvement
QDM..... Quality Data Management
QIP.....Quality Improvement Project
Qsource®..... EQRO, a registered trademark
SOF..... State Operated Facility
SMI.....Severe Mental Illness
SQL.....Structured Query Language
SUD .....Substance Use Disorder
UB .....Uniform Bill
UM ..... Utilization Management
W15..... Well Child Visits During the First 15 Months

Overview

In accordance with Title 42 *Code of Federal Regulations* (CFR) § 438.364, Qsource has produced this *2021 Annual EQRO Technical Report* to summarize the quality, timeliness, and accessibility of care furnished to enrollees in the Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) program by the managed care entities (MCEs). Indiana's MCEs include Anthem Blue Cross and Blue Shield (Anthem), CareSource Indiana (CareSource), MDwise, and Managed Health Services (MHS).

OMPP contracted with Qsource to conduct external quality review (EQR) activities and ensure that the results of those activities are reviewed to perform an external, independent assessment and produce an annual report. Qsource serves as OMPP's external quality review organization (EQRO) and prepared this *2021 Annual EQRO Technical Report* to document the Indiana Health Coverage Programs' MCE performance in providing services to enrollees and to identify areas for improvement and recommend interventions to improve the process and outcomes of care. This section provides a brief history of OMPP, the organization's strategy for the Indiana Health Coverage Programs, EQR activities conducted in 2021, the guidelines for this report, and intended uses for this report.

Office of Medicaid Policy & Planning Background

The Indiana Family and Social Services Administration is the single state agency responsible for administering Medicaid programs. Per the U.S. Census Bureau, the population of Indiana in 2021 was 6.805 million. Per FSSA's Data and Analytics unit, the Medicaid enrollment in December 2021 was 1,971,017, of which 1,643,811 were in managed care. OMPP's programs, called the Indiana Health Coverage Programs (IHCPs), includes three risk-based managed care programs and each services a specific population.

- **Healthy Indiana Plan** (HIP) was created in January 2008 under a separate Section 1115 waiver authority. 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 to a non-traditional Medicaid model (the updated 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 under 138% of the Federal Poverty Level (FPL) between the ages of 19 and 64. The Healthy Indiana Plan 2.0 program began February 1, 2015.
- **Hoosier Care Connect** (HCC) provides health coverage for nearly 90,000 aged, blind, and disabled members who are not dually eligible for Medicare. The program was implemented April 1, 2015, under a 1915(b) waiver authority. The HCC is a risk-based program that contracts with MCEs to administer and to deliver services to

members. The HCC replaced a predecessor program, Care Select, which ended June 30, 2015. The program also covers many of Indiana's foster children.

- **Hoosier Healthwise** (HHW), which includes Indiana's CHIP population, serves approximately 600,000 children and pregnant women. The program began in 1994 with members having the option to voluntarily enroll with an MCE in 1996. By 2005, enrollment with an MCE was mandatory for select populations, namely, low-income families, pregnant women, and children. Most enrollees in Indiana's Children's Health Insurance Program (CHIP), which covers children in families up to 250% of the FPL, are also enrolled in HHW. This program is authorized by a 1932(a) state plan amendment.

Enrollees

As a result of the Affordable Care Act (ACA) Medicaid expansion, Indiana's Medicaid and CHIP enrollment grew significantly from 2013 through 2020, going from 1,120,674 enrollees to 1,872,110 enrollees as of June 2021. And nearly 700,000 of those enrollees have Medicaid coverage because of the expanded eligibility guidelines implemented by the ACA and the state's HIP 2.0 waiver.

Total enrollees grew steadily throughout 2020 for all three IHCPs. HIP had the largest growth with 193,501 enrollees, HHW coming in second with 111,158 and HCC grew by 7,127.

Table 1 presents the IHCP enrollment for 2020 by month.

Table 1. Total IHCP Enrollees by Month												
	Jan-20	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**
Healthy Indiana Plan												
Anthem	183,517	183,847	199,598	211,032	221,288	231,438	239,719	247,900	256,064	264,654	272,361	279,983
CareSource	36,371	36,726	39,366	41,797	43,923	46,050	47,901	49,486	51,002	52,877	55,062	57,416
MDwise	101,224	101,205	106,578	111,893	116,507	120,941	124,495	127,924	131,321	134,976	138,494	142,298
MHS	72,337	72,656	77,259	81,351	85,021	88,603	91,694	94,529	97,350	100,731	103,855	107,253
Total	**393,449**	**394,434**	**422,801**	**446,073**	**466,739**	**487,032**	**503,809**	**519,839**	**535,737**	**553,238**	**569,772**	**586,950**
Hoosier Care Connect												
Anthem	54,238	54,412	54,651	55,212	55,948	56,569	56,960	57,232	57,252	57,725	58,291	58,786
MHS	32,737	32,902	32,965	33,311	33,809	34,285	34,439	34,549	34,619	34,867	35,128	35,316
Total	**86,975**	**87,314**	**87,616**	**88,523**	**89,757**	**90,854**	**91,399**	**91,781**	**91,871**	**92,592**	**93,419**	**94,102**
Hoosier Healthwise												
Anthem	221,520	224,022	225,476	232,361	238,089	244,261	249,093	253,181	257,590	262,854	267,027	271,912
CareSource	51,479	51,931	51,920	53,365	54,705	56,162	57,277	58,213	59,255	60,577	61,812	63,434
MDwise	187,741	188,432	188,359	192,123	195,176	198,306	200,923	203,001	205,139	208,009	210,324	212,889
MHS	140,804	141,828	142,442	145,501	148,170	151,002	153,293	155,139	157,115	159,629	161,835	164,467
Total	**601,544**	**606,213**	**608,197**	**623,350**	**636,140**	**649,731**	**660,586**	**669,534**	**679,099**	**691,069**	**700,998**	**712,702**

Table 2 presents the IHCP enrollees by age group.

Table 2. IHCP Enrollees Age Group at December 2020					
	0-18	**19-30**	**31-50**	**51-65**	**Over 65**
Healthy Indiana Plan					
Anthem	2	93,306	132,379	54,225	71
CareSource	0	21,313	26,026	10,064	13
MDwise	2	52,738	65,726	23,798	34
MHS	2	39,784	48,282	19,163	22
Total	**6**	**207,141**	**272,413**	**107,250**	**140**
Hoosier Care Connect					
Anthem	17,815	7,474	12,360	18,273	2,864
MHS	13,723	4,733	6,790	8,519	1,551
Total	**31,538**	**12,207**	**19,150**	**26,792**	**4,415**
Hoosier Healthwise					
Anthem	260,827	10,096	989	0	0
CareSource	60,682	2,440	311	1	0
MDwise	204,502	7,810	576	1	0
MHS	157,786	6,156	525	0	0
Total	**683,797**	**26,502**	**2,401**	**2**	**0**

OMPP Quality Strategy Overview

Under regulations at 42 CFR 438.340(a) and 42 CFR 457.1240(e), CMS requires state Medicaid agencies that contract with MCEs to develop and maintain a Medicaid quality strategy to assess and improve the quality of health care and services provided by MCEs. Indiana's quality strategies provide a road map for how to achieve population health and health delivery excellence.

In its 2020 Plan, Indiana outlined specific quality initiatives for the HHW, HIP and HCC programs. The initiatives outlined global aims that the OMPP has identified that support the objectives for all its programs. These are:

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

OMPP Strategic Objectives for Quality Improvement

The development of the HHW, HIP, and HCC quality strategy initiatives is based on identified trends in health care issues within the state of Indiana, attainment of the current quality strategy goals, close monitoring by OMPP of the managed care entities' performance and unmet objectives, and opportunities for improvement identified in the external quality review.

While each MCE has identified quality improvements for 2020, there are several initiatives in place that encompass all Medicaid programs. The initiatives are at the forefront of planning and implementation of this Quality Strategy. Ongoing monitoring will provide OMPP with quality-related data for future monitoring and planning.

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 quarterly updates to OMPP regarding the quality improvement projects that were identified in their annual work plan. The Quality Strategy Committee is informed of the updates by the MCEs.

Tables 3 - 5 present the strategic initiatives for each IHCP.

Table 3. Hoosier Healthwise Quality Strategy Initiatives		
Measure	**Methodology**	**Goal**
Improvements in Children and Adolescents Well-Care Percentage of members with well-child visits during first 21 years of life. HEDIS measures, well-child visits in the first 30 months of life and child and adolescent well-care visits for ages 3-21, using hybrid data.	OMPP utilizes HEDIS measures for tracking the percentages of well-child services in children and adolescents.	Achieve at or above the 90th percentile of the NCQA 2022 Quality Compass improvements in children and adolescent well-child W30 and WCV HEDIS measures.
Early Periodic Screening, Diagnosis and Treatment	OMPP utilizes HEDIS measures for tracking the percentages. OMPP is aligning its EPSDT program requirements with the American Academy of Pediatrics Bright Futures guidelines. OMPP anticipates the contracted health plans will provide follow-up and outreach to providers about the Bright Futures guidelines and provider toolkits.	OMPP monitors EPSDT compliance through MCE reporting of HEDIS prevention and screening, access/availability of care and utilization measures specific to children and adolescents. OMPP verifies compliance through the inclusion of several of these HEDIS measures as part of our HHW pay for outcomes program including well child visits (W30, WCV and CIS), annual dental visits and lead screening for children.
Completion of Health Needs Screen	Administrative reporting.	Achieve at or above the 60% for all new members completing the health needs screening within 90 days of enrollment.
Annual Dental Visit	OMPP utilizes HEDIS for tracking the percentage of members, aged 2-20 years, who had at least one dental visit during the measurement year.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for member dental visits during the measurement year.
Lead Screening in Children	OMPP utilizes HEDIS for tracking the percentage of children 2 years of age who had one or more capillary or venous blood lead tests for lead poisoning by their second birthday.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for lead screening in children.
Asthma Medication Ratio	OMPP utilizes HEDIS for tracking the percentage of children aged 5-11 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater.	Achieve at or above the 90th percentile of the NCQA 2022 Quality Compass for asthma medication ratio.
Timeliness of Ongoing Prenatal Care (HEDIS)	OMPP utilizes HEDIS for tracking the percentage of women receiving timeliness of ongoing prenatal care.	Achieve at or above the 50th percentile of the NCQA 2022 Quality Compass for timeliness of prenatal care.

Table 3. Hoosier Healthwise Quality Strategy Initiatives		
Measure	**Methodology**	**Goal**
Prenatal Depression Screening in Pregnant Women	OMPP utilizes HEDIS for tracking the percentage of women receiving prenatal depression screening in pregnant women	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for prenatal depression screening.

Table 4. Healthy Indiana Plan Quality Strategy Initiatives		
Measure	**Methodology**	**Goal**
Access to Care HIP members shall have access to primary care within a maximum of 30 miles of the member's residence and at least two providers of each specialty type within 60 miles of member's residence.	The MCE must ensure that each member has an ongoing source of primary care appropriate to the member's needs. Data is collected through administrative data.	90% of all HIP members shall have access to primary care within a minimum of 30 miles of member's residence and at least two providers of each specialty type within 60 miles of member's residence.
Access to Care HIP members shall have access to dental care within a maximum of 30 miles of the member's residence and vision care within a maximum of 60 miles of the member's residence.	The MCE must ensure that each member has an ongoing source of dental and vision care appropriate to the member's needs. Data is collected through administrative data.	90% of all HIP members shall have access to dental care within a maximum of 30 miles of the member's residence and vision care within a maximum of 60 miles of member's residence.
POWER Account Roll-Over (HEDIS AAP) HIP members who obtain a preventive exam during the measurement year receive power account roll-over. Only codes and code combinations listed in the categories 'Preventive Care Counseling Office Visit' and 'Alternative Preventive Care Counseling Visit' apply to this measure.	OMPP utilizes HEDIS for tracking the percentage of HIP members who receive a qualifying preventive exam.	Achieve rate at or above the 75th percentile of the NCQA 2022 Quality Compass of members who received a preventative exam.

Table 4. Healthy Indiana Plan Quality Strategy Initiatives		
Measure	**Methodology**	**Goal**
Prenatal Depression Screening in Pregnant Women	OMPP utilizes HEDIS for tracking the percentage of women receiving prenatal depression screening in pregnant women.	Achieve at or above the 75th percentile of the NCQA 2022Quality Compass for prenatal depression screening.
Timeliness of Ongoing Prenatal Care	OMPP utilizes HEDIS for tracking the percentage of women receiving timeliness of ongoing prenatal care.	Achieve at or above the 50th percentile of the NCQA 2022 Quality Compass for the timeliness of prenatal.
Frequency of Post-partum Care	OMPP utilizes HEDIS for tracking the percentage of women who receive required post-partum visits.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for required post-partum visits.
Pregnant Women Smoking Cessation Increase the referral of pregnant women who smoke to the Indiana Tobacco Quitline for smoking cessation services.	Monthly Indiana Tobacco Quitline reports	Achieve an increase in the percentage who are referred to and have one contact with the Indiana Tobacco Quitline.
Completion of Health Needs Screen	Administrative reporting	Achieve at or above the 60% for all new members completing the health needs screening within ninety (90) days of enrollment.
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 7 day	HEDIS measure using administrative data	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 30 day	HEDIS measure using administrative data	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.

Table 5. Hoosier Care Connect Quality Strategy Initiatives		
Measure	**Methodology**	**Goal**
Adult Preventive Care (HEDIS)	OMPP is using the adult preventive care HEDIS measure for tracking preventive care.	Achieve at or above the 75th percentile for NCQA 2022 Quality Compass for members 20 years and older who had a preventive care visit.
Annual Dental Visit (HEDIS)	OMPP is utilizing the annual dental visit HEDIS measures for tracking annual dental visits.	Achieve at or above the 75th percentile for NCQA 2022 Quality Compass for members ages 2to 20 years who had a dental visit.

Table 5. Hoosier Care Connect Quality Strategy Initiatives		
Measure	**Methodology**	**Goal**
Completion of Health Needs Screen (≥60%)	Administrative reporting	Achieve completion of a Health Needs Screen for > 60%of all members during the first 90 days of enrollment.
Completion of Comprehensive Health Assessment Tool	Administrative reporting	Achieve completion of a comprehensive health assessment for >79% for all members who are stratified into complex case management or the Right Choice Program following the initial screening, during the first 150 days of enrollment.
Improvement in Behavioral Health (HEDIS) Percentage of members who received follow-up within seven days of discharge from hospitalization for mental health disorders: with MRO	HEDIS-like measure based on specifications developed by OMPP, including Medication Rehabilitation Option HCPCS codes.	Achieve at or above 75th percentile for NCQA 2022 Quality Compass for members who receive follow-up within seven days of discharge from hospitalization for mental health disorders—with Medicaid rehabilitation option services.

EQR Activities

EQR includes four mandated activities and can include optional activities. Each state agency may also assign other responsibilities to its designated EQRO, such as the provision of ongoing technical assistance. This section summarizes the activities that Qsource performed for OMPP in 2021, in accordance with the CMS *External Quality Review (EQR) Protocols* (released in 2012 and 2019).

In addition to EQR mandatory activities, 42 CFR § 438.358 outlines six optional activities the state may initiate in the future.

EQR Mandatory Activities

As set forth in Title 42 *Code of Federal Regulations* (CFR) Section 438, Part 358 (42 § 438.358), incorporated by 42 CFR § 457.1250, four mandatory EQR activities must be conducted to assess the performance of the MCEs.

Table 6 presents the EQR activities conducted in 2021 and the corresponding measurement period for the activity.

Table 6. EQR Activities Conducted in 2021

Protocol #	Activity Name	Mandatory or Optional	Measurement Period
1	***Validation of Performance Improvement Projects***	Mandatory	January 1, 2020 – December 31, 2020
2	***Validation of Performance Measures***	Mandatory	January 1, 2020 – December 31, 2020
3	***Review of Compliance with Medicaid and CHIP Managed Care Regulations***	Mandatory	January 1, 2020 – December 31, 2020
4	***Validation of Network Adequacy***	Mandatory	January 1, 2020 – December 31, 2020

Qsource followed the CMS Protocols published in October 2019 for Compliance Assessment and PMV. Qsource followed the CMS Protocols published in September 2012 for the Quality Improvement Protocol.

Qsource is responsible for the creation and production of this *2021 Annual EQRO Technical Report*, which compiles the results of these EQR activities. Qsource's efforts are a primary means of assessing the quality, timeliness, and accessibility of services provided by the MCEs.

This report includes the following results of these activities:

1. A brief description of the data collection, aggregation, and analyses for each of the EQR compliance activities
2. A summary of findings from each review
3. Strengths and weaknesses demonstrated by each MCE in providing healthcare services to enrollees

4. Recommendations for improving the quality of these services, including how OMPP can target goals and objectives in achieving the goals of the quality strategy to better support improvement

This *2021 Annual EQRO Technical Report* is based on detailed findings that can be reviewed in the individual EQR activity reports provided to OMPP.

EQRO Team

The review team included the following staff:

- Rebel McKnight, CPHIT, CPEHR, Qsource, Indiana EQRO Program Manager
- John Couzins, MPH, CHCA, Qsource, EQRO Director
- Victoria Warner, Qsource, EQRO Operations Leader
- Jazzmin Kennedy, Qsource, Clinical Quality Improvement Advisor
- Jackie Sourek, MBA, Qsource, Technical Writer
- Fujin Lu, MD, MS, Qsource, Analyst
- Kathy Haley, MP, CFE, CCA, COC, CHC, Myers and Stauffer
- Catherine Snider, Myers and Stauffer
- Kristy Lawrence, Lawrence Policy Consulting
- Emily Brammer, Axon Advisors, LLC

Quality of Care

While quality of care has varying applications, CMS described it as the degree to which preferred enrollee health outcomes were likely to be increased through the efforts of the MCEs providing enrollee services, including their organization and operations. OMPP required the MCEs to conduct quality improvement projects, which included mechanisms to assess the quality and appropriateness of care furnished to the enrollees. OMPP's Quality Strategy included the goal of advancing plan models to improve the health of the enrollees by monitoring the implementation of quality improvement projects by the MCEs. Qsource's validation of those QIPs was part of Qsource's evaluation of quality of care. Each MCE was required to report on performance measures related to quality of care to the State. OMPP asked the MCEs to meet targets for those performance measures.

Qsource's Compliance Assessment of each MCE evaluated quality of care for enrollees by reviewing Availability of Services, Practice Guidelines, Health Information Systems, Quality Assessment and Performance Improvement, Coordination and Continuity of Care, and Subcontractual Relationships and Delegation, Provider Selection, and Confidentiality.

Timeliness of Care

For quality care to be effective, it must be delivered in a timely manner. Thus, various standards for timely care were monitored through MCE compliance with federal and state regulations. Multiple QIPs, validated by Qsource, addressed the timeliness of care for enrollees. Qsource's validation of performance measures looked at timeliness measures determined by OMPP.

This year's Compliance Assessment reviewed the Availability of Services, Assurances of Adequate Capacity and Services, Health Information Systems, Quality Assessment and Performance Improvement, Coordination and Continuity of Care, Coverage and Authorization of Services, and Subcontractual Relationships and Delegation standards looking at the timeliness of care.

Access to Care

Just as quality of care is critical for enrollee health outcomes, so is access to care. The Plans' provider capacity is monitored through network adequacy evaluation, which assesses the availability of critical provider specialties by time and distance and how quickly enrollees can obtain needed appointments. Compliance with applicable federal, state, and contractual regulations also addresses access to care requirements, ensuring accessibility for all enrollees, including those with limited English proficiency and physical or mental disabilities. Network adequacy was analyzed to determine if enrollees' access to care met requirements.

Technical Report Guidelines

To assist both EQROs and state agencies, CMS supplemented the requirements of 42 CFR § 438.364, as incorporated by 42 CFR § 457.1250, and provided guidelines in the 2019 EQR Protocols for producing annual technical reports.

In addition to this Overview, this year's technical report includes the following EQR-activity-specific sections, followed by an overall Conclusions and Recommendations section:

- Protocol 1. Validation of Performance Improvement Projects (*MCEs reference these as Quality Improvement Projects (QIPs) and used throughout this report*)
- Protocol 2. Validation of Performance Measures
- Protocol 3. Review of Compliance with Medicaid and Children's Health Insurance Program (CHIP) Managed Care
- Protocol 4. Validation of Network Adequacy

This report is based on detailed findings that can be reviewed in the individual EQR activity reports provided to OMPP.

