2024 Annual

EQR Technical Report

Indiana Family and Social Services

Office of Medicaid Policy and Planning

Final

Indiana Family and Social Services Administration

Qsource

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Acknowledgements, Acronyms, and Initialisms[1]

ADT ..... Admission, Discharge, Transfer
ANA ..... Annual Network Adequacy
Anthem ..... Blue Cross Blue Shield Anthem, Managed Care Entity
AOD ..... Alcohol and Other Drug Abuse/Dependence
AON ..... Area of Noncompliance
Axon ..... Axon Advisors, Limited Liability Company
BH ..... Behavioral Health
BR ..... Biased Rate
CA ..... Compliance Assessment
CareSource ..... CareSource Indiana, Managed Care Entity
CET ..... Care Engagement Team
CFR ..... Code of Federal Regulations
CHIP ..... Children's Health Insurance Program
CHW ..... Community Health Worker
CM ..... Care-Case Management
CMS ..... Centers for Medicare & Medicaid Services
CY ..... Calendar Year
ED ..... Emergency Department
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
ER ..... Emergency Room
FSSA ..... Indiana Family and Social Services Administration
FUA ..... Follow-up After Emergency Department Visit for Drug Abuse or Dependence
HCC ..... Hoosier Care Connect
HCP-LAN ..... Health Care Payment Learning & Action Network
HEDIS® ..... Healthcare Effectiveness Data and Information Set, a registered trademark of the NCQA
HHS ..... Department of Health and Human Services
HHW ..... Hoosier Healthwise
HIE ..... Health Information Exchange
HIP ..... Healthy Indiana Plan
HNS ..... Health Needs Screening
ID ..... Identification
IHCP ..... Indiana Health Coverage Programs
IHIE ..... Indiana Health Information Exchange
IS ..... Information Systems
ISCA/ISCAT ..... Information Systems Capability Assessment Tool
LCSW ..... Licensed Clinical Social Worker
MCE ..... Managed Care Entity
MDwise ..... Managed Care Entity
MHS ..... Managed Health Services, Managed Care Entity
MSLC ..... Myers & Stauffer Limited Liability Company
MSR ..... Minimum Submission Review
MY ..... Measurement Year
NA ..... Not Applicable
NB ..... No Benefit
NCQA ..... (NCQA)
NPI ..... National Provider Identifier
NQ ..... Not Required
NR ..... Not Reported
OB/GYN ..... Obstetrician/Gynecologist
OMPP ..... Office of Medicaid Policy and Planning
P4O ..... Payment-for-Outcomes

[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.*

P&P ..... Policy and Procedure
PCP ..... Primary Care Provider/Physician
PDF ..... Portable Document Format
PDSA ..... Plan-Do-Study-Act
PMP ..... Primary Medical Provider
PMV ..... Performance Measure Validation
QIP ..... Quality Improvement Project
QR ..... Quick Response
Qsource® ..... EQRO, a registered trademark
RFI ..... Request for Information
SDOH ..... Social Determinants of Health
SMS ..... Short Message Service
SQL ..... Structured Query Language
SSI ..... Supplemental Security Income
SUD ..... Substance Use Disorder
UHC ..... UnitedHealthcare
UM ..... Utilization Management
VBP ..... Value-Based Payment

Overview

In accordance with Title 42 *Code of Federal Regulations* (CFR) § 438.364, Qsource has produced this *2024 Annual External Quality Review Organization (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) and their respective Indiana Health Coverage Plans (IHCPs). Indiana's MCEs include Anthem, CareSource, MDwise, Managed Health Services (MHS), and UnitedHealthcare (UHC).

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 EQRO and prepared this *2024 Annual EQRO Technical Report* to document the MCEs' IHCPs' performance in providing services to enrollees, identify areas for improvement, and recommend interventions to improve the process and outcomes of care.

This section provides a brief history of OMPP, the population(s) served by each IHCP, enrollee data for each MCE, OMPP's quality improvement initiative descriptions with calendar year (CY) 2023 results, the mandatory EQR activities conducted by Qsource in 2024 (including targeted quality objectives), guidelines provided by the Centers for Medicare & Medicaid Services (CMS) for reporting EQR activities, and the intended utilization for this report.

OMPP Background

The FSSA OMPP manages the administration of Medicaid health coverage programs for Indiana Hoosiers. OMPP's collection of programs offers three risk-based IHCPs, which are described below. Each serves as a safeguard for providing necessary services to distinct, susceptible populations throughout Indiana.

- **The Healthy Indiana Plan** (HIP) was created in January 2008 under a separate Section 1115 waiver authority. The HIP 2.0 model is a health insurance program that offsets medical, vision, and dental service costs for adults between the ages of 19 and 64 who meet designated income limitations. The HIP program provides qualified adults access to comprehensive benefits without high-cost premiums or expensive copays. HIP is responsible for supplying preventive health care and services to thousands of Indiana residents while encouraging appropriate