The appendices provide additional EQR activity information:

- Appendix A | PMV Measure Rates
- Appendix B | ANA Findings

Quality Improvement Project (QIP) Validation

Overview

As part of its external quality review (EQR) contract with the Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy & Planning (OMPP), Qsource annually validates the quality improvement projects (QIPs) of the managed care entities (MCEs) providing services for Indiana Medicaid members. Qsource's *Annual QIP Validation Reports* present validation findings by MCE.

The primary objective of QIP validation is to determine each QIP's compliance with the requirements set forth in Title 42 of the *Code of Federal Regulations* (CFR), Section 438.330(d)(2) [42 § 438.330(d)(2)], as incorporated by 42 CFR § 457.1240, including the following:

- Measuring performance with objective quality indicators
- Implementing interventions for quality improvement
- Evaluating intervention effectiveness
- Planning and initiating activities to increase or sustain improvement

Qsource's scoring methodology determines whether a QIP is valid by rating the QIP's percentage of compliance with CMS's EQR *Protocol 3: Validating Performance Improvement Projects (PIPs)* (Version 2.0; September 2012).

Each QIP involves 10 required activities, and each activity consists of one or more elements essential to the successful completion of a QIP. The elements within each activity are scored as Met, Not Met, or Not Assessed. Overall validation status is determined by the percentage score of all elements Met.

QIP Study Description

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 and select their own topics. For this year's EQR, Qsource validated the 31 QIPs shown in Table 7 Anthem had nine QIPs, CareSource had six QIPs, MDwise had five QIPs, and MHS had eleven QIPs.

The QIP topics were as follows:

Table 7. QIP Topics by MCE

QIP Topic	Anthem			CareSource		MDwise		MHS		
	HIP	HHW	HCC	HIP	HHW	HIP	HHW	HIP	HHW	HCC
Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)	X	X	X			X	X	X	X	X
Follow-up After Hospitalization for Mental Illness (FUH)	X	X	X					X	X	X
Health Needs Screening (HNS)	X	X	X			X		X	X	X
Completion of Health Needs Screening for New Members				X	X					
Improve Substance Use Follow-up and Treatment Outcomes Through Care/Case Management (FUA)				X	X					
Improve Lead Testing in Children 12-24 Months					X					
Improve Well Child Visits for Children 3-6 Years					X					
Postpartum Timeliness						X				
Well Child Visits During the First 15 Months (W15)							X		X	X

Table 8 lists the 10 QIP steps used for assessing the QIP methodology.

Table 8. QIP Assessment Steps	
QIP Activities	
1	State the Study Topic(s)
2	Define the Study Questions
3	Use a Representative or Generalizable Study Population
4	State the Study Indicators
5	Use Sound Sampling Methods
6	Use Valid and Reliable Data Collection Procedures
7	Analyze Data and Interpret Study Results
8	Describe Improvement Strategies
9	Assess for Real Improvement
10	Assess for Sustained Improvement

Methodology

The primary objective of QIP validation is to determine the compliance of each MCE with the requirements set forth in 42 CFR § 438.330(d). QIP study topics must reflect Indiana's Medicaid population in terms of demographic characteristics and, if applicable, in terms of the prevalence and potential consequences (risks) of disease.

Qsource's QIP validation team consists of experienced clinicians specializing in quality improvement, a healthcare data analyst, and a biostatistician with expertise in statistics and study design. Qsource's scoring methodology determines whether a QIP is valid by rating the MCE's percentage of compliance using CMS's *EQR Protocol 3: Validating Performance Improvement Projects (PIPs)* (Version 2.0; September 2012).

Qsource evaluates each QIP's performance on each evaluation element and details the number of elements Met compared to the number of elements assessed for each activity.

Qsource also provides percentage scores and determines an overall validation status for the QIP. Percentage scores are calculated by dividing the number of elements Met by the number of elements assessed for each activity.

A Met validation status indicates confidence that the conducted QIP is valid, while a Not Met status indicates that the reported QIP results are not credible. Qsource uses the Not Assessed designation for some activities when the QIP has not yet progressed to those activities in the CMS protocol. These evaluation criteria are described in **Table 9**.

Table 9. QIP Validation Status Criteria	
Status	**Criteria**
Met	80–100% of all elements are **Met** across all activities.
Not Met	Less than 80% of all elements are **Met**.
Not Assessed	Not applicable due to the QIP timeline; removed from all calculations.

Validation Results

Table 10 presents each QIP's element percentages and overall validation status by IHCP and QIP.

Table 10. QIP Validation Results Summary			
QIP Activities	**Elements Met/Applicable**		**Validation Status (%)**
	Met	**Applicable**	
Anthem			
Healthy Indiana Plan			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*	6	21	Not Met (29%)
QIP 2: *Follow-up After Hospitalization for Mental Illness (FUH)*	7	29	Not Met (24%)
QIP 3: *Health Needs Screening (HNS)*	6	29	Not Met (21%)
HHW			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*	6	21	Not Met (29%)
QIP 2: *Follow-up After Hospitalization for Mental Illness (FUH)*	7	29	Not Met (24%)
QIP 3: *Health Needs Screening (HNS)*	6	29	Not Met (21%)
Hoosier Care Connect			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*	6	21	Not Met (29%)
QIP 2: *Follow-up After Hospitalization for Mental Illness (FUH)*	7	29	Not Met (24%)
QIP 3: *Health Needs Screening (HNS)*	6	29	Not Met (21%)
CareSource			
Healthy Indiana Plan			
QIP 1: *Completion of Health Needs Screening (HNS) for New Members*	26	29	Met (90%)
QIP 2: *Improve Substance Use Follow-Up and Treatment Outcomes Through Care/Case Management (FUA)*	28	29	Met (97%)

Table 10. QIP Validation Results Summary			
QIP Activities	**Elements Met/Applicable**		**Validation Status (%)**
	Met	**Applicable**	
Hoosier Healthwise			
QIP 1: *Completion of Health Needs Screening (HNS) for New Members*	27	29	Met (93%)
QIP 2: *Improve Lead Testing in Children 12-24 Months*	28	29	Met (97%)
QIP 3: *Improve Well Child Visits for Children 3-6 Years*	25	29	Met (86%)
QIP 4: *Improve Substance Use Follow-Up and Treatment Outcomes Through Care/Case Management (FUA)*	28	29	Met (97%)
MDwise			
Healthy Indiana Plan			
QIP 1: *Follow-up After Emergency Department Services for Substance Use Disorder (FUA)*	6	21	Not Met (29%)
QIP 2: *Health Needs Screenings (HNS)*	8	21	Not Met (38%)
QIP 3: *Postpartum Timeliness*	3	21	Not Met (14%)
Hoosier Healthwise			
QIP 1: *Follow-up After Emergency Department Services for Substance Use Disorder (FUA)*	6	21	Not Met (29%)
QIP 2: *Well Child Visits During the First 15 Months (W15)*	7	21	Not Met (33%)
MHS			
Healthy Indiana Plan			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*	16	28	Not Met (57%)
QIP 2: *Follow-up After Hospitalization for Mental Illness (FUH)*	15	29	Not Met (52%)
QIP 3: *Health Needs Screening (HNS)*	16	29	Not Met (55%)

Table 10. QIP Validation Results Summary			
QIP Activities	**Elements Met/Applicable**		**Validation Status (%)**
	Met	**Applicable**	
Hoosier Healthwise			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*	15	29	Not Met (52%)
QIP 2: *Follow-up After Hospitalization for Mental Illness (FUH)*	14	29	Not Met (48%)
QIP 3: *Health Needs Screening (HNS)*	16	29	Not Met (55%)
QIP 4: *Well Child Visits Within the First 15 Months (W15)*	12	29	Not Met (41%)
Hoosier Care Connect			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*	13	29	Not Met (45%)
QIP 2: *Follow-up After Hospitalization for Mental Illness (FUH)*	13	29	Not Met (45%)
QIP 3: *Health Needs Screening (HNS)*	16	29	Not Met (55%)
QIP 4: *Well Child Visits Within the First 15 Months (W15)*	14	29	Not Met (48%)

Study Questions, Indicators, and Measurements

Tables 11 - 14 list the study questions and indicators of each QIP and summarizes each QIP's reported goals and measurement/ remeasurement results.

Table 11. QIP Measurement Results: Anthem			
QIP Activities	**MY 2020 Goal**	**Benchmark**	**MY 2020 Rate**
Healthy Indiana Plan			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *FUA 7 Day 2020*	22.99%	17.25%	17.25%
QIP 2: *Follow-up After Hospitalization for Mental Illness (FUH)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			

Table 11. QIP Measurement Results: Anthem			
QIP Activities	**MY 2020 Goal**	**Benchmark**	**MY 2020 Rate**
Study Indicator 1: *FUH 7 Day 2020*	51.72%	68.62%	31.11%
QIP 3: *Health Needs Screening (HNS)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *The HNS is to be completed by all newly enrolled members, within their first 90 days of eligibility.*	65.00%	46.05%	49.33%
Hoosier Healthwise			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *FUA 7 Day 2020*	22.99%	5.00%	5.00%
QIP 2: *Follow-up After Hospitalization for Mental Illness (FUH)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *FUH 7 Day 2020*	51.72%	68.62%	51.51%
QIP 3: *Health Needs Screening (HNS)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *The HNS is to be completed by all newly enrolled members, within their first 90 days of eligibility and consists of 13 questions.*	65.00%	29.09%	23.00%
Hoosier Care Connect			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *FUA 7 Day 2020*	22.99%	13.65%	13.65%
QIP 2: *Follow-up After Hospitalization for Mental Illness (FUH)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *FUH 7 Day 2020*	51.72%	45.88%	43.09%
QIP 3: *Health Needs Screening (HNS)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *The HNS is to be completed by all newly enrolled members, within their first 90 days of eligibility.*	65.00%	16.66%	47.00%

Table 12. QIP Measurement Results: CareSource			
QIP Activities	**MY 2020 Goal**	**Benchmark**	**MY 2020 Rate**
Healthy Indiana Plan			
QIP 1: *Completion of Health Needs Screening (HNS) for New Members*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *Health Needs Screening (HNS) completed within 90 days*	≥60%	26.68%	40.39%
QIP 2: *Improve Substance Use Follow-Up and Treatment Outcomes Through Care/Case Management (FUA)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *Percent of members with Substance Abuse Disorder (SUD) Diagnosis Engaged in Care-Case Management*	5%	2.56%	2.83%
Study Indicator 2: *Improve Substance Use Follow-Up and Treatment Outcomes Through Care/Case Management (FUA) 7*	17.75%	11.78%	15.82%
Study Indicator 3: *Improve Substance Use Follow-Up and Treatment Outcomes Through Care/Case Management (FUA) 30*	27.79%	17.68%	21.74%
Hoosier Healthwise			
QIP 1: *Completion of Health Needs Screening (HNS) for New Members*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *Health Needs Screening (HNS) completed with 90 days*	≥60%	12.05%	45.53%
QIP 2: *Improve Lead Testing in Children 12-24 Months*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *Number of children with evidence of a blood lead test between 12-24 months*	63.48%	34.22%	63.47%
Study Indicator 2: *Difference between MMR vaccine and blood lead testing rates*	Reduce by 20%	39.12%	18.94%
QIP 3: *Improve Well Child Visits for Children 3-6 Years*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *Percentage of Children Between 3-6 Years of Age Who Had One or More Well-Child Visit*	79%	57.70%	54.65%
QIP 4: *Improve Substance Use Follow-Up and Treatment Outcomes Through Care/Case Management (FUA)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *Percent of Members with SUD Diagnosis Engaged in Care-Case Management*	5%	1.18%	1.15%

Table 12. QIP Measurement Results: CareSource			
QIP Activities	**MY 2020 Goal**	**Benchmark**	**MY 2020 Rate**
Study Indicator 2: *Improve Substance Use Follow-Up and Treatment Outcomes Through Care/Case Management (FUA) 7*	17.75%	0%	6.67%
Study Indicator 3: *Improve Substance Use Follow-Up and Treatment Outcomes Through Care/Case Management (FUA) 30*	27.79%	0%	13.33%

Table 13. QIP Measurement Results: MDwise			
QIP Activities	**MY 2020 Goal**	**Benchmark**	**MY 2020 Rates**
Healthy Indiana Plan			
QIP 1: *Follow-up After Emergency Department Services for Substance Use Disorder (FUA)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *7-Day FUA Rate*	15.40%	13.40%	14.66%
Study Indicator 2: 30-*Day FUA Rate*	22.82%	20.82%	22.2%
Study Indicator 3: *Number of Target Members Engaged in CM*	137	135	3,098
QIP 2: *Health Needs Screenings (HNS)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *Number of CM referrals for HIP pregnant members*	2,257	1,963	4,082
QIP 3: *Postpartum Timeliness* (PPC)			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *Postpartum Timeliness (PPC) rate*	68.91%	66.91%	65.25%%
Hoosier Healthwise			
QIP 1: *Follow-up After Emergency Department Services for Substance Use Disorder (FUA)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *7-Day FUA Rate*	5.88%	3.88%	8.3%
Study Indicator 2: *30-Day FUA Rate*	7.83%	5.83%	10.2%
Study Indicator 3: *Number of Target Members Engaged in CM*	7	5	3,098
QIP 2: *Well Child Visits During the First 15 months (W15)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			

Table 13. QIP Measurement Results: MDwise			
QIP Activities	**MY 2020 Goal**	**Benchmark**	**MY 2020 Rates**
Study Indicator 1: *Well-Child Visits During the First 15 Months (W15)*	74.26%	74.26%	48.18%

Table 14. QIP Measurement Results: MHS			
QIP Activities	**MY 2020 Goal**	**Benchmark**	**MY 2020 Rates**
Healthy Indiana Plan			
QIP 1: ***Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)***			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *FUA-7*	11.41%	9.31%	14.63%
Study Indicator 2: *FUA-30*	17.75%	14.29%	19.99%
QIP 2: ***Follow-up After Hospitalization for Mental Illness (FUH)***			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *FUH-7*	36.68%	34.09%	32.68%
Study Indicator 2: *FUH-30*	53.87%	52.00%	52.92%
QIP 3: ***Health Needs Screening (HNS)***			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *Health needs screening completion rate*	70.00%	34.22%	70.37%
Hoosier Healthwise			
QIP 1: ***Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)***			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *FUA-7*	6.41%	5.43%	6.60%
Study Indicator 2: *FUA-30*	6.82%	6.52%	9.43%
QIP 2: ***Follow-up After Hospitalization for Mental Illness (FUH)***			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *FUH-7*	52.45%	47.46%	50.59%
Study Indicator 2: *FUH-30*	73.13%	72.12%	73.84%
QIP 3: ***Health Needs Screening (HNS)***			

Table 14. QIP Measurement Results: MHS			
QIP Activities	**MY 2020 Goal**	**Benchmark**	**MY 2020 Rates**
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *Health needs screening completion rate*	60.00%	43.82%	60.85%
QIP 4: *Well Child Visits Within the First 15 Months (W15)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *W15 (Well Child Visits in the First 15 Months of Life)*	65.83%	63.99%	54.88%
Hoosier Care Connect			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *FUA-7*	6.41%	5.36%	12.38%
Study Indicator 2: *FUA-30*	10.5.%	9.01%	16.59%
QIP 2: *Follow-up After Hospitalization for Mental Illness (FUH)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *FUH-7*	38.68%	32.91%	36.54%
Study Indicator 2: *FUH-30*	59.15%	56.69%	61.08%
QIP 3: *Health Needs Screening (HNS)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *Health needs screening completion rate*	70.00%	35.01%	79.03%
QIP 4: *Well Child Visits Within the First 15 Months (W15)*			
Study Question(s): *The MCE did not include a study question in the QIP.*			
Study Indicator 1: *W15 (Well Child Visits in the First 15 Months of Life)*	59.02%	52.94%	39.71%

Conclusions and Recommendations

Anthem

Overall, Anthem's nine 2020 QIPs contained partial or incomplete information for most of the study activities. Detailed analysis and statistical testing were missing in all the QIPs; therefore, any reported improvement could not be proven valid. In addition, it is a protocol requirement to report the statistical test results between baseline and remeasurements to conclude that the probability of the increases was due to the intervention and not a random or intervening factor. The missing information compromised the QIP results and the validity of the studies. The MCE should use the CMS guidance for clarification and to increase understanding of the protocol requirements. In addition, the MCE should organize and present QIP activity data in an orderly format and assure all required information is included.

Healthy Indiana Plan, Hoosier Healthwise, and Hoosier Care Connect should incorporate the following recommendations into their respective QIP activities:

1. The MCE should determine a study question(s) that identifies the focus of the QIP topic and establish the framework for data collection, analysis, and interpretation.
2. The MCE study question(s) should be clear, simple, and answerable. The question should be stated in a way that supports their ability to determine whether the intervention(s) have a measurable impact for a clearly defined population.
3. The MCE should indicate the type of sampling used to ensure valid and reliable information.
4. The MCE should define their data collection procedures to ensure that the data used to measure performance is valid and reliable.
5. The MCE should create a data collection plan that includes:
    - The data to be collected;
    - The data sources;
    - How and when the data are to be collected;
    - Who will collect the data; and
    - Instruments used to collect the data.
6. The MCE needs to conduct statistical analysis, and present for baseline and each remeasurement period.
7. The MCE could use the CMS guidance for clarification and understanding of each element related to the study.

CareSource

CareSource demonstrated a sound study design for their six QIPs and created the foundation for CareSource to continue implementing improvement strategies and achieving real and sustained study outcomes. CareSource appropriately conducted and selected the sampling and data collection activities. These activities ensured that CareSource properly defined and collected the necessary data to produce accurate study indicator rates.

While CareSource demonstrated sound study designs for its QIPs, it did not achieve real and sustained improvement for any of the six QIPs. The documentation of the barrier identification process did not include supporting data or analysis results.

CareSource also failed to identify priority barriers and narrow the focus of interventions toward those barriers. The COVID pandemic is a recognized barrier that affected many of the interventions and included suspension of one quarter of activity.

Healthy Indiana Plan and Hoosier Healthwise should incorporate the following recommendations into their respective QIP activities:

1. Ensure that all statistical testing is done correctly, and the documentation of the statistical testing outcomes is accurate and consistent throughout the QIP.
2. Conduct cause and barrier analyses more frequently and incorporate quality improvement science such as PDSA cycles into its improvement strategies and action plans. The data and results of specific PDSA cycles should be included in the QIP documentation.
3. Identify barriers through quantitative data analysis. Data to support identified barriers should be documented in the QIP Summary Form.
4. A QIP topic should be clear and understandable. The QIP study question should be clear and answerable.
5. The MCE should determine a study question(s)that identifies the focus of the QIP topic and establish a framework for data collection, analysis and interpretation.
6. Tracking and showing a direct correlation between efforts and benefits is the best way to sustain quality improvement.

MDwise

Overall, MDwise's five 2020 QIPs contained partial or incomplete information for most of the study activities. Detailed analysis and statistical testing were missing in all the QIPs; therefore, any reported improvement could not be proven valid. In addition, it is a protocol requirement to report the statistical test results between baseline and remeasurements to conclude that the probability of the increases was due to the intervention and not a random or intervening factor. The missing information compromised the QIP results and the validity of the studies. The MCE should use the CMS guidance for clarification and to increase understanding of the protocol requirements. In addition, the MCE should organize and represent QIP activity data in an orderly format and assure all required information is included.

Healthy Indiana Plan and Hoosier Healthwise should incorporate the following recommendations into their respective QIP activities:

1. The MCE should determine a study question(s) that identifies the focus of the QIP topic and establish the framework for data collection, analysis, and interpretation.
2. The MCE study question(s) should be clear, simple, and answerable. The question should be stated in a way that supports their ability to determine whether the intervention(s) have a measurable impact for a clearly defined population.

3. The MCE should indicate the type of sampling used to ensure valid and reliable information.
4. The MCE should define their data collection procedures to ensure that the data used to measure performance is valid and reliable.
5. The MCE should create a data collection plan that includes:
    - The data to be collected;
    - The data sources;
    - How and when the data are to be collected;
    - Who will collect the data; and
    - Instruments used to collect the data.
6. The MCE needs to conduct statistical analysis, and present for baseline and each remeasurement period.
7. The MCE could use the CMS guidance for clarification and understanding of each element related to the study.

MHS

Overall, MHS's 11 2020 QIPs contained partial or incomplete information for most of the study activities. Detailed analysis and statistical testing were missing in all the QIPs; therefore, any reported improvement could not be proven valid. In addition, it is a protocol requirement to report the statistical test results between baseline and remeasurements to conclude that the probability of the increases was due to the intervention and not a random or intervening factor. The missing information compromised the QIP results and the validity of the studies. The MCE should use the CMS guidance for clarification and to increase understanding of the protocol requirements.

In addition, the MCE should organize and represent QIP activity data in an orderly format and assure all required information is included.

Healthy Indiana Plan, Hoosier Healthwise, and Hoosier Care Connect should incorporate the following recommendations into their respective QIP activities:

1. The MCE should determine a study question(s) that identifies the focus of the QIP topic and establish the framework for data collection, analysis, and interpretation.
2. The MCE study question(s) should be clear, simple, and answerable. The question should be stated in a way that supports their ability to determine whether the intervention(s) have a measurable impact for a clearly defined population.
3. The MCE should indicate the type of sampling used to ensure valid and reliable information.
4. The MCE should define their data collection procedures to ensure that the data used to measure performance is valid and reliable.

5. The MCE should create a data collection plan that includes:
    - The data to be collected;
    - The data sources;
    - How and when the data are to be collected;
    - Who will collect the data; and
    - Instruments used to collect the data.
6. The MCE needs to conduct statistical analysis, and present for baseline and each remeasurement period.
7. The MCE could use the CMS guidance for clarification and understanding of each element related to the study.

Performance Measure Validation (PMV)

Overview

The Balanced Budget Act of 1997 established certain managed care quality safeguards that were further described by Title 42 of the Code of Federal Regulations, Section 438.320 (42 CFR § 438.320), which defines "external quality review" as the "analysis and evaluation … of aggregated information on quality, timeliness, and access to health care services. Qsource's overarching goal is to evaluate each plan over multiple activities to ensure quality, timeliness, and access to care. The Indiana Family and Social Services (FSSA) Office of Medicaid Policy and Planning (OMPP) has contracted with Qsource, an external quality review organization (EQRO), to conduct mandatory EQR activities required by the Balanced Budget Act of 1997 and codified in the Code of Federal Regulations, Title 42, sections 457 and 438 (42 CFR §§ 457 and 438). One of the mandatory activities is performance measure validation (PMV) of managed care entities (MCEs), as required by 42 CFR § 438.358(b)(1)(ii) and in accordance with § 438.330(b)(2).

The 2021 PMV, which validates performance measures for measurement year (MY) 2020, was conducted virtually rather than onsite due to the COVID-19 pandemic. The validation activities for these measures were conducted as outlined in Centers for Medicare & Medicaid Services' (CMS's) EQR Protocol 2: Validation of Performance Measures (October 2019). This report includes findings from the National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS®) Record of Administration, Data Management and Processes (Roadmap); MCE-reported results from the 0510 Report, Institution for Mental Disease (IMD) Member Use; and a review of source code for the applicable measures.

MCE and IHCP Information

Qsource validated performance measures calculated and reported by each MCE, which manage the following Indiana Health Coverage Programs (IHCPs): Healthy Indiana Plan (HIP), Hoosier Healthwise (HHW), and Hoosier Care Connect (HCC). Information about the IHCPs appears in **Table 15**.

Table 15. IHCP Information

Anthem	
IHCP Name	Healthy Indiana Plan / Hoosier Healthwise / Hoosier Care Connect
IHCP Location	Conducted Virtually
Review Date	April 25, 2022
CareSource	
IHCP Name	Healthy Indiana Plan / Hoosier Healthwise
IHCP Location	Conducted Virtually
Review Date	April 19, 2022

Table 15. IHCP Information	
MDwise	
IHCP Name	Healthy Indiana Plan/Hoosier Healthwise
IHCP Location	Conducted Virtually
Review Date	April 26, 2022
MHS	
IHCP Name	Healthy Indiana Plan / Hoosier Healthwise / Hoosier Care Connect
IHCP Location	Conducted Virtually
Review Date	April 21, 2022

Performance Measures for Validation

Qsource validated the set of three performance measures identified by OMPP, which are listed and defined in **Table 16**. These measures are collected and reported by the MCE annually. The measurement period for this validation was calendar year 2020 (January 1–December 31, 2020).

Table 16. MCE Performance Measures	
Measure Name	**Measure Steward**
Member use for members with an Approved Diagnosis of Severe Mental Illness (SMI)	OMPP
Member use for Substance Use Disorders (SUD)-related conditions	OMPP
Member use not diagnosed with SMI and not being treated for SUD	OMPP

Validation Activities and Methodology

Pre-Review Strategy

Qsource defined the scope of the validation to include the OMPP required metrics. This validation included data source, reporting frequency, and format of those measures. The annual PMV normally includes pre-onsite reviews, an onsite visit, and post-onsite analyses. Due to the COVID-19 pandemic, all regularly scheduled onsite reviews were migrated to virtual reviews using of online meeting software.

Qsource obtained the list of performance measures selected by OMPP for validation and requested the NCQA HEDIS Roadmap from each IHCP to complete comprehensive systems review of those systems contributing to the measures.

Methods of Data Collection and Analysis

Qsource followed CMS's EQR *Protocol 2*, which identifies key data sources that should be reviewed as part of the validation process:

- **In place of the Information Systems Capabilities Assessment Tool, Qsource accepted the NCQA HEDIS Roadmap**—Completed Roadmaps received from the MCEs were reviewed to ensure all sections were complete and all attachments were available. The validation team reviewed all Roadmap documents, noting issues or items needing follow-up.

- **Source Code (Programming Language) for Performance Measures**—The validation team completed line-by-line code review and observation of program logic flow to ensure compliance with measure technical specifications. Areas of deviation were identified to evaluate the impact of the deviation on the measure and assess the degree of bias (if any).
- **Performance Measure Reports**—Qsource reviewed calculated rates for the current measurement period.
- **Supporting Documentation**—Qsource reviewed additional information to complete the validation process, including, but not limited to, policies and procedures (P&Ps), file layouts, system flow diagrams, system log files, and data collection process descriptions. Issues or areas needing clarification were flagged for follow-up.

Review Activities

Qsource conducted a virtual review with each MCE. Information was collected using several methods, including staff interviews, system demonstrations, review of data output files, primary source verification, observation of data processing, and review of data reports. The virtual review agenda was shared with the MCE:

- **Claims and Encounter System Review**—The validation team reviewed information systems focusing on the processing of claims and encounter data.
- **Enrollment Systems Review**—The validation team reviewed information systems focusing on enrollment data and processing.
- **Data Integration and Primary Source Review**— The validation team discussed source code logic and reviewed the process for integrating all data sources to produce the analytic file for reporting of selected measures.

Data Integration, Data Control, and Performance Measure Documentation

Table 17 presents the validation findings across all four MCEs and three IHCPs.

Table 17. Data Integration, Data Control, and Performance Measure Documentation

	Healthy Indiana Plan	Hoosier Healthwise	Hoosier Care Connect
Data Integration	Acceptable	Acceptable	Acceptable
Data Control	Acceptable	Acceptable	Acceptable
Performance Measure Documentation	Acceptable	Acceptable	Acceptable

Data Integration

Accurate data integration is essential to calculating valid performance measures. The steps used to combine various data sources, and other administrative data must be carefully controlled and validated. Qsource validated the data integration process used by the MCEs, which included a review of file consolidations or extracts, comparison of source data to

warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms.

Data Control

The organizational infrastructure of an MCE must support all necessary information systems. Qsource validated the data control processes used by each IHCP, which included a review of disaster recovery procedures, data backup protocols, and related P&Ps.

Performance Measure Documentation

Sufficient, complete documentation is necessary to support validation activities. Qsource reviewed all related documentation, which included the completed Roadmap, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of performance measure calculations, and other related documentation.

Performance Measure Specific Findings

Based on all validation activities, Qsource determined validation results for each performance measure for each IHCP. **Table 18** displays the key review results. Actual reported measure rates are included in Appendix A.

Table 18. Key Performance Measure Review Results

Measure	Key Review Findings and Recommendations
Anthem **Healthy Indiana Plan / Hoosier Healthwise / Hoosier Care Connect**	
Member use for Members with an Approved Diagnosis of SMI	Met all specifications for the measure.
Member use for SUD-related conditions	Met all specifications for the measure.
Member use not diagnosed with SMI and not being treated for SUD	Met all specifications for the measure.
CareSource **Healthy Indiana Plan / Hoosier Healthwise**	
Member use for Members with an Approved Diagnosis of SMI	Met all specifications for the measure.
Member use for SUD-related conditions	Met all specifications for the measure.
Member use not diagnosed with SMI and not being treated for SUD	Met all specifications for the measure.
MDwise **Healthy Indiana Plan / Hoosier Healthwise**	
Member use for Members with an Approved Diagnosis of SMI	Met all specifications for the measure.
Member use for SUD-related conditions	Met all specifications for the measure.
Member use not diagnosed with SMI and not being treated for SUD	Met all specifications for the measure.
MHS **Healthy Indiana Plan / Hoosier Healthwise / Hoosier Care Connect**	
Member use for Members with an Approved Diagnosis of SMI	Met all specifications for the measure.
Member use for SUD-related conditions	Met all specifications for the measure.
Member use not diagnosed with SMI and not being treated for SUD	Met all specifications for the measure.

Conclusions

Anthem

Overall, the IS capabilities assessment found that Anthem fully met requirements indicating its systems have the capability to provide quality and timely care. Qsource validated data integration, data control processes and ensured performance measure documentation was complete and sufficient to support validation activities. Anthem's claims / encounter data system, GBD Facets, had edit criteria in place to ensure accurate claims processing. Throughout the various phases of the enrollment file receipt process, reports were generated for validation and edit purposes and an audit trail was provided. Inovalon, a NCQA-certified software was used for measure production ensuring reconciliation and monitoring for accurate data reporting. These results indicated an overall high confidence in Anthem's ability to provide quality and timely care for its enrollees.

CareSource

Overall, the IS capabilities assessment found that CareSource fully met requirements indicating its systems have the capability to provide quality and timely care. Qsource validated data integration, data control processes and ensured performance measure documentation was complete and sufficient to support validation activities. The Facets System continued to be the medical claims processing system and only routine upgrades were made during the measurement year. Claim review was in place and acknowledgement files were used to ensure complete and accurate data transfer. New members' data and state enrollment files were obtained daily and were systematically loaded into the Facets membership system. The information was reconciled as subsequent state enrollment files were received. Data quality reports were produced when data extracts were received and after the extracts had been converted to a relational database (Data Mart). These reports included the exact amount of missing information for each data field and the frequency, by value, missing in each data field.

These results indicated an overall high confidence in CareSource's ability to provide quality and timely care for its enrollees.

MDwise

Overall, the IS capabilities assessment found that MDwise fully met requirements indicating its systems have the capability to provide quality and timely care. Qsource validated data integration, data control processes and ensured performance measure documentation was complete and sufficient to support validation activities. MDwise claims processing system was Health Rules Payor. Audits were completed on all claim types in the claims department daily, procedural, and financial aspects were also examined. Enrollment files were posted to a secure site and MDwise retrieved and processed. Membership increased for all product lines from the prior year. MDwise uses an internally developed platform for data integration and measure development. Data was extracted from the data warehouse using SAS and loaded into NCQA-certified software, Cotiviti, during data refreshes by the HEDIS IS Lead. Standard

control procedures were executed after each load to ensure completeness and accuracy of each dataset. These results indicated an overall high confidence in MDwise's ability to provide quality and timely care for its enrollees.

MHS

Overall, the IS capabilities assessment found that MHS fully met requirements indicating its systems have the capability to provide quality and timely care. Qsource validated data integration, data control processes and ensured performance measure documentation was complete and sufficient to support validation activities. Amysis Advance 6.2.2 continued to be the medical claims processing system for both medical and behavioral health. Daily EDI dashboard reports were generated to ensure proper claim controls were maintained. A claim code editing software analyzed claims real-time against coding standards set by the state of Indiana, National Correct Coding Initiative, American Medical Association, and medical specialty organizations to ensure provider-coding accuracy. On a monthly basis the data integrity team reconciled membership data. Manual review and correction were performed within the UMV system. MHS had a SQL Server Integration Services package that extracted data from the Enterprise Data Warehouse and fed into the NCQA-certified software, QSI-XL tool. The QSI-XL tool provided reports on the files loaded with record counts, rejected records, etc. Data validation queries were also used to assess the completeness of the data loaded. These results indicated an overall high confidence in MHS's ability to provide quality and timely care for its enrollees.

Compliance Assessment (CA)

Overview

Indiana Family & Social Services Administration's (FSSA) Office of Medicaid Policy & Planning (OMPP) has contracted with Qsource, an external quality review organization (EQRO), to conduct external quality review (EQR) activities for managed care entities (MCEs) as required by the *Balanced Budget Act of 1997* and codified in the *Code of Federal Regulations*, Title 42, sections 438 and 457 (42 CFR §§ 438 and 457). The CFR requires a compliance assessment to be conducted within the previous three-year period to evaluate MCE compliance with certain standards, including access to care, structure and operations, and quality measurement and improvement. This assessment was conducted in accordance with the CMS *EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations* (October 2019). This *2021 Compliance Assessment Report*, hereafter abbreviated as the CA Report, summarizes compliance scores for activities conducted in calendar year 2020 by MCE and includes the following sections:

- Overview
- Methodology
- Results
- Appendices (including completed compliance tools)

The scope of this CA is based on Protocol 3, in which the CA evaluates MCE compliance across 11 standard areas, as listed in **Table 19.**

Table 19. Compliance Standards

CFR Citation	2021 Standard	Standard Abbreviation
42 CFR § 438.206	Availability of Services	AOS
42 CFR § 438.207	Assurances of Adequate Capacity and Services	AACS
42 CFR § 438.208	Coordination and Continuity of Care	CCC
42 CFR § 438.210	Coverage and Authorization of Services	CAS
42 CFR § 438.214	Provider Selection (Credentialing/ Recredentialing)	PS
42 CFR § 438.224	Confidentiality	CON
42 CFR § 438.228	Grievance and Appeals System	GA
42 CFR § 438.230	Subcontractual Relationships and Delegation	SRD
42 CFR § 438.236	Practice Guidelines	PG
42 CFR § 438.242	Health Information Systems	HIS
42 CFR § 438.330	Quality Assessment and Performance Improvement	QAPI

OMPP has elected to conduct comprehensive CAs every three years for the following Indiana Health Coverage Programs (IHCPs) managed by each contracted MCE: Hoosier Care Connect (HCC), Hoosier Healthwise (HHW), and Healthy Indiana Plan (HIP). **Table 20** displays IHCPs managed by each MCE.

Table 20. IHCPs

MCE	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect
Anthem	X	X	X
CareSource	X	X	
Managed Health Services	X	X	X
MDwise	X	X	

Qsource evaluated each MCE's compliance with relevant regulatory requirements for each standard and each standard was categorized according to domain of care: quality, timeliness, and access to care (**Table 22**). The review (look-back) period for the 2021 CA included evaluation of MCE documentation, activities, and services occurring during calendar year 2020. All documentation provided for review addressed requirements effective from January 1, 2020, through December 31, 2020.

Standards and Measures Reviewed

OMPP requires a review of all the compliance standards every three years. **Table 21** lists the standards and elements used to evaluate each MCE's compliance for the 2021 CA.

Table 21. Standards and Domains of Care

Standard	Quality	Timeliness	Access
Availability of Services		✓	✓
Assurances of Adequate Capacity and Services	✓	✓	✓
Grievance and Appeals System			✓
Practice Guidelines	✓		
Health Information Systems	✓	✓	✓
Quality Assessment and Performance Improvement (QAPI)	✓	✓	✓
Coordination and Continuity of Care	✓	✓	✓
Coverage and Authorization of Services		✓	✓
Subcontractual Relationships and Delegation	✓	✓	✓
Provider Selection (Credentialing/ Recredentialing)	✓		
Confidentiality	✓		✓

To reduce duplication of assessment activities, OMPP has chosen to allow certain standard elements to be deemed compliant in cases where an MCE, accredited by the National Committee for Quality Assurance (NCQA), has achieved a full score on an element with similar requirements to the regulatory or contractual element. For this review, Anthem had five elements deemed compliant based on NCQA accreditation, CareSource had two elements deemed compliant, MDwise had 10 elements deemed compliant and MHS had 14 elements deemed compliant.

In addition to compliance standards, the CA includes reviews of a random sample of UM denial, grievance, appeal, and credentialing/recredentialing files. Qsource asked that each MCE provide the universe of 2020 files, from which Qsource abstracted a random sample and an oversample. Files in this selection included 15: 10 sample and 5 oversample.

Methodology

While the CA is normally conducted in pre-onsite, onsite, and post-onsite phases, the 2021 CA review was conducted virtually using online meeting software tools due to the COVID-19 pandemic. All other protocols for the 2021 CA review remained the same, guided by the CMS's EQR Protocol 3 (October 2019). From start to finish, the CA was conducted in three phases: pre-virtual review, virtual review, and post-virtual review. Qsource worked closely with OMPP and MCEs throughout the CA to ensure a supportive and coordinated process and provided additional technical assistance to the MCEs in preparing for the virtual review.

Pre-Virtual-Review Activities

Prior to conducting the virtual review, Qsource distributed a Compliance Assessment External Quality Review Guide to explain the process to each MCE. In addition, an agenda for the virtual review with instructions for review sessions was provided to the MCEs. These activities, detailed in **Table 22**, gave all parties the opportunity to address questions and issues before the virtual review phase.

Table 22. Pre-Virtual-Review Activities

Step 1: Prepare evaluation tools and submit to OMPP.
Qsource developed compliance standard and file review tools in consultation with OMPP representatives.
Step 2: Submit tools to the MCE and request documentation.
♦ The MCE submitted requested documentation and data to Qsource.
Step 3: Review pre-virtual-review documentation.
♦ Qsource used the evaluation tools to examine all information received before the virtual review for insight into the MCE's structure, operations, and enrollee and provider populations. ♦ Surveyors took notes, identified issues requiring further clarification or follow-up, and asked the MCE for additional documentation if necessary. ♦ From the 2020 universe of grievance, appeals, denials and credentialing/recredentialing files submitted by the MCE, Qsource reviewed a random sample of 10 provided by the MCE.

Table 22. Pre-Virtual-Review Activities
Step 4: Develop and submit a virtual review agenda.
Qsource surveyors developed an agenda to assist MCE staff in planning participation, gathering documentation, and addressing logistical issues.

Virtual Review

The virtual reviews for each MCE were conducted in April 2022. Qsource surveyors used the tools along with personal observations, interviews with MCE staff members, system demonstrations, and file/document reviews to facilitate analyses and compilation of findings. The MCEs also provided additional P&Ps and other documents for surveyors during the virtual review. **Table 23** details these activities.

Table 23. Virtual Review Activities
Step 1: Review documentation and record findings.
♦ Qsource surveyors assessed P&Ps, reports, and other documents, including files for the grievances, appeals, denials and credentialing/recredentialing file review. ♦ The surveyors used approved tools to record findings and any applicable strengths, suggestions for each standard element and file review.
Step 2: Interact with MCE staff to augment assessment.
♦ MCE staff was available throughout the virtual review to answer questions, give interviews, and help surveyors find necessary information. ♦ Surveyors included relevant notes taken during MCE staff interviews in their compliance tool findings.

Table 23. Virtual Review Activities
Step 3: Summarize findings at the completion of the assessment.
Qsource surveyors summarized their findings for MCE staff and informed them of next steps for completing the assessment.

Post-Virtual-Review Activities

After analyzing the compiled data, Qsource prepared this CA Report and submitted to OMPP for approval. **Table 24** details these post-virtual-review activities.

Table 24. Post-Virtual-Review Activities
Step 1: Analyze the MCE's performance.
Qsource determined compliance scores for each element and standard using assigned point values in the compliance standard tool.
Step 2: Prepare a report of findings and recommendations.
♦ Qsource submitted a draft report of findings and recommendations to OMPP and the MCE within 15 business days after completing the onsite visit. ♦ Both OMPP and the MCE were given the opportunity to provide feedback on the report draft. ♦ After addressing feedback, Qsource prepared and submitted the final *2021 Compliance Assessment Report* within 60 days of completing the virtual review.
Step 3: Provide post-assessment support to the MCE.
Qsource provides the MCE with technical assistance as needed to foster performance improvement.

Compliance Assessment Scoring

Throughout the documentation review and virtual assessment processes, Qsource reviewers used the survey tools to collect information and document findings regarding the compliance with regulatory and contractual standards through a review of policies and procedures (P&Ps), quality studies, reports, medical records/files, and other related documentation. Each standard element has an assigned point value of 1, and Qsource analyzed every element in the survey tools. Qsource determined performance scores by adding the total points earned for each standard element on a scale of 0 to 1. Scores for each standard were calculated by dividing the total points earned for all elements in the standard by the total points possible for all elements in the standard.

The number of elements for each standard is provided in **Table 25**.

Table 25. Standard Elements

Standard	MCE Elements
Availability of Services	13
Assurances of Adequate Capacity and Services	2
Coordination and Continuity of Care	4
Coverage and Authorization of Services	59
Provider Selection (Credentialing / Recredentialing)	3
Confidentiality	1
Grievance and Appeals System	44
Subcontractual Relationships and Delegation	4

Table 25. Standard Elements

Standard	MCE Elements
Practice Guidelines	3
Health Information Systems	4
Quality Assessment and Performance Improvement	6

Findings

Compliance Standards

Table 26 includes overall compliance scores for all standards evaluated in 2021 for the CA. Additional results and the previous measurement year's results are provided in the *2021 Compliance Assessment Reports*.

Table 26. 2021 Compliance Standard Scores

	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect
Anthem			
Availability of Services	100%	100%	100%
Assurances of Adequate Capacity and Services	50%	50%	50%
Coordination and Continuity of Care	100%	100%	100%
Coverage and Authorization of Services	100%	100%	100%
Provider Selection (Credentialing/ Recredentialing)	100%	100%	100%

Table 26. 2021 Compliance Standard Scores			
	Hoosier Healthwise	**Healthy Indiana Plan**	**Hoosier Care Connect**
Confidentiality	100%	100%	100%
Grievance and Appeals System	100%	100%	100%
Subcontractual Relationships and Delegation	100%	100%	100%
Practice Guidelines	100%	100%	100%
Health Information Systems	100%	100%	100%
Quality Assessment and Performance Improvement	100%	100%	100%
Overall Anthem Compliance Standard Score	**99.3%**	**99.3%**	**99.3%**
CareSource			
Availability of Services	84.6%	84.6%	NA*
Assurances of Adequate Capacity and Services	50%	50%	NA
Coordination and Continuity of Care	100%	100%	NA
Coverage and Authorization of Services	95.9%	95.9%	NA

Table 26. 2021 Compliance Standard Scores			
	Hoosier Healthwise	**Healthy Indiana Plan**	**Hoosier Care Connect**
Provider Selection (Credentialing/ Recredentialing)	100%	100%	NA
Confidentiality	100%	100%	NA
Grievance and Appeals System	100%	100%	NA
Subcontractual Relationships and Delegation	100%	100%	NA
Practice Guidelines	100%	100%	NA
Health Information Systems	100%	100%	NA
Quality Assessment and Performance Improvement	100%	100%	NA
Overall CareSource Compliance Standard Score	**96.2%**	**96.2%**	**NA**
MDwise			
Availability of Services	100%	100%	NA
Assurances of Adequate Capacity and Services	50%	50%	NA
Coordination and Continuity of Care	100%	100%	NA

Table 26. 2021 Compliance Standard Scores			
	Hoosier Healthwise	**Healthy Indiana Plan**	**Hoosier Care Connect**
Coverage and Authorization of Services	99.4%	99.4%	NA
Provider Selection (Credentialing/ Recredentialing)	100%	100%	NA
Confidentiality	100%	100%	NA
Grievance and Appeals System	100%	100%	NA
Subcontractual Relationships and Delegation	93.8%	93.8%	NA
Practice Guidelines	100%	100%	NA
Health Information Systems	100%	100%	NA
Quality Assessment and Performance Improvement	100%	100%	NA
Overall MDwise Compliance Standard Score	**98.9%**	**98.9%**	**NA**
MHS			
Availability of Services	100%	100%	100%
Assurances of Adequate Capacity and Services	50%	50%	50%

Table 26. 2021 Compliance Standard Scores			
	Hoosier Healthwise	**Healthy Indiana Plan**	**Hoosier Care Connect**
Coordination and Continuity of Care	100%	100%	100%
Coverage and Authorization of Services	98.0%	98.0%	98.0%
Provider Selection (Credentialing/ Recredentialing)	100%	100%	100%
Confidentiality	100%	100%	100%
Grievance and Appeals System	97.7%	97.7%	97.7%
Subcontractual Relationships and Delegation	100%	100%	100%
Practice Guidelines	100%	100%	100%
Health Information Systems	100%	100%	100%
Quality Assessment and Performance Improvement	100%	100%	100%
Overall MHS Compliance Standard Score	**97.8%**	**97.8%**	**97.8%**

** Not applicable*

File Reviews

Table 27 includes scores for each file review for the CA. These findings support the CA standard scores assigned to the MCEs. Detailed results for individual standard elements and file reviews can be found in the completed tools in the *2021 Compliance Assessment Reports*.

Table 27. 2021 File Review Scores

File Review	Score
Anthem	
UM Denials	100%
Grievances	100%
Appeals	97.5%
Credentialing	100%
Recredentialing	100%
CareSource	
UM Denials	97.6%
Grievances	100%
Appeals	100%
Credentialing	100%
Recredentialing	100%
MDwise	
UM Denials	100%
Grievances	100%
Appeals	100%
Credentialing	98.45%
Recredentialing	100%
MHS	
UM Denials	97.5%
Grievances	100%
Appeals	100%
Credentialing	100%
Recredentialing	100%

Strengths, Suggestions, and Weaknesses

Table 28 provides strengths by compliance standard for the CA, while the AONs, or weaknesses, identified are in Table 29. Qsource also identified suggestions where an element was fully compliant, but a revision/update could further strengthen that element's compliance. The MCEs were not held accountable for addressing suggestions; therefore, suggestions were not monitored or included in this report. If an MCE was not listed, it had no identified strengths or weaknesses in those areas.

Table 28. CA Strengths by Standard

Standard Title	Strength
Anthem	
Coverage and Authorization	The PLUTO demonstration was well received. This tool is available on the Provider Portal and makes it easy for providers to search what services require authorization and what does not. Anthem provided clear explanations for each service.
Grievance and Appeals	Anthem files were identified clearly, organized, and included highlighted criteria for each element. This surveyor was able to locate element criteria efficiently and in a timely manner.
Grievance and Appeals **Element 25**	Resolution and Notification–Specific Timeframes–Expedited Appeals: The MCE policy states expedited appeals will be resolved within forty-eight (48) hours of receipt of the appeal request, less time than the criteria require.
CareSource	
Availability of Services **Element 11**	Provider Directories – Provider Types: The MCE has a simple, user friendly way for members to request a copy of a member handbook and/or a provider directory with no cost to the member.
Quality Assessment and Performance Improvement **Element 1**	Basic Elements -1: The MCE took a proactive approach to 1(a) by including detailed descriptions of its 2020 Performance Improvement Projects in its CareSource Quality Management Improvement Program Description IN Medicaid HHW pages 20-24 and HIP pages 17-29.
Quality Assessment and Performance Improvement **Element 7**	Program Review by the State: The MCE has detailed and written policy regarding the "Program Review by the State."
MDwise	
Availability of Services **Element 12**	Provider Directories–Updating Requirements: MDwise took a proactive approach to refresh their information in the Directory every two weeks when the CFR only requires updates every 30 days.

Table 28. CA Strengths by Standard	
Standard Title	**Strength**
Assurances of Adequate Capacity and Services **Element 1**	Nature of Supporting Documentation: MDwise took a proactive approach to its GEO Access Reports. They were easy to read and identify areas of the state without access.
Assurances of Adequate Capacity and Services **Element 2**	Timing of Documentation: MDwise provided a comprehensive example for part C1 since they changed transportation providers.
Grievance and Appeals **Element 23**	Resolution and Notification–Specific Timeframes–Grievances: MCE policy is to resolve grievances within a shorter time frame of 30 calendar days, rather than 90 days, of receipt of the Grievance and allowed an extension up to 14 days if additional time is needed to resolve the Grievance.
MHS	
Grievances and Appeals **Element 23**	Resolution and Notification-Specific Timeframes-Grievances: The MCE policy is to resolve grievances expeditiously as possible, but not to exceed 30 calendar days from the date of receipt, which is more expeditious than the 90 days allowed per CFR.
Practice Guidelines **Element 3**	Application of Guidelines: The MCE took a proactive approach to 2020 Utilization Management Program Description. It is easy to read and well documented.

Table 29. CA Weaknesses (AONs) by Standard	
Standard Title	**Weakness**
Anthem	
Assurances of Adequate Capacity and Services **Element 1**	Nature of Supporting Documentation: The MCE should have sufficient access to specialty services for enrollees.
CareSource	
Availability of Services **Element 1**	Appropriate Providers: (a) MCE should have policies and procedures on how they maintain and monitor an appropriate provider network, along with a policy and procedures stating that the MCE has agreements. (b) In addition, the MCE should include how they maintain and monitor an appropriate provider network that is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities in their policy and procedures.
Availability of Services **Element 5**	Out of Network Payment: The MCE should have a policy that states out-of-network costs to the enrollee are no greater than they would be if the services were furnished within the network and that the out-of-network provider must coordinate with the MCE for payment.
Assurances of Adequate Capacity of Services **Element 1**	Nature of Supporting Documentation: The MCE should have policy and procedure discussing how they monitor and ensure network has sufficient coverage. The MCE should have sufficient access to specialty services for enrollees.
Coverage and Authorization of Services **Element 21**	Advance Directives: The MCE should have a policy that indicates; “Advance directive information must reflect changes in Indiana law as soon as possible, but no later than 90 days after the effective date of the change.”
Coverage and Authorization of Services **Element 31**	Electronic Information: The MCE should have a policy and member notification / right, that states "information is available in paper form without charge upon request, to be received within five business days.” The policy should include details where this tagline is available on the websites.
Coverage and Authorization of Services **Element 37**	Provider Termination Notice: The MCE should have a policy that states, “The MCE will provide written notice of termination of a contracted provider to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the enrollee must be within 15 calendar days after receipt or issuance of the termination notice.” In addition, CareSource should consult OMPP about their current contract language to ensure it is meeting the 42 CFR 438.10(f)(1) 15-day requirement.

Table 29. CA Weaknesses (AONs) by Standard	
Standard Title	**Weakness**
MDwise	
Assurances of Adequate Capacity and Services **Element 1**	Nature of Supporting Documentation: The MCE should have sufficient access to specialty services for enrollees.
Coverage and Authorization of Services **Element 36**	Written Material Requirements: MDwise should: Include “font size no smaller than 12 points” in the “Readability, Accuracy and Translation of Member Materials Policy and Procedure” document. Change pg. 2, section 2 of the “Member Handbook Design and Format Guidelines” where it states in step 1. “Use 10-point or 11-point type for body copy.” To “no smaller than 12 points”.
Subcontractual Relationships and Delegation **Element 4**	Subcontractor Agreements–3: MDwise should have a policy or language in its subcontractor contracts that states that the MCE has a right to audit subcontractors under 42 CFR 438.230 (c)(3)(i) up to 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
MHS	
Assurances of Adequate Capacity and Services **Element 1**	Nature of Supporting Documentation: The MCE should have sufficient access to specialty services for enrollees.
Coverage and Authorization of Services **Element 31**	Electronic Information: The MCE should have a policy that states, “The enrollee is informed that the information provided electronically is available in paper form without charge upon request and provided within 5 business days of the request.” The policy should also include details where the tagline is available on all electronic formats via the web for those items that are to be required in paper format.
Coverage and Authorization of Services **Element 37**	Provider Termination Notice: The MCE should change current language in the Member Reassignment policy, pg. 1 to: “In the event that MHS is not notified by the provider timely, members will be notified by letter no later than fifteen (15) days from receipt of the provider termination request."

CAP Submission

Within 15 business days of receiving notification from OMPP that an AON requires a CAP, the MCE must submit its completed CAP to OMPP. CAPs will be considered submitted once all parties have been notified via email within the required timeframe. Following CAP evaluation, OMPP will send the MCE either a letter of approval or a denial with a request for additional clarifying information, if needed.

Conclusions and Recommendations

Anthem

Anthem received an overall score of 99.3%, scoring 100% on all standards other than Assurances of Adequate Capacity and Services. Qsource identified three strengths, two suggestions and one AON in the 2021 review. In addition, the compliance score for Anthem for the virtual UM Denials file review was 100%, Grievances file review was 100%, Appeals file review was 97.5%, Credentialing file review was 100% and Recredentialing file review was 100%. Anthem's rating of high compliance in all eleven standards demonstrated quality, timeliness, and access to care for its enrollees.

CareSource

CareSource received an overall score of 96.2%, scoring 100% on all standards other than Availability of Services 84.6%, Assurances of Adequate Capacity and Services 50% and Coverage and Authorization of Services 95.9%. Qsource identified three strengths, three suggestions, and six AONs in the 2021 review. In addition, the compliance score for CareSource virtual UM Denials file review was 97.6%, Grievances file review was 100%, Appeals file review was 100%, Credentialing file review was 100% and Recredentialing file review was 100%. CareSource's rating of high compliance in all eleven standards demonstrated quality, timeliness, and access to care for its enrollees.

MDwise

MDwise received an overall score of 98.9%, scoring 100% on all standards other than Assurances of Adequate Capacity and Services 50%, Coverage and Authorization of Services 99.4% and Subcontractual Relationships and Delegation 93.8%. Qsource identified four strengths, three suggestions, and three AONs in the 2021 review. In addition, the compliance score for MDwise virtual UM Denials file review was 100%, Grievances file review was 100%, Appeals file review was 100%, Credentialing file review was 98.45% and Recredentialing file review was 100%. MDwise's rating of high compliance in all eleven standards demonstrated quality, timeliness, and access to care for its enrollees.

MHS

MHS received an overall score of 97.8%, scoring 100% on all standards other than Assurances of Adequate Capacity and Services 50%, Coverage and Authorization of Services 98% and Grievance and Appeals System 97.7%. Qsource identified two strengths, seven suggestions, and three AONs during the 2021 CA. In addition, the compliance score for MHS for the virtual

UM Denials file review was 97.5%, Grievances file review was 100%, Appeals file review was 100%, Credentialing file review was 100% and Recredentialing file review was 100%. MHS's rating of high compliance in all eleven standards demonstrated quality, timeliness, and access to care for its enrollees.

Recommendations

1. Overall, the MCEs did well in the Compliance Assessment, however, Assurances of Adequate Capacity, Coverage and Authorization of Services and Grievance and Appeals standards had the lowest scores.
2. The MCEs were able to show how they monitor and maintain provider capacity, however, policy and procedure stating the requirement and the reporting obligations to OMPP were missing for all the MCEs.
3. Policy and Procedures need to be reviewed annually with an audit trail being kept for quality assurance.
4. The purpose of the documentation and policies is not only to give proof for audits and reviews. The documentation should be used to inform and educate appropriate staff of the requirements and regulations that are expected to be followed by the plan and plan staff. Each document is a training opportunity and a resource for the plan.

Annual Network Adequacy (ANA)

Overview

As the external quality review organization (EQRO) for the Indiana Family & Social Services Administration (FSSA) Office of Medicaid Policy & Planning (OMPP), Qsource is required by the Balanced Budget Act of 1997 to assess each managed care entity's (MCE's) "strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries," according to Title 42 of the Code of Federal Regulations (CFR), Part 438.364 (a)(3) (42 CFR § 438.364). One activity included in the external quality review (EQR) contract with OMPP is to complete an annual review of the adequacy of each MCE's provider network. This activity is conducted by Myers & Stauffer Limited Liability Company (MSLC), Qsource's subcontractor, at the direction of OMPP.

This report presents the results of the Annual Network Adequacy (ANA) review. It describes the review methodologies, the findings for each task, and MSLC's recommendations for improvement.

Qsource evaluated each MCE to determine if it had an adequate provider network to ensure the effective and efficient delivery of healthcare to enrollees, pursuant to 42 CFR § 438.68. Geographic network adequacy analysis was conducted to assess the network adequacy of each MCE.

The 2021 ANA review covered the period of January 1 to December 31, 2020, and measured member access to primary medical providers (PMPs). MSLC analyzed the following:

- Percentage of members who live within 30 miles of a PMP
- Ratio of PMPs to members
- Member distribution by driving distance to the nearest PMP
- PMP accessibility by geography
- Demographics of members lacking sufficient access to a PMP

Methodology

Standards

The ANA review measures whether members have a provider within a reasonable distance from their residence. The 2021 ANA review focused on member access to one provider type, PMPs. The accessibility standard for PMPs is one within 30 miles of each MCE member.

Source Data

Postal addresses of providers' service locations and members' residences are necessary to measure adherence to provider network accessibility standards. Other provider data necessary for the analysis were provider type, provider specialty, and PMPs' patient restrictions, if any, regarding age or gender. In

addition to members' home addresses, each member's gender and date of birth are also required.

Qsource requested and received from the MCEs a separate listing of the members and PMP providers under the MCE's purview for the following programs, when applicable:

- Healthy Indiana Plan (HIP)
- Hoosier Healthwise (HHW)
- Hoosier Care Connect (HCC)

In addition to including the detailed data outlined above, Qsource's written request to the MCEs specified the listings should include only members and PMP providers who were eligible on October 1, 2020. The written request also specified the PMP provider listings should include a separate record for each location at which the individual practitioner was eligible to perform PMP services for the plan on that date. Additionally, the written request specified the IHCP provider types and specialties that qualify as PMP providers.

Analysis

Esri ArcGIS™ mapping software was used to assign standardized addresses and geocodes to postal addresses submitted by the MCEs, and to calculate the driving distance from the members' residence to the closest PMP, factoring in any reported PMP patient restrictions. Results were validated and further analyzed in Structured Query Language (SQL) in a Microsoft SQL Server database. Duplicative and invalid data records were excluded from the analysis. Analysis results were summarized by county, program, and member demographics to identify potential issues. Underserved members were measured by count and by percentage of members impacted within analysis groupings. Geographic maps of results were generated within Esri ArcGIS™.

All analyses were conducted based on a specified point in time, October 2020, and results provided assume that all variables utilized in the analyses were consistent across the entire period being reviewed.

Findings are presented in summary form, with highlights regarding areas of concern and a summary of strengths, suggestions for improvement, and Areas of Noncompliance (AONs).

Findings

Analysis of PMP Network Access

MCEs are contractually obligated to ensure all members have access to a PMP within 30 miles of the member's residence. The tables in this section measure each MCE's PMP network accessibility by IHCP.

Table 30 measures the percentage of MCE members who live within 30 miles of a PMP. All members for each plan and program had a PMP within the required 30 miles of their residence. Indiana's smaller geographic area and the narrow focus on PMPs only are contributing factors to these results.

Table 30. Percentage of Members with Sufficient Access to a PMP

	Healthy Indiana Plan	Hoosier Healthwise	Hoosier Care Connect	All Programs
Anthem	100%	100%	100%	**100%**
CareSource	100%	100%	NA*	**100%**
MDwise	100%	100%	NA	**100%**
MHS	100%	100%	100%	**100%**

** Not Applicable*

For Anthem's HHW members, 91% were between 0–5 miles of a PMP, while the greatest driving distance of 21–25 miles affected just 0.01% of the HHW members. HIP and HCC members' experience with driving distances is identical to HHW members with little variability in the distribution across miles.

For CareSource's HHW members, over 87% were between 0–5 miles of a PMP, while the greatest driving distance of 21–25 miles affected just 0.03% of the HHW members. HIP members' experience with driving distances is identical to HHW members with little variability in the distribution across miles.

For MDwise's HHW members, approximately 91% were between 0–5 miles of a PMP, while the greatest driving distance of 21–25 miles affected just 0.01% of the HHW members. HIP members' experience with driving distances is identical to HHW members with little variability in the distribution across miles.

For MHS' HHW members, approximately 90% were between 0–5 miles of a PMP, while the greatest driving distance of 21–25 miles affected just 0.01% of the HHW members. HIP and HCC members' experience with driving distances is identical to HHW members with little variability in the distribution across miles.

Rural Versus Urban and PMP-to-Member Ratios

Another factor influencing provider network accessibility is population density. Indiana's 92 counties were categorized as either rural or urban based on the Federal Office of Rural Health Policy (FORHP). The 62 rural counties and 30 urban counties were ranked according to the percentage of members having a PMP within 30 miles. Table 31 shows the ratio of PMPs to members for each MCE. These tables include a summary of PMP accessibility for MCE members in rural versus urban counties, as well as a comparison of the health programs managed by each MCE.

Table 31. Ratio of PMPs to MCE Members

Scope of Analysis	Anthem			CareSource			MDwise			MHS		
	Count of Members	Count of Providers	Provider-to-Member Ratio	Count of Members	Count of Providers	Provider-to-Member Ratio	Count of Members	Count of Providers	Provider-to-Member Ratio	Count of Members	Count of Providers	Provider-to-Member Ratio
Rural vs Urban Comparison*												
Rural Counties†	123,571	1,974	1:63	29,591	656	1:45	101,727	4,350	1:23	76,913	880	1:87
Urban Counties	411,007	4,705	1:87	82,267	1,927	1:43	284,643	12,818	1:22	211,988	3,044	1:70
Health Program Comparison												
HIP	230,811	6,277	1:37	53,854	1,968	1:27	160,032	16,706	1:10	97,557	3,250	1:30
HHW	248,339	6,569	1:38	58,004	2,524	1:23	226,338	16,904	1:13	156,097	3,368	1:46
HCC	55,428	6,540	1:8	NA**	NA	NA	NA	NA	NA	35,247	3,559	1:10
Statewide	**534,578**	**7,098[1]**	**1:75**	**111,858**	**2,800[2]**	**1:40**	**386,370**	**17,504[3]**	**1:22**	**288,901**	**4,066[4]**	**1:71**

** There are providers who have offices in both rural and urban counties, resulting in the total of the rural and urban county count of providers being higher than the statewide unique count.*

† Includes metropolitan counties designated as eligible for Rural Health funding by the FORHP.

*** Not Applicable*

[1] Includes 812 out-of-state providers, not included in the rural-vs-urban comparison. Additionally, be aware that providers enrolled in multiple health programs are counted a single time in Anthem statewide provider count.

[2] Includes 517 out-of-state providers, not included in the rural-vs-urban comparison. There may be providers with multiple service locations spanning rural, urban and/or out-of-state. They are counted once in each of these three areas in which they practice. Additionally, be aware that providers enrolled in multiple health programs are counted a single time in CareSource statewide provider count.

[3] Includes 2,990 out-of-state providers, not included in the rural-vs-urban comparison. Additionally, be aware that providers enrolled in multiple health programs are counted a single time in MDwise statewide provider count.

[4] Includes 142 out-of-state providers, not included in the rural-vs-urban comparison. Additionally, be aware that providers enrolled in multiple health programs are counted a single time in MHS statewide provider count.

While there were no problems in analyzing Anthem's, CareSource's, and MHS's provider-to-member ratios, Qsource encountered problems in geographically analyzing MDwise's provider-to-member ratio due to a considerable number of PMPs listed with service locations in both rural and urban counties, and sometimes out-of-state. There were 2,886 PMPs found to have listings in more than one county, which can skew the count of rural vs. urban providers. When combined with the number of provider service locations per PMP, the resulting provider-to-member calculations may be favorable because of the inclusion of all service locations. Items of note included:

- 85 PMPs had service locations in rural counties, urban counties, and out-of-state. This group had an average of 10 service locations each, although 40 PMPs had between 10 and 42 service locations.
- 2,569 PMPs had service locations in rural and urban counties, but not out-of-state. This group on average had 8 service locations, although 675 PMPs had between 10 to 45 service locations.
- The remaining PMPs had multiple service locations, but all service locations for a given provider were grouped as urban, rural, or out-of-state. This group on average had 6 service locations each, although the 39 PMPs with the most service locations had between 10 and 41 locations.

Figures 1-4 highlight the counties (outlined in red) with the most members per provider for each MCE. These counties may be areas where additional providers could provide the most impact to the member population. Note, the dots represent provider service locations. Refer to Appendix B for PMP-to-member ratios by county.

Figure 1. Counties with Higher Provider-to-Member Ratios: Anthem

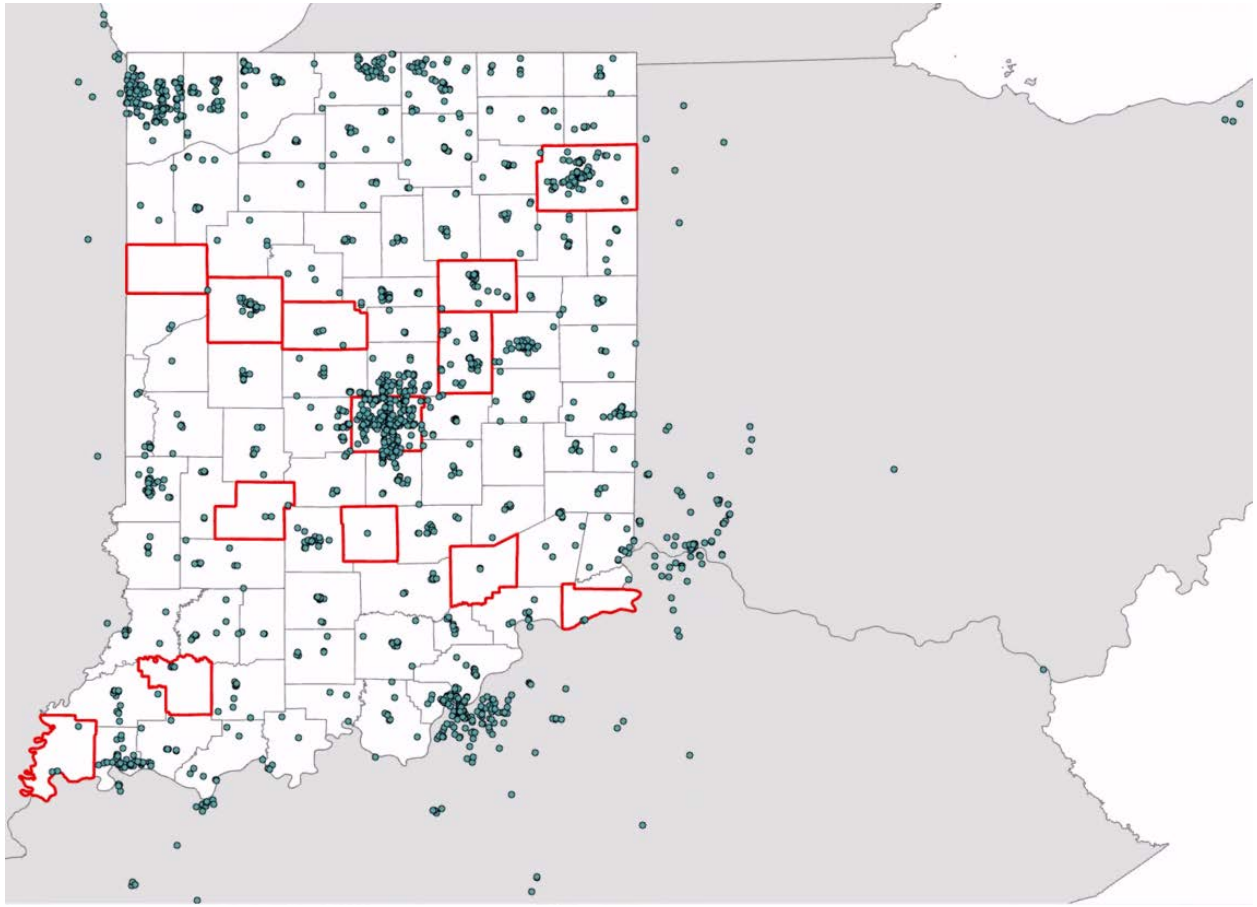


Figure 2. Counties with Higher Provider-to-Member Ratios: CareSource

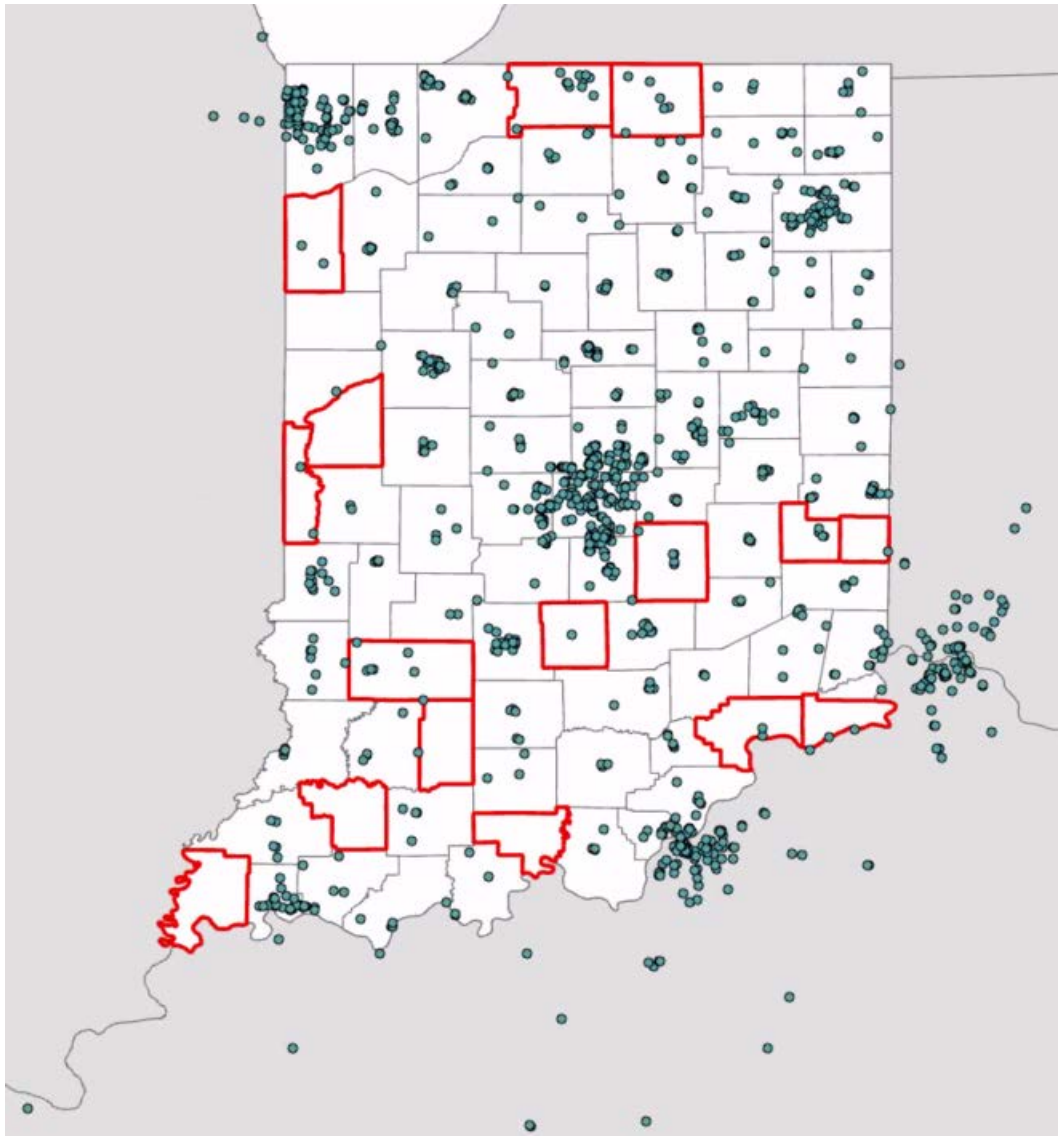


Figure 3. Counties with Higher Provider-to-Member Ratios: MDwise

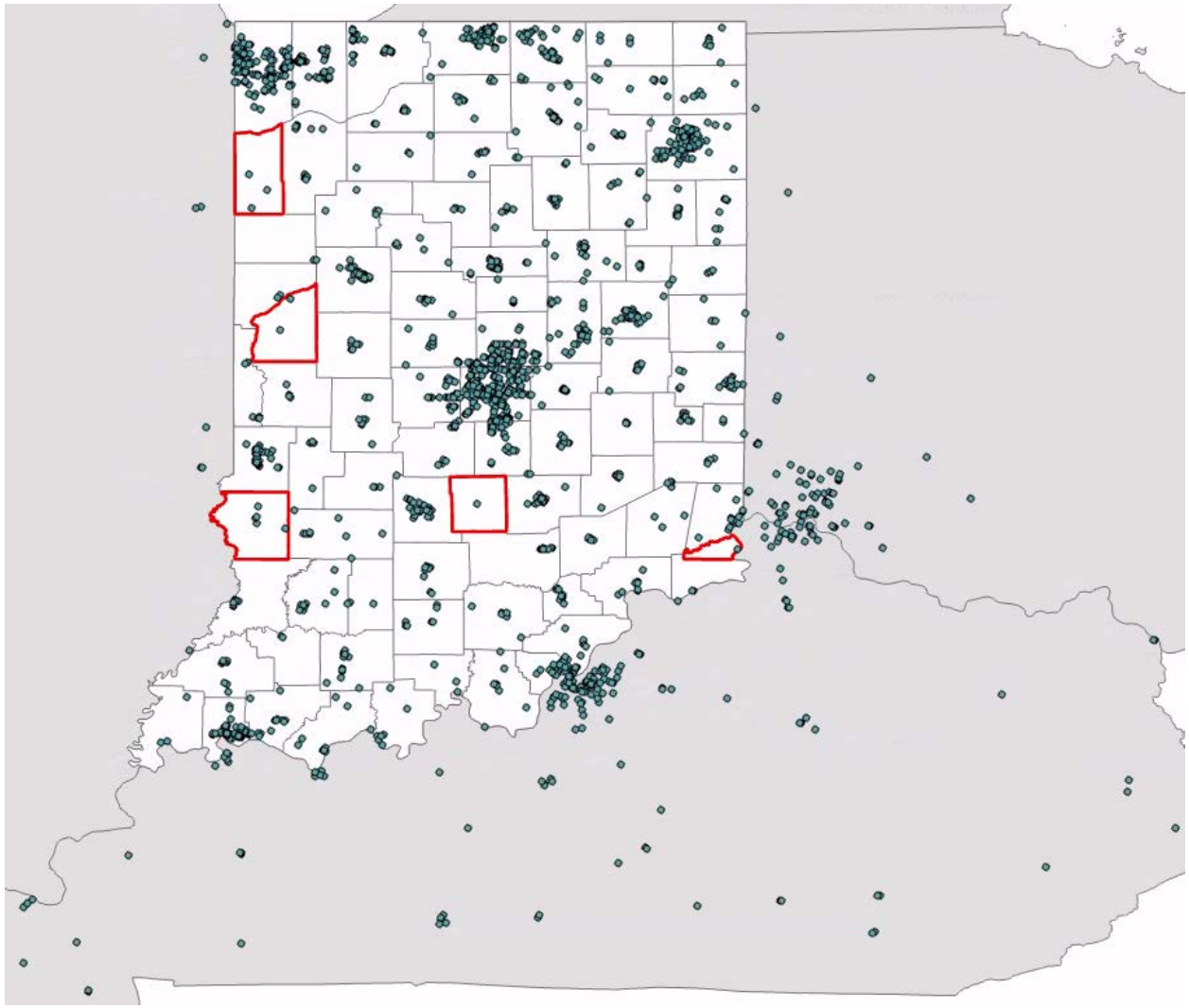
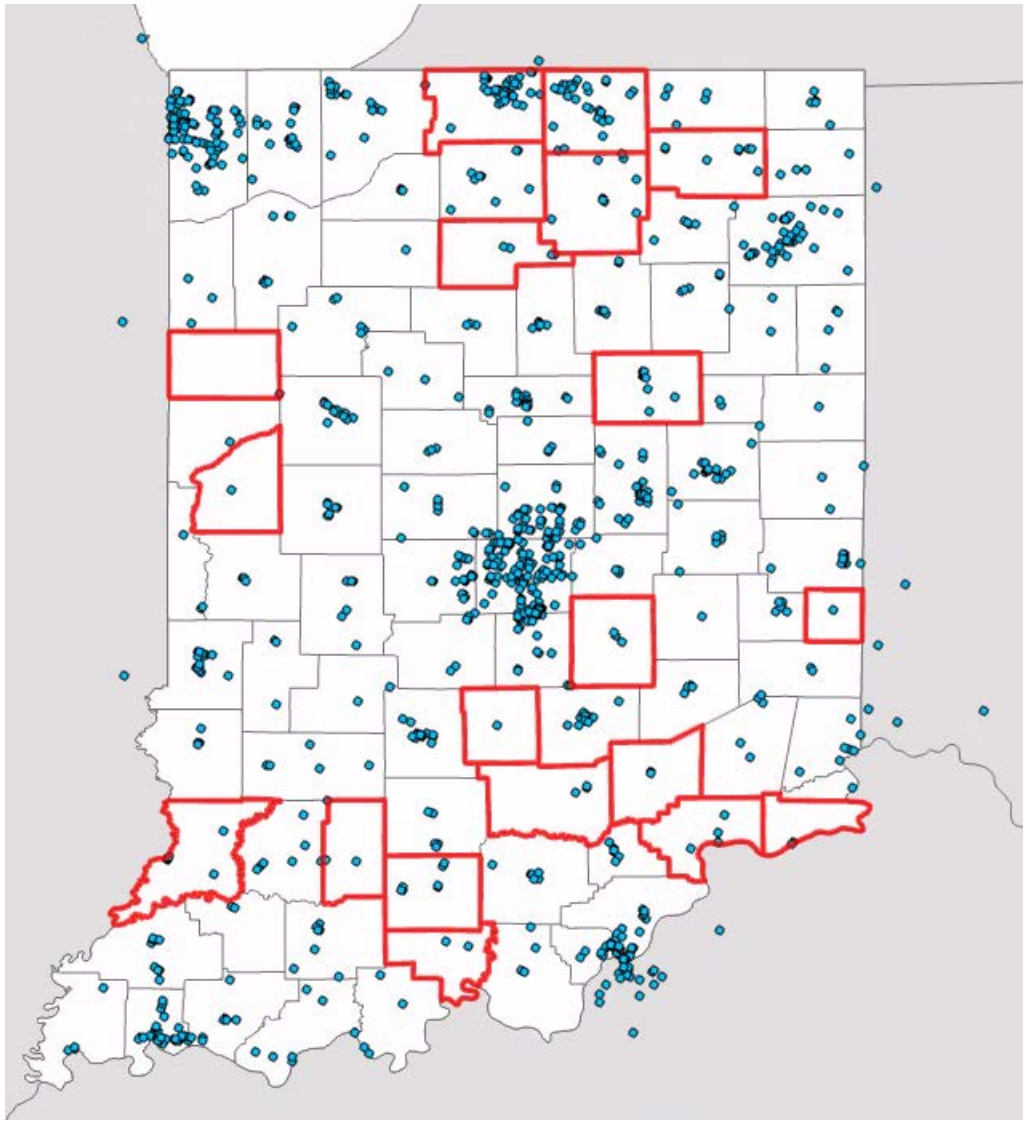


Figure 4. Counties with Higher Provider-to-Member Ratios: MHS



Demographics of Members Lacking Sufficient Access to a PMP

Member demographics analyzed were age, gender, and urban versus rural residence. Because earlier analysis showed that 100% of MCE members across the HHW, HIP, and HCC health programs had a PMP within 30 miles of their residence, this also results in no disparities based on age, gender or rural versus urban designation. It is important to remember, though, that additional factors such as healthcare providers' patient restrictions when based on gender or age, could result in disparities if they exist.

Strengths, Suggestions, and AONs

The ANA review assists OMPP, Qsource, and the MCE in identifying strengths, suggestions, and AONs in addition to network adequacy scores. Strengths indicate that the MCE demonstrated proficiency on a given standard and can be identified regardless of compliance score; the lack of an identified strength should not be interpreted as a shortcoming on the part of the MCE. Suggestions are recommendations that are not required to meet compliance but include improvements for the MCE to consider regardless of score. AONs are identified where the MCE achieved less than 100% compliance and reflect what the MCE should do to improve performance.

As shown in **Table 32-35**, all MCEs were compliant with the geographic accessibility standard.

Table 32. Strengths, Suggestions, and AONs: Anthem

Strengths	
HHW, HIP, and HCC	Anthem has met the requirements for geographic accessibility to a PMP for 100% of Anthem HHW, HIP and HCC members. All members are within 25 miles of a PMP. (The contractual requirement is 30 miles.) Approximately 90% of its members are within 5 miles of a PMP.
Suggestions	
HHW, HIP, and HCC	♦ Anthem could further ensure PMP network adequacy by targeting the counties identified with additional assessments, such as: ♦ Secret shopper calls ♦ Review of call center reporting from members in those counties regarding access to service. ♦ Anthem may want to consider incorporating additional data quality validations into both their member records and provider records. Refer to Appendix B where records excluded from analysis are enumerated, including: ♦ 0.3% of member address records submitted by Anthem appeared to be for out-of-state residences. ♦ 98.6% of the 3,166,642 PMP provider records submitted by Anthem were duplicates.
AONs	
HHW, HIP, and HCC	None noted.

Table 33. Strengths, Suggestions, and AONs: CareSource

Strengths	
HHW and HIP	CareSource has met the requirements for geographic accessibility to a PMP for 100% of CareSource HHW and HIP members. All members are within 25 miles of a PMP. (The contractual requirement is 30 miles.) Over 87% of its members are within 5 miles of a PMP.

Table 33. Strengths, Suggestions, and AONs: CareSource	
Suggestions	
HHW and HIP	♦ CareSource could further ensure PMP network adequacy by targeting the counties identified with additional assessments, such as: ♦ Secret shopper calls ♦ Review of call center reporting from members in those counties regarding access to service. ♦ CareSource may want to consider eliminating from their members' provider directory those provider service locations that are an unreasonable driving distance from any members. ♦ CareSource may want to consider incorporating additional data quality validations into both their member records and provider records. Refer to Refer to Appendix B where records excluded from analysis are enumerated, including: ♦ 1.9% of member address records submitted by CareSource appeared to be for out-of-state residences. ♦ 48.9% of member records submitted by CareSource appeared to be duplicates.
AONs	
HHW and HIP	None noted.

Table 34. Strengths, Suggestions, and AONs: MDwise	
Strengths	
HHW and HIP	Based on the information provided, MDwise has met the requirements for geographic accessibility to a PMP for 100% of MDwise HHW and HIP members. All members are within 25 miles of a PMP. (The contractual requirement is 30 miles.) Approximately 90% of its members are within 5 miles of a PMP.
Suggestions	
HHW and HIP	♦ MDwise could further ensure PMP network adequacy by targeting the counties identified with additional assessments, such as: ♦ Secret shopper calls ♦ Review of call center reporting from members in those counties regarding access to service. ♦ A review of MDwise providers who appear to practice at an unusually considerable number of service locations may identify service locations that are no longer current, and thereby improve the accuracy of provider directories offered to members. ♦ MDwise may want to consider incorporating additional data quality validations into both their member records and provider records. Refer to Appendix B where records excluded from analysis are enumerated, including: ♦ 0.5% of member address records submitted by MDwise appeared to be for out-of-state residences. ♦ 1.2% of PMP provider records were obstetricians who accept obstetric patients only, hence are not available to all MDwise members.
AONs	
HHW and HIP	None noted.

Table 35. Strengths, Suggestions, and AONs: MHS	
Strengths	
HHW, HIP, and HCC	MHS has met the requirements for geographic accessibility to a PMP for 100% of MHS HHW, HIP and HCC members. All members are within 25 miles of a PMP. (The contractual requirement is 30 miles.) Approximately 90% of its members are within 5 miles of a PMP.
Suggestions	
HHW, HIP, and HCC	♦ MHS could further ensure PMP network adequacy by targeting the counties identified with additional assessments, such as: ♦ Secret shopper calls.

Table 35. Strengths, Suggestions, and AONs: MHS	
	♦ Review of call center reporting from members in those counties regarding access to service. ♦ MHS may want to consider incorporating additional data quality validations into both their member records and provider records. Refer to Appendix B where records excluded from analysis are enumerated, including: ♦ 0.3% of member address records submitted by MHS appeared to be for out-of-state residences. ♦ 3.4% of PMP provider records were obstetricians who accept obstetric patients only, hence are not available to all MHS members.
AONs	
HHW, HIP, and HCC	None noted.

Conclusions and Recommendations

The MCEs demonstrated a shared strength for providing access to their enrollees to PMPs within the required travel time standard. Based on the analyses of the MCE's geographical network adequacy, Qsource concludes that the MCEs all met the requirements for geographic accessibility to a PMP for 100% of the MCE's members. All members are within 25 miles of a PMP. (The contractual requirement is 30 miles.)

Recommendations

1. MCEs are encouraged to maintain accurate provider lists in all member materials and ensure service locations are correct which will improve member accessibility.
2. MCEs may want to consider incorporating additional data quality validations into both their member records and provider records.
3. Each MCE is encouraged to build relationships to contract with all the providers in the IHCP to reduce the distance that members must travel for services
4. Qsource suggests each MCE use the total count of providers available against the total count of providers contracted within the IHCP for accurate benchmarking
5. Qsource suggested that MCEs continue to monitor their provider network and implement correct action for identified deficiencies.
6. Ensure that the MCEs use the same methodology to count providers.

Conclusions and Recommendations

Qsource conducted mandatory EQR activities for the OMPP program for calendar year 2020. From the aggregation and analyses of data across activities for all MCEs providing health services, Qsource provides the following conclusions and recommendations for improving the quality and timeliness of care as well as enrollee access to care.

QIP Validation

The OMPP Quality and Outcomes staff works collaboratively with internal stakeholders and the MCEs to improve the oversight and reporting processes by ensuring that all contracted health plans are measuring, calculating, and reporting in the same manner. Quality team staff reviewed the health plans' proposed 2020 QMIP Work Plans and QIPs. The MCE's selected QIP topics focused on improving quality health outcomes by ensuring follow-up after hospitalization for mental illness or substance abuse, improving lead testing in children 12 to 24 months, improving well child visits for children during first 15 months and 3 to 6 years, continued monitoring of health needs screenings, and improving postpartum visit timeliness.

Analysis of each QIP revealed that the MCEs demonstrated an understanding of the improvement process by providing descriptions of the intervention, barriers, and likelihood to create a change, as well as future considerations for the interventions implemented. At the same time, weaknesses were noted in a majority of the QIPs regarding missing or incomplete information for many of the study activity's elements which compromised the ability of Qsource to evaluate and make conclusions about the results and the validity of the study. Qsource recommends that the MCEs change their QIP processes to ensure all information is correctly and completely reported and consult CMS training materials for the 2019 CMS PIP Protocol 1.

PMV

PMV is designed to assess the accuracy of reported performance measures and determine the extent to which the reported rates follow the measure specifications and reporting requirements. To assess MCE performance over time, Qsource validated three measures: member use for members with an Approved Diagnosis of Severe Mental Illness (SMI), member use for Substance Use Disorders (SUD)-related conditions and member use not diagnosed with SMI and not being treated for SUD. Qsource defined the scope of the validation to include the OMPP required metrics. This validation included data source, reporting frequency, and format of those measures. In addition to document review, Qsource audit included system demonstrations, review of data output files, observation of data processing, and review of data reports.

All the MCEs met all specifications for the designated measures. In addition, the data integration, control, and performance measure documentation review indicated an overall high

confidence in the MCE's ability to provide quality and timely care for its enrollees. No deficiencies were noted in the MCE's processes for data collection and performance measure reporting.

CA

OMPP's 2021 compliance assessment is the first year of a new three-year review cycle, with standards reviewed for the MCEs including Availability of Services, Assurances of Adequate Capacity and Services, Grievance and Appeals System, Practice Guidelines, Health Information Systems, Quality Assessment and Performance Improvement (QAPI), Coordination and Continuity of Care, Coverage and Authorization of Services, Subcontractual Relationships and Delegation, Provider Selection (Credentialing/ Recredentialing), and Confidentiality.

All the MCEs demonstrated acceptable performance across key metrics and scores for all three categories of quality, timeliness and access were high. An analysis of MCE strengths and weaknesses during the 2021 ACA revealed that the MCEs demonstrated compliance with federal and contractual regulations in operational practice. The weakness noted across all MCEs was in Assurances of Adequate Capacity and Services. The MCEs had viable evidence they do monitor their provider networks, but P&P was missing.

Qsource recommends the MCEs conduct internal quality checks to ensure program processes align with the most recent federal regulations as well as all contract and contract amendment requirements moving forward. They should ensure processes are in place and all P&P is reviewed yearly with an audit trail.

ANA

As noted in OMPP's Quality Strategy Plan, ensuring enrollees have adequate and timely access is key to quality care. The MCEs are contractually required to maintain an administrative and organizational structure that supports effective and efficient delivery of services to members. Furthermore, Indiana is continually evaluating ways to increase cost-effectiveness. The overarching goal to improve access to care extends throughout the quality improvement efforts of OMPP and is embedded into the expectations of the contracted health plans.

The MCEs demonstrated a shared strength for providing access to their enrollees to PMPs within the required travel time standard. Based on the analyses of the MCE's geographical network adequacy, Qsource concludes all MCEs met the requirements for geographic accessibility to a PMP for 100% of the MCE's members. All members were within 25 miles of a PMP. (The contractual requirement is 30 miles.) Toward achievement of Quality Strategy Plan goals, Qsource recommends that the MCEs be proactive in monitoring and adding providers to their network to ensure a robust provider network for their enrollees, ensure provider lists in enrollee materials are correct, and further ensure PMP network adequacy by targeting the counties identified with additional assessments, such as secret shopper calls and reviewing call center reporting from members.

Appendix A | PMV Measure Rates

Qsource accepted the MCE data submissions from OMPP for each reported measure. The data consisted of MCE-reported totals for each quarter. Qsource used the quarterly totals to complete this report.

Table A-1. Quarter 1 Institution for Mental Diseases (IMD) Member Use

Measure Name	Item	Anthem			CareSource		MDwise		MHS		
		HHW	HIP	HCC	HHW	HIP	HHW	HIP	HHW	HIP	HCC
Counts of Total Days and IMD Stays	Total Days of All members in IMDs in the Reporting Period	0	2,216	482	0	683	0	1,046	5	786	366
	Total Stays of All members in IMDs in the Reporting Period	0	492	105	0	117	0	152	1	151	64
	Average Length of Stay in IMDs	0	4.5	4.6	0	5.8	0	6.9	5.0	5.2	5.7
Count of Members	Number of members in IMD Whose Stay was 15 Days or Less in a Calendar Month	0	438	99	0	99	0	140	1	137	55
	Number of members in IMD Whose Stay Exceeded 15 Days in a Calendar Month	0	0	1	0	0	0	12	0	1	1
	Number of members Waiting for Placement in a State Operated Facility (SOF)	0	0	0	0	0	0	0	0	0	0
	Number of members Whose IMD Stay Exceeded 15 Days in the Calendar Month, are awaiting placement in a SOF and therefore are required to be disenrolled from Risk Based Managed Care	0	0	0	0	0	0	0	0	0	0

Table A-2. Quarter 2 Institution for Mental Diseases (IMD) Member Use for Members with an Approved Diagnosis of Severe Mental Illness (SMI)

Measure Name	Item	Anthem			CareSource		MDwise		MHS		
		HHW	HIP	HCC	HHW	HIP	HHW	HIP	HHW	HIP	HCC
Counts of Total Days and IMD Stays	Total Days of all members in IMDs in the Reporting Period	0	1,257	303	0	339	0	578	0	545	254
	Total Stays of all members in IMDs in the Reporting Period	0	2,249	59	0	54	0	100	0	100	40
	Average Length of Stay in IMDs	0	5.0	5.1	0	6.3	0	5.8	0	5.5	6.4
Count of Members	Number of members in IMD Whose Stay was 30 Days or less in a Calendar Month	0	217	47	0	47	0	100	0	100	40
	Number of members in IMD Whose Stay Exceeded 30 Days in a Calendar Month but was less than 60 Consecutive Days	0	0	0	0	0	0	0	0	0	0
	Number of members Whose IMD Stay Exceeded 60 Consecutive Days	0	0	0	0	0	0	0	0	0	0
	Number of members Waiting for Placement in a State Operated Facility (SOF)	0	0	0	0	0	0	0	0	0	0

Table A-3. Quarter 2 Institution for Mental Diseases Member Use for SUD-related conditions											
Measure Name	**Item**	**Anthem**			**CareSource**		**MDwise**		**MHS**		
		HHW	**HIP**	**HCC**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HCC**
Counts of Total Days and IMD Stays	Total Days of all members with SUD-related conditions in IMDs in the Reporting Period	0	1,020	114	0	527	0	717	0	412	48
	Total Stays of all members in IMDs in the Reporting Period	0	223	22	0	92	0	148	0	93	9
	Average Length of Stay in IMDs	0	4.6	5.2	0	5.7	0	4.8	0	4.4	5.3
Count of Members	Number of members with SUD-related conditions in IMDs Whose Stay was 15 Days or less in a Calendar Month	0	191	18	0	83	0	148	0	93	9
	Number of members with SUD-related Conditions in IMDs Whose Stay Exceeded 15 Days in a Calendar Month	0	0	0	0	0	0	0	0	0	0
	Number of members with SUD-related conditions Waiting for Placement in a State Operated Facility (SOF)	0	0	0	0	0	0	0	0	0	0
	Number of members with SUD-related conditions whose IMDs Stay Exceeded 30 Days in the Calendar Month, are awaiting placement in a SOF and therefore are required to be disenrolled from Risk Based Managed Care	0	0	0	0	0	0	0	0	0	0

Table A-4. Quarter 2 Institution for Mental Diseases (IMD) Member Use (not diagnosed with SMI and not being treated for SUD)											
Measure Name	**Item**	**Anthem**			**CareSource**		**MDwise**		**MHS**		
		HHW	**HIP**	**HCC**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HCC**
Counts of Total Days and IMD Stays	Total Days of all members in IMDs not diagnosed with SMI and not being treated for SUD-related issues in the Reporting Period	0	356	127	0	91	0	167	11	149	121
	Total Stays of all members not diagnosed with SMI and not being treated for SUD-related issues in IMDs in the Reporting Period	0	62	23	0	13	0	27	2	26	16
	Average Length of Stay in IMDs	0	5.7	5.5	0	7.0	0	6.2	5.5	5.7	7.6
Count of Members	Number of members not diagnosed with SMI and not being treated for SUD-related issues in IMDs Whose Stay was 15 Days or less in a Calendar Month	0	56	19	0	12	0	27	2	26	16
	Number of members not diagnosed with SMI and not being treated for SUD-related issues in IMDs Whose Stay Exceeded 15 Days in a Calendar Month	0	0	0	0	0	0	0	0	0	0
	Number of members not diagnosed with SMI and not being treated for SUD-related issues Waiting for Placement in a State Operated Facility (SOF)	0	0	0	0	0	0	0	0	0	0
	Number of members not diagnosed with SMI and not being treated for SUD-related issues whose IMDs Stay Exceeded 30 Days in the Calendar Month, are awaiting placement in a SOF and therefore are required to be disenrolled from Risk Based Managed Care	0	0	0	0	0	0	0	0	0	0

Table A-5. Quarter 3 Institution for Mental Diseases (IMD) Member Use for Members with an Approved Diagnosis of Severe Mental Illness (SMI)

Measure Name	Item	Anthem			CareSource		MDwise		MHS		
		HHW	HIP	HCC	HHW	HIP	HHW	HIP	HHW	HIP	HCC
Counts of Total Days and IMD Stays	Total Days of all members in IMDs in the Reporting Period	0	1,464	424	0	475	0	947	3	681	249
	Total Stays of all members in IMDs in the Reporting Period	0	277	76	0	67	0	163	1	126	41
	Average Length of Stay in IMDs	0	5.3	5.6	0	7.1	0	5.8	3.0	5.4	6.1
Count of Members	Number of members in IMD Whose Stay was 30 Days or less in a Calendar Month	0	248	63	0	63	0	163	1	126	41
	Number of members in IMD Whose Stay Exceeded 30 Days in a Calendar Month but was less than 60 Consecutive Days	0	0	0	0	0	0	0	0	0	0
	Number of members Whose IMD Stay Exceeded 60 Consecutive Days	0	0	0	0	0	0	0	0	0	0
	Number of members Waiting for Placement in a State Operated Facility (SOF)	0	0	0	0	0	0	0	0	0	0

Table A-6. Quarter 3 Institution for Mental Diseases Member Use for SUD-related conditions

Measure Name	Item	Anthem			CareSource		MDwise		MHS		
		HHW	HIP	HCC	HHW	HIP	HHW	HIP	HHW	HIP	HCC
Counts of Total Days and IMD Stays	Total Days of all members with SUD-related conditions in IMDs in the Reporting Period	0	1,382	121	0	661	0	746	11	535	109
	Total Stays of all members in IMDs in the Reporting Period	0	288	22	0	124	0	160	1	121	21
	Average Length of Stay in IMDs	0	4.8	5.5	0	5.3	0	4.7	11.0	4.4	5.2
Count of Members	Number of members with SUD-related conditions in IMDs Whose Stay was 30 Days or less in a Calendar Month	0	246	19	0	107	0	160	1	121	21
	Number of members with SUD-related conditions in IMDs Whose Stay Exceeded 30 Days in a Calendar Month	0	0	0	0	0	0	0	0	0	0
	Number of members with SUD-related conditions Waiting for Placement in a State Operated Facility (SOF)	0	0	0	0	0	0	0	0	0	0
	Number of members with SUD-related conditions Whose IMDs Stay Exceeded 30 days in the Calendar Month, are awaiting placement in a SOF and therefore are required to be disenrolled from Risk Based Managed Care	0	0	0	0	0	0	0	0	0	0

Table A-7. Quarter 3 Institution for Mental Diseases (IMD) Member Use (not diagnosed with SMI and not being treated for SUD)											
Measure Name	**Item**	**Anthem**			**CareSource**		**MDwise**		**MHS**		
		HHW	**HIP**	**HCC**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HCC**
Counts of Total Days and IMD Stays	Total Days of all members in IMDs not diagnosed with SMI and not being treated for SUD-related issues in the Reporting Period	0	489	273	0	91	3	277	0	180	162
	Total Stays of all members not diagnosed with SMI and not being treated for SUD-related issues in IMDs in the Reporting Period	0	90	40	0	14	1	44	0	37	22
	Average Length of Stay in IMDs	0	5.4	6.8	0	6.5	3.0	6.3	0	4.9	7.4
Count of Members	Number of members not diagnosed with SMI and not being treated for SUD-related issues in IMDs Whose Stay was 15 Days or less in a Calendar Month	0	81	31	0	14	1	43	0	37	22
	Number of members not diagnosed with SMI and not being treated for SUD-related issues in IMDs Whose Stay Exceeded 15 Days in a Calendar Month	0	0	0	0	0	0	1	0	0	0
	Number of members not diagnosed with SMI and not being treated for SUD-related issues Waiting for Placement in a State Operated Facility (SOF)	0	0	0	0	0	0	0	0	0	0
	Number of members not diagnosed with SMI and not being treated for SUD-related issues Whose IMDs Stay Exceeded 30 Days in the Calendar Month, are awaiting placement in a SOF and therefore are required to be disenrolled from Risk Based Managed Care	0	0	0	0	0	0	0	0	0	0

Table A-8. Quarter 4 Institution for Mental Diseases (IMD) Member Use for Members with an Approved Diagnosis of Severe Mental Illness (SMI)

Measure Name	Item	Anthem			CareSource		MDwise		MHS		
		HHW	HIP	HCC	HHW	HIP	HHW	HIP	HHW	HIP	HCC
Counts of Total Days and IMD Stays	Total Days of all members in IMDs in the Reporting Period	3	1,408	379	0	369	0	1,007	0	626	222
	Total Stays of all members in IMDs in the Reporting Period	1	286	65	0	56	0	146	0	119	35
	Average Length of Stay in IMDs	3.0	4.9	5.8	0	6.6	0	6.9	0	5.3	6.3
Count of Members	Number of members in IMD Whose Stay was 30 Days or less in a Calendar Month	1	230	55	0	52	0	145	0	119	35
	Number of members in IMD Whose Stay exceeded 30 Days in a Calendar Month but was less than 60 Consecutive Days	0	0	0	0	0	0	1	0	0	0
	Number of members Whose IMD Stay exceeded 60 Consecutive Days	0	0	0	0	0	0	0	0	0	0
	Number of members Waiting for Placement in a State Operated Facility (SOF)	0	0	0	0	0	0	0	0	0	0

Table A-9. Quarter 4 Institution for Mental Diseases Member Use for SUD-related conditions											
Measure Name	**Item**	**Anthem**			**CareSource**		**MDwise**		**MHS**		
		HHW	**HIP**	**HCC**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HCC**
Counts of Total Days and IMD Stays	Total Days of all members with SUD-related conditions in IMDs in the Reporting Period	0	1,998	108	8	567	8	567	0	463	73
	Total Stays of all members in IMDs in the Reporting Period	0	400	21	1	116	1	116	0	113	15
	Average Length of Stay in IMDs	0	5.0	5.1	8.0	4.9	8.0	4.9	0	4.1	4.9
Count of Members	Number of members with SUD-related conditions in IMDs Whose Stay was 30 Days or less in a Calendar Month	0	345	19	1	100	1	100	0	113	15
	Number of members with SUD-related conditions in IMDs Whose Stay Exceeded 30 Days in a Calendar Month	0	0	0	0	0	0	0	0	0	0
	Number of members with SUD-related conditions Waiting for Placement in a State Operated Facility (SOF)	0	0	0	0	0	0	0	0	0	0
	Number of members with SUD-related conditions Whose IMDs Stay Exceeded 30 Days in the Calendar Month, are awaiting placement in a SOF and therefore are required to be disenrolled from Risk Based Managed Care	0	0	0	0	0	0	0	0	0	0

Table A-10. Quarter 4 Institution for Mental Diseases (IMD) Member Use (not diagnosed with SMI and not being treated for SUD)											
Measure Name	**Item**	**Anthem**			**CareSource**		**MDwise**		**MHS**		
		HHW	**HIP**	**HCC**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HCC**
Counts of Total Days and IMD Stays	Total Days of all members in IMDs not diagnosed with SMI and not being treated for SUD-related issues in the Reporting Period	0	502	249	0	122	0	306	0	210	166
	Total Stays of all members not diagnosed with SMI and not being treated for SUD-related issues in IMDs in the Reporting Period	0	97	42	0	21	0	42	0	43	23
	Average Length of Stay in IMDs	0	5.2	5.9	0	5.8	0	7.3	0	4.9	7.2
Count of Members	Number of members not diagnosed with SMI and not being treated for SUD-related issues in IMDs Whose Stay was 15 Days or less in a Calendar Month	0	84	36	0	21	0	39	0	43	21
	Number of members not diagnosed with SMI and not being treated for with SUD-related issues in IMDs Whose Stay Exceeded 15 Days in a Calendar Month	0	0	0	0	0	0	3	0	0	0
	Number of members not diagnosed with SMI and not being treated for with SUD-related issues Waiting for Placement in a State Operated Facility (SOF)	0	0	0	0	0	0	0	0	0	0
	Number of members not diagnosed SMI and not being treated for with SUD-related issues whose IMDs Stay Exceeded 30 Days in the Calendar Month, are awaiting placement in a SOF and therefore are required to be disenrolled from Risk Based Managed Care	0	0	0	0	0	0	0	0	0	0

Appendix B | Additional ANA Findings
Detailed Analysis of PMP Network Access

Table B-1. Anthem PMP Provider Network Adequacy by Program

	HIP	HHW	HCC	All Programs
Count of Providers	6,277	6,569	6,540	**7,098***
Count of Members	230,811	248,339	55,428	**534,578**
Provider-to-Member Ratio	1:37	1:38	1:8	**1:75**
Count of Provider Service Locations	14,014	14,828	14,755	**16,324**
Count of Members within 30 miles of a Provider	230,811	248,339	55,248	**534,578**
Percentage of Members within 30 miles of a Provider Service Location	100%	100%	100%	**100%**

** Includes 812 out-of-state providers. Additionally, be aware that providers enrolled in multiple health programs are counted a single time in Anthem statewide provider count.*

Table B-2. CareSource PMP Provider Network Adequacy by Program

	HIP	HHW	All Programs
Count of Providers	1,968	2,524	**2,800***
Count of Members	53,854	58,004	**111,858**
Provider-to-Member Ratio	1:27	1:23	**1:40**
Count of Provider Service Locations	6,372	8,508	**14,880**
Count of Members within 30 miles of a Provider	53,854	58,004	**111,858**
Percentage of Members within 30 miles of a Provider Service Location	100%	100%	**100%**

** Includes 517 out-of-state providers, not included in the rural-vs-urban comparison. Additionally, be aware that providers enrolled in multiple health programs are counted a single time in CareSource statewide provider count.*

Table B-3. MDwise PMP Provider Network Adequacy by Program			
	HIP	**HHW**	**All Programs**
Count of Providers	16,706	16,904	**17,504***
Count of Members	160,032	226,338	**386,370**
Provider-to-Member Ratio	1:10	1:13	**1:22**
Count of Provider Service Locations	60,007	60,108	**62,056**
Count of Members within 30 miles of a Provider	160,032	226,338	**386,370**
Percentage of Members within 30 miles of a Provider Service Location	100%	100%	**100%**

** Includes 2,990 out-of-state providers, not included in the rural-vs-urban comparison. Additionally, be aware that providers enrolled in multiple health programs are counted a single time in MDwise statewide provider count.*

Table B-4. MHS PMP Provider Network Adequacy by Program				
	HIP	**HHW**	**HCC**	**All Programs**
Count of Providers	3,250	3,368	3,559	**4,066***
Count of Members	97,557	156,097	35,247	**288,901**
Provider-to-Member Ratio	1:30	1:46	1:10	**1:71**
Count of Provider Service Locations	3,584	3,765	3,997	**4,251**
Count of Members within 30 miles of a Provider	97,557	156,097	35,247	**288,901**
Percentage of Members within 30 miles of a Provider Service Location	100%	100%	100%	**100%**

** Includes 142 out-of-state providers, not included in the rural-vs-urban comparison. Additionally, be aware that providers enrolled in multiple health programs are counted a single time in MHS statewide provider count.*

Provider Network Accessibility by County

Population density influences provider network accessibility. **Tables B-5 through B-8** categorize Indiana's 92 counties as either rural or urban based on the FORHP.

Table B-5. Anthem Provider-to-Member Ratio by County

Region[2] / County	Rural[3] / Urban	Count of Anthem Members	Anthem Provider-to-Member Ratio
Region 1 – North		**129,376**	**1:80**
DeKalb	Rural	2,600	1:68
Elkhart	Urban	10,057	1:54
Fulton	Rural	1,650	1:55
Jasper	Rural	2,505	1:76
Kosciusko	Rural	3,901	1:87
LaGrange	Rural	1,174	1:69
Lake	Urban	50,964	1:78
LaPorte	Urban	10,933	1:75
Marshall	Rural	3,446	1:35
Newton	Rural	1,046	1:52
Noble	Rural	2,098	1:57
Porter	Urban	12,842	1:54
Pulaski	Rural	914	1:42
St. Joseph	Urban	19,901	1:52
Starke	Rural	2,393	1:53

[2] Regions are Indiana Health Coverage Program's Provider Relations Regions.

https://www.in.gov/medicaid/providers/contact-information/provider-relations-consultants/

[3] Includes metropolitan counties designated as eligible for Rural Health funding by the FORHP.

Table B-5. Anthem Provider-to-Member Ratio by County

Region[2] / County	Rural[3] / Urban	Count of Anthem Members	Anthem Provider-to-Member Ratio
Steuben	Rural	1,632	1:78
Whitley	Urban	1,320	1:29
Region 2 – North Central		**101,514**	**1:85**
Adams	Rural	1,514	1:61
Allen	Urban	30,997	1:111
Benton	Rural	442	There are no Anthem PMPs in this county
Blackford	Rural	954	1:64
Carroll	Rural	923	1:31
Cass	Rural	2,389	1:50
Clinton	Rural	1,676	1:168
Delaware	Urban	7,887	1:55
Fountain	Rural	946	1:95
Grant	Rural	6,563	1:104
Howard	Urban	6,217	1:67
Huntington	Rural	1,926	1:36
Jay	Rural	1,553	1:52
Madison	Urban	16,078	1:102
Miami	Rural	2,399	1:55
Montgomery	Rural	2,665	1:27
Randolph	Rural	1,501	1:42
Tippecanoe	Urban	9,180	1:103
Tipton	Rural	866	1:96

Table B-5. Anthem Provider-to-Member Ratio by County			
Region[2] / County	**Rural[3] / Urban**	**Count of Anthem Members**	**Anthem Provider-to-Member Ratio**
Wabash	Rural	1,733	1:40
Warren	Rural	375	1:25
Wells	Rural	1,642	1:39
White	Rural	1,088	1:32
Region 3 – Central		**149,346**	**1:94**
Boone	Urban	2,236	1:25
Hamilton	Urban	10,201	1:28
Hendricks	Urban	7,131	1:35
Johnson	Urban	13,501	1:47
Marion	Urban	110,325	1:112
Morgan	Urban	5,952	1:49
Region 4 – Southwest		**76,980**	**1:67**
Clay	Urban	2,079	1:55
Crawford	Rural	1,033	1:43
Daviess	Rural	2,821	1:36
Dubois	Rural	1,650	1:43
Gibson	Rural	3,123	1:65
Greene	Rural	3,628	1:71
Knox	Rural	2,929	1:73
Lawrence	Rural	4,584	1:52
Martin	Rural	837	1:64
Orange	Rural	1,322	1:25
Owen	Rural	2,217	1:148

Table B-5. Anthem Provider-to-Member Ratio by County			
Region[2] / County	**Rural[3] / Urban**	**Count of Anthem Members**	**Anthem Provider-to-Member Ratio**
Parke	Rural	975	1:13
Perry	Rural	1,900	1:76
Pike	Rural	1,197	1:100
Posey	Urban	1,868	1:267
Putnam	Rural	2,584	1:42
Spencer	Rural	1,484	1:93
Sullivan	Rural	1,721	1:75
Vanderburgh	Urban	24,291	1:93
Vermillion	Rural	1,073	1:14
Vigo	Urban	8,362	1:55
Warrick	Urban	5,302	1:40
Region 5 – Southeast		**77,362**	**1:68**
Bartholomew	Urban	3,662	1:43
Brown	Rural	1,057	1:211
Clark	Urban	8,664	1:54
Dearborn	Urban	2,145	1:47
Decatur	Rural	1,785	1:41
Fayette	Rural	2,594	1:96
Floyd	Urban	5,855	1:76
Franklin	Rural	1,466	1:42
Hancock	Urban	5,974	1:60
Harrison	Urban	4,030	1:72
Henry	Rural	4,189	1:48

Table B-5. Anthem Provider-to-Member Ratio by County			
Region[2] / County	**Rural[3] / Urban**	**Count of Anthem Members**	**Anthem Provider-to-Member Ratio**
Jackson	Rural	3,670	1:53
Jefferson	Rural	2,299	1:77
Jennings	Rural	2,138	1:102
Monroe	Urban	9,681	1:79
Ohio	Rural	244	1:81
Ripley	Rural	1,995	1:46
Rush	Rural	1,744	1:44
Scott	Rural	2,606	1:70
Shelby	Urban	3,372	1:42
Switzerland	Rural	669	1:335
Union	Rural	436	1:26
Washington	Rural	2,791	1:48
Wayne	Rural	4,296	1:44
All Regions		**534,578**	**1:75**

Table B-6. CareSource Provider-to-Member Ratio by County			
Region[4] / County	**Rural[5] / Urban**	**Count of CareSource Members**	**CareSource Provider-to-Member Ratio**
Region 1 – North		**22,024**	**1:49**
DeKalb	Rural	626	1:5
Elkhart	Urban	1,761	1:220
Fulton	Rural	199	1:33
Jasper	Rural	460	1:29
Kosciusko	Rural	1,250	1:38
LaGrange	Rural	340	1:24
Lake	Urban	8,064	1:58
LaPorte	Urban	1,771	1:48
Marshall	Rural	465	1:93
Newton	Rural	232	1:116
Noble	Rural	698	1:6
Porter	Urban	1,808	1:48
Pulaski	Rural	200	1:50
St. Joseph	Urban	2,774	1:121
Starke	Rural	393	1:39
Steuben	Rural	580	1:53
Whitley	Urban	403	1:3
Region 2 – North Central		**26,592**	**1:35**

[4] Regions are Indiana Health Coverage Program's Provider Relations Regions.

https://www.in.gov/medicaid/providers/contact-information/provider-relations-consultants/

[5] Includes metropolitan counties designated as eligible for Rural Health funding by the FORHP.

Table B-6. CareSource Provider-to-Member Ratio by County

Region[4] / County	Rural[5] / Urban	Count of CareSource Members	CareSource Provider-to-Member Ratio
Adams	Rural	474	1:53
Allen	Urban	7,718	1:27
Benton	Rural	167	1:14
Blackford	Rural	225	1:38
Carroll	Rural	367	1:33
Cass	Rural	737	1:67
Clinton	Rural	721	1:28
Delaware	Urban	1,862	1:29
Fountain	Rural	302	CareSource has no providers enrolled in this county
Grant	Rural	1,346	1:96
Howard	Urban	1,734	1:28
Huntington	Rural	725	1:5
Jay	Rural	399	1:36
Madison	Urban	2,861	1:18
Miami	Rural	755	1:38
Montgomery	Rural	661	1:18
Randolph	Rural	584	1:83
Tippecanoe	Urban	3,137	1:41
Tipton	Rural	190	1:38
Wabash	Rural	569	1:14
Warren	Rural	113	1:13
Wells	Rural	461	1:38

Table B-6. CareSource Provider-to-Member Ratio by County			
Region[4] / County	**Rural[5] / Urban**	**Count of CareSource Members**	**CareSource Provider-to-Member Ratio**
White	Rural	484	1:17
Region 3 – Central		**32,745**	**1:39**
Boone	Urban	675	1:9
Hamilton	Urban	3,015	1:10
Hendricks	Urban	1,672	1:11
Johnson	Urban	2,296	1:12
Marion	Urban	24,041	1:47
Morgan	Urban	1,046	1:14
Region 4 – Southwest		**11,892**	**1:47**
Clay	Urban	423	1:42
Crawford	Rural	137	CareSource has no providers enrolled in this county
Daviess	Rural	393	1:79
Dubois	Rural	423	1:85
Gibson	Rural	341	1:43
Greene	Rural	609	1:305
Knox	Rural	445	1:64
Lawrence	Rural	800	1:15
Martin	Rural	144	1:144
Orange	Rural	250	1:13
Owen	Rural	389	1:97
Parke	Rural	268	1:54
Perry	Rural	315	1:63

Table B-6. CareSource Provider-to-Member Ratio by County			
Region[4] / County	**Rural[5] / Urban**	**Count of CareSource Members**	**CareSource Provider-to-Member Ratio**
Pike	Rural	187	CareSource has no providers enrolled in this county
Posey	Urban	254	CareSource has no providers enrolled in this county
Putnam	Rural	525	1:66
Spencer	Rural	251	1:36
Sullivan	Rural	314	1:35
Vanderburgh	Urban	2,865	1:42
Vermillion	Rural	237	1:119
Vigo	Urban	1,778	1:40
Warrick	Urban	544	1:11
Region 5 – Southeast		**18,605**	**1:47**
Bartholomew	Urban	960	1:40
Brown	Rural	243	1:243
Clark	Urban	2,258	1:35
Dearborn	Urban	870	1:26
Decatur	Rural	544	1:60
Fayette	Rural	741	1:148
Floyd	Urban	1,344	1:28
Franklin	Rural	524	1:33
Hancock	Urban	906	1:30
Harrison	Urban	579	1:21
Henry	Rural	949	1:33
Jackson	Rural	784	1:30

Table B-6. CareSource Provider-to-Member Ratio by County			
Region[4] / County	**Rural[5] / Urban**	**Count of CareSource Members**	**CareSource Provider-to-Member Ratio**
Jefferson	Rural	368	1:184
Jennings	Rural	481	1:48
Monroe	Urban	1,880	1:38
Ohio	Rural	79	1:79
Ripley	Rural	437	1:24
Rush	Rural	319	1:53
Scott	Rural	526	1:40
Shelby	Urban	968	1:121
Switzerland	Rural	151	1:151
Union	Rural	158	1:158
Washington	Rural	581	1:53
Wayne	Rural	1,955	1:58
All Regions		**111,858**	**1:40**

Table B-7. MDwise Provider-to-Member Ratio by County			
Region[6] / County	**Rural[7] / Urban**	**Count of MDwise Members**	**MDwise Provider-to-Member Ratio**
Region 1 – North		**78,915**	**1:23**
DeKalb	Rural	2,456	1:12
Elkhart	Urban	3,501	1:10
Fulton	Rural	1,210	1:23
Jasper	Rural	1,830	1:10
Kosciusko	Rural	3,608	1:13
LaGrange	Rural	1,252	1:13
Lake	Urban	30,973	1:27
LaPorte	Urban	8,281	1:21
Marshall	Rural	1,745	1:17
Newton	Rural	789	1:72
Noble	Rural	3,406	1:16
Porter	Urban	5,227	1:11
Pulaski	Rural	658	1:20
St. Joseph	Urban	8,661	1:9
Starke	Rural	1,625	1:11
Steuben	Rural	1,787	1:11
Whitley	Urban	1,906	1:8

[6] Regions are Indiana Health Coverage Program's Provider Relations Regions.

https://www.in.gov/medicaid/providers/contact-information/provider-relations-consultants/

[7] Includes metropolitan counties designated as eligible for Rural Health funding by the FORHP.

Table B-7. MDwise Provider-to-Member Ratio by County			
Region[6] / County	**Rural[7] / Urban**	**Count of MDwise Members**	**MDwise Provider-to-Member Ratio**
Region 2 – North Central		**93,867**	**1:21**
Adams	Rural	1,113	1:14
Allen	Urban	28,836	1:14
Benton	Rural	827	1:17
Blackford	Rural	1,159	1:11
Carroll	Rural	1,267	1:19
Cass	Rural	4,110	1:38
Clinton	Rural	3,945	1:17
Delaware	Urban	9,427	1:14
Fountain	Rural	1,280	1:67
Grant	Rural	2,817	1:16
Howard	Urban	6,680	1:20
Huntington	Rural	2,700	1:10
Jay	Rural	1,253	1:10
Madison	Urban	4,887	1:6
Miami	Rural	3,050	1:33
Montgomery	Rural	1,623	1:9
Randolph	Rural	2,425	1:36
Tippecanoe	Urban	9,984	1:14
Tipton	Rural	520	1:3
Wabash	Rural	2,206	1:10
Warren	Rural	592	1:8
Wells	Rural	1,439	1:11

Table B-7. MDwise Provider-to-Member Ratio by County			
Region[6] / County	**Rural[7] / Urban**	**Count of MDwise Members**	**MDwise Provider-to-Member Ratio**
White	Rural	1,727	1:9
Region 3 – Central		**120,389**	**1:21**
Boone	Urban	1,696	1:6
Hamilton	Urban	7,444	1:3
Hendricks	Urban	5,623	1:4
Johnson	Urban	5,013	1:6
Marion	Urban	97,672	1:21
Morgan	Urban	2,941	1:9
Region 4 – Southwest		**40,000**	**1:17**
Clay	Urban	2,854	1:44
Crawford	Rural	262	1:12
Daviess	Rural	1,682	1:13
Dubois	Rural	684	1:4
Gibson	Rural	926	1:14
Greene	Rural	1,590	1:32
Knox	Rural	997	1:4
Lawrence	Rural	2,148	1:8
Martin	Rural	324	1:41
Orange	Rural	613	1:5
Owen	Rural	957	1:46
Parke	Rural	1,495	1:29
Perry	Rural	473	1:12
Pike	Rural	273	1:23

Table B-7. MDwise Provider-to-Member Ratio by County			
Region[6] / County	**Rural[7] / Urban**	**Count of MDwise Members**	**MDwise Provider-to-Member Ratio**
Posey	Urban	722	1:11
Putnam	Rural	1,122	1:10
Spencer	Rural	374	1:8
Sullivan	Rural	1,834	1:56
Vanderburgh	Urban	4,437	1:5
Vermillion	Rural	1,857	1:12
Vigo	Urban	13,528	1:21
Warrick	Urban	848	1:2
Region 5 – Southeast		**53,199**	**1:17**
Bartholomew	Urban	4,147	1:8
Brown	Rural	545	1:68
Clark	Urban	4,787	1:14
Dearborn	Urban	3,749	1:24
Decatur	Rural	1,951	1:10
Fayette	Rural	2,448	1:24
Floyd	Urban	2,972	1:7
Franklin	Rural	1,323	1:22
Hancock	Urban	1,656	1:7
Harrison	Urban	1,018	1:9
Henry	Rural	4,221	1:21
Jackson	Rural	1,922	1:10
Jefferson	Rural	1,151	1:13
Jennings	Rural	2,121	1:23

Table B-7. MDwise Provider-to-Member Ratio by County			
Region[6] / County	**Rural[7] / Urban**	**Count of MDwise Members**	**MDwise Provider-to-Member Ratio**
Monroe	Urban	3,578	1:4
Ohio	Rural	472	1:118
Ripley	Rural	1,709	1:14
Rush	Rural	782	1:9
Scott	Rural	1,711	1:20
Shelby	Urban	1,595	1:6
Switzerland	Rural	675	1:16
Union	Rural	418	1:38
Washington	Rural	1,240	1:14
Wayne	Rural	7,008	1:13
All Regions		**386,370**	**1:22**

Table B-8. MHS Provider-to-Member Ratio by County			
Region[8] / County	**Rural[9] / Urban**	**Count of MHS Members**	**MHS Provider-to-Member Ratio**
Region 1 – North		**96,985**	**1:112**
DeKalb	Rural	1,461	1:70
Elkhart	Urban	24,259	1:240
Fulton	Rural	1,303	1:130
Jasper	Rural	1,389	1:99
Kosciusko	Rural	4,075	1:120
LaGrange	Rural	917	1:71
Lake	Urban	22,939	1:88
LaPorte	Urban	3,884	1:60
Marshall	Rural	2,097	1:70
Newton	Rural	661	1:110
Noble	Rural	1,707	1:122
Porter	Urban	4,480	1:54
Pulaski	Rural	744	1:74
St. Joseph	Urban	23,641	1:129
Starke	Rural	1,170	1:98
Steuben	Rural	1,693	1:113
Whitley	Urban	565	1:31

[8] Regions are Indiana Health Coverage Program's Provider Relations Regions.

https://www.in.gov/medicaid/providers/contact-information/provider-relations-consultants/

[9] Includes metropolitan counties designated as eligible for Rural Health funding by the FORHP.

Table B-8. MHS Provider-to-Member Ratio by County			
Region[8] / County	**Rural[9] / Urban**	**Count of MHS Members**	**MHS Provider-to-Member Ratio**
Region 2 – North Central		**59,244**	**1:76**
Adams	Rural	1,181	1:91
Allen	Urban	13,811	1:75
Benton	Rural	387	1:194
Blackford	Rural	535	1:67
Carroll	Rural	591	1:54
Cass	Rural	1,423	1:55
Clinton	Rural	1,081	1:98
Delaware	Urban	5,721	1:66
Fountain	Rural	480	1:160
Grant	Rural	5,907	1:174
Howard	Urban	4,202	1:63
Huntington	Rural	1,256	1:90
Jay	Rural	844	1:77
Madison	Urban	7,292	1:74
Miami	Rural	1,568	1:92
Montgomery	Rural	1,871	1:67
Randolph	Rural	1,034	1:80
Tippecanoe	Urban	6,035	1:57
Tipton	Rural	567	1:63
Wabash	Rural	1,216	1:68
Warren	Rural	226	1:45
Wells	Rural	749	1:50

Table B-8. MHS Provider-to-Member Ratio by County			
Region[8] / County	**Rural[9] / Urban**	**Count of MHS Members**	**MHS Provider-to-Member Ratio**
White	Rural	1,267	1:75
Region 3 – Central		**64,112**	**1:54**
Boone	Urban	1,787	1:27
Hamilton	Urban	6,520	1:30
Hendricks	Urban	4,669	1:50
Johnson	Urban	5,117	1:39
Marion	Urban	43,657	1:65
Morgan	Urban	2,362	1:62
Region 4 – Southwest		**26,749**	**1:56**
Clay	Urban	675	1:68
Crawford	Rural	725	1:363
Daviess	Rural	985	1:58
Dubois	Rural	1,993	1:100
Gibson	Rural	568	1:32
Greene	Rural	855	1:39
Knox	Rural	3,327	1:145
Lawrence	Rural	1,662	1:57
Martin	Rural	496	1:124
Orange	Rural	2,367	1:169
Owen	Rural	951	1:86
Parke	Rural	399	1:44
Perry	Rural	447	1:37
Pike	Rural	435	1:87

Table B-8. MHS Provider-to-Member Ratio by County			
Region[8] / County	**Rural[9] / Urban**	**Count of MHS Members**	**MHS Provider-to-Member Ratio**
Posey	Urban	528	1:59
Putnam	Rural	1,574	1:63
Spencer	Rural	649	1:46
Sullivan	Rural	373	1:47
Vanderburgh	Urban	4,047	1:41
Vermillion	Rural	320	1:32
Vigo	Urban	2,224	1:28
Warrick	Urban	879	1:22
Region 5 – Southeast		**42,081**	**1:77**
Bartholomew	Urban	4,733	1:89
Brown	Rural	666	1:333
Clark	Urban	6,218	1:60
Dearborn	Urban	762	1:32
Decatur	Rural	759	1:69
Fayette	Rural	951	1:56
Floyd	Urban	2,296	1:64
Franklin	Rural	434	1:87
Hancock	Urban	1,085	1:49
Harrison	Urban	999	1:45
Henry	Rural	1,321	1:55
Jackson	Rural	2,279	1:253
Jefferson	Rural	2,890	1:126
Jennings	Rural	1,593	1:145

Table B-8. MHS Provider-to-Member Ratio by County			
Region[8] / County	**Rural[9] / Urban**	**Count of MHS Members**	**MHS Provider-to-Member Ratio**
Monroe	Urban	3,301	1:51
Ohio	Rural	15	1:29
Ripley	Rural	746	1:41
Rush	Rural	622	1:62
Scott	Rural	1,383	1:99
Shelby	Urban	3,300	1:165
Switzerland	Rural	604	1:302
Union	Rural	179	1:179
Washington	Rural	1,103	1:79
Wayne	Rural	3,742	1:94
All Regions		**288,901**	**1:71**

PMP Access by Member Demographics

Table B-9. Anthem Member Demographics

Demographics			Count of Members	
Age	**Gender**	**Rural*/Urban**	**With Access**	**Without Access**
Pediatric (18 years and younger)	Male	Rural	29,229	0
Adult (19–64 years)	Male	Rural	26,793	0
65+ years	Male	Rural	287	0
Pediatric (18 years and younger)	Female	Rural	27,455	0
Adult (19–64 years)	Female	Rural	39,368	0
65+ years	Female	Rural	439	0
Pediatric (18 years and younger)	Male	Urban	101,948	0
Adult (19–64 years)	Male	Urban	82,340	0
65+ years	Male	Urban	1,267	0
Pediatric (18 years and younger)	Female	Urban	96,442	0
Adult (19–64 years)	Female	Urban	126,795	0
65+ years	Female	Urban	2,215	0

** Includes metropolitan counties designated as eligible for Rural Health funding by the FORHP.*

Table B-10. CareSource Member Demographics				
Demographics			Count of Members	
Age	Gender	Rural*/Urban	With Access	Without Access
Pediatric (18 years and younger)	Male	Rural	7,561	0
Adult (19–64 years)	Male	Rural	6,200	0
65+ years	Male	Rural	42	0
Pediatric (18 years and younger)	Female	Rural	7,411	0
Adult (19–64 years)	Female	Rural	8,316	0
65+ years	Female	Rural	61	0
Pediatric (18 years and younger)	Male	Urban	20,412	0
Adult (19–64 years)	Male	Urban	18,302	0
65+ years	Male	Urban	106	0
Pediatric (18 years and younger)	Female	Urban	20,172	0
Adult (19–64 years)	Female	Urban	23,149	0
65+ years	Female	Urban	126	0

** Includes metropolitan counties designated as eligible for Rural Health funding by the FORHP.*

Table B-11. MDwise Member Demographics				
Demographics			Count of Members	
Age	Gender	Rural*/Urban	With Access	Without Access
Pediatric (18 years and younger)	Male	Rural	28,205	0
Adult (19–64 years)	Male	Rural	16,770	0
65+ years	Male	Rural	57	0
Pediatric (18 years and younger)	Female	Rural	27,315	0
Adult (19–64 years)	Female	Rural	29,306	0
65+ years	Female	Rural	73	0
Unknown	Unknown	Rural	1	0
Pediatric (18 years and younger)	Male	Urban	81,240	0
Adult (19–64 years)	Male	Urban	44,264	0
65+ years	Male	Urban	98	0
Pediatric (18 years and younger)	Female	Urban	80,153	0
Adult (19–64 years)	Female	Urban	78,726	0
65+ years	Female	Urban	159	0
Unknown	Unknown	Rural	3	0

** Includes metropolitan counties designated as eligible for Rural Health funding by the FORHP.*

Table B-12. MHS Member Demographics				
Demographics			Count of Members	
Age	Gender	Rural*/Urban	With Access	Without Access
Pediatric (18 years and younger)	Male	Rural	22,175	0
Adult (19–64 years)	Male	Rural	12,642	0
65+ years	Male	Rural	187	0
Pediatric (18 years and younger)	Female	Rural	20,642	0
Adult (19–64 years)	Female	Rural	21,001	0
65+ years	Female	Rural	266	0
Pediatric (18 years and younger)	Male	Urban	61,580	0
Adult (19–64 years)	Male	Urban	33,452	0
65+ years	Male	Urban	730	0
Pediatric (18 years and younger)	Female	Urban	58,768	0
Adult (19–64 years)	Female	Urban	56,197	0
65+ years	Female	Urban	1,261	0

** Includes metropolitan counties designated as eligible for Rural Health funding by the FORHP.*

Figures B-1 through B-8 present a visual representation of the rural versus urban demographics.

Figure B-1. Anthem Rural Demographics

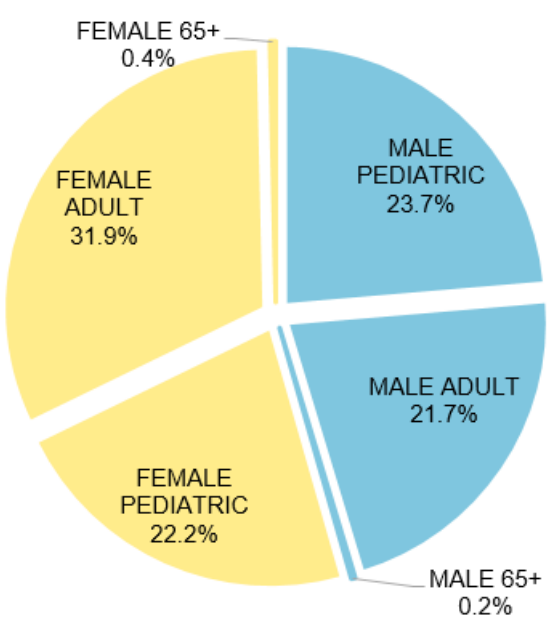


Figure B-2. Anthem Urban Demographics

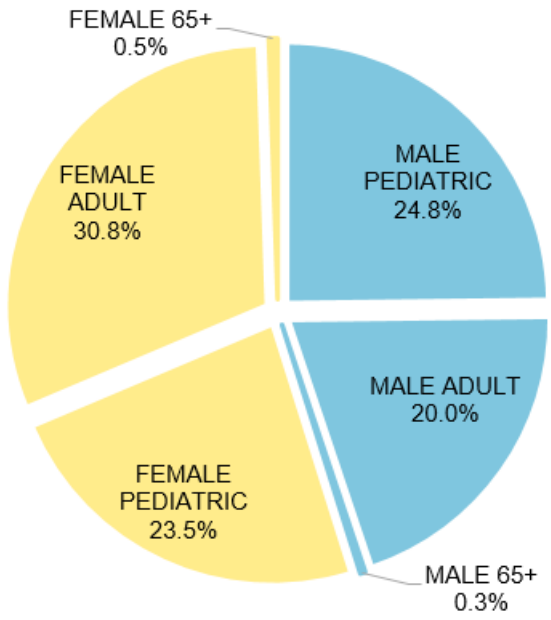


Figure B-3. CareSource Rural Demographics

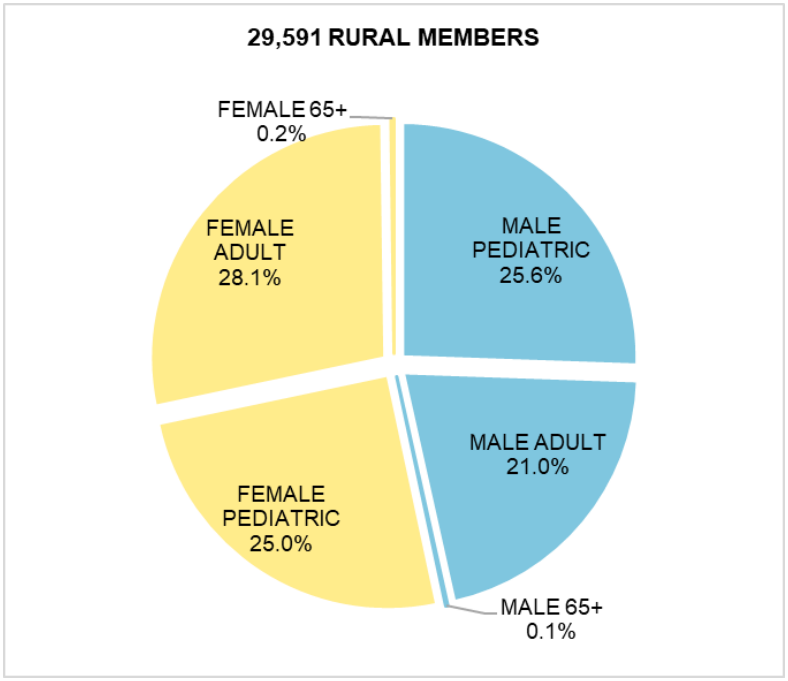


Figure B-4. CareSource Urban Demographics

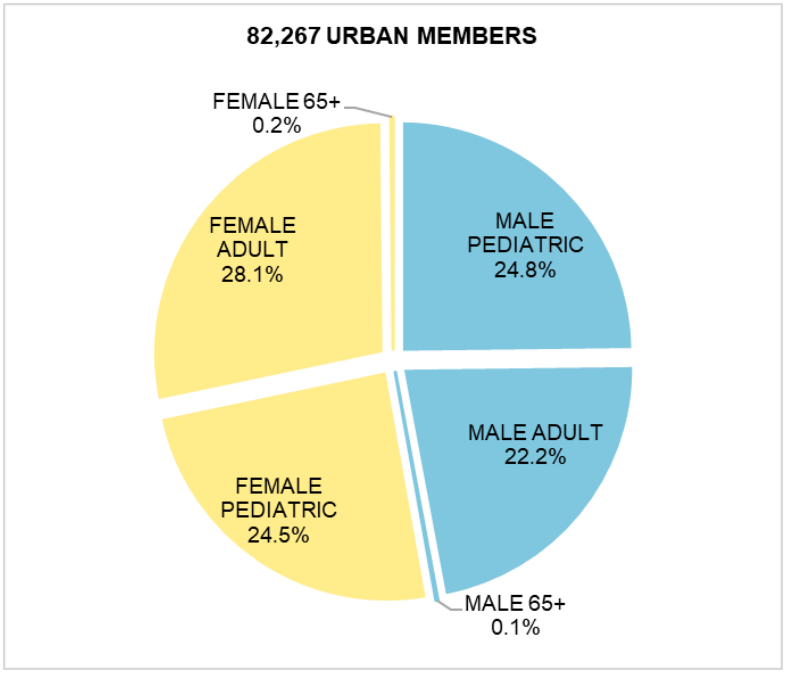


Figure B-5. MDwise Rural Demographics

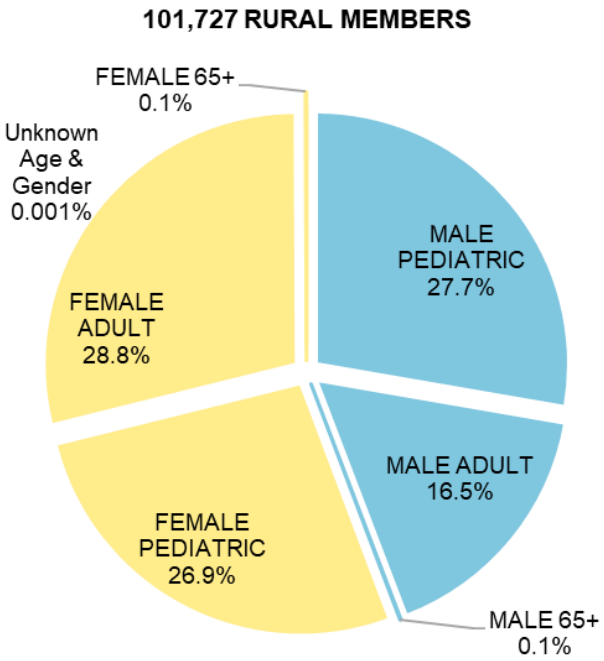


Figure B-6. MDwise Urban Demographics

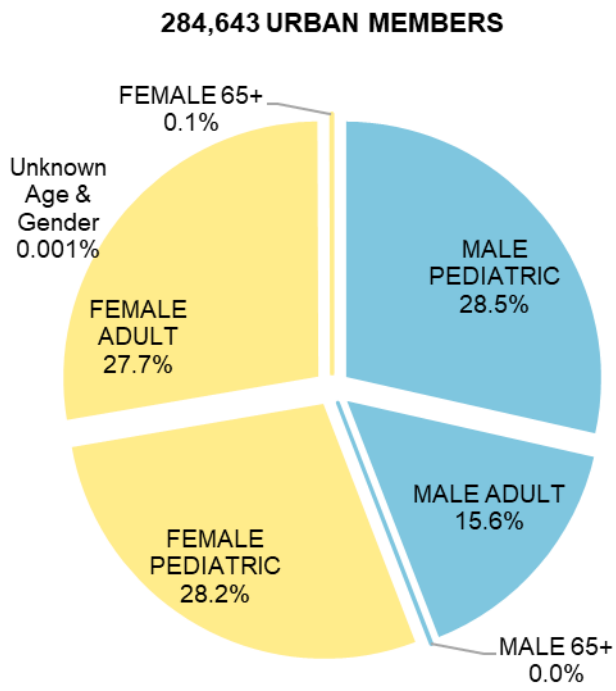


Figure B-7. MHS Rural Demographics

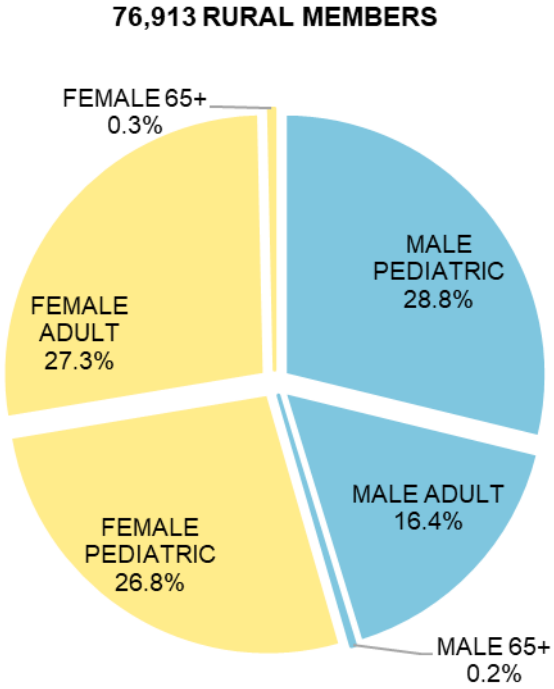


Figure B-8. MHS Urban Demographics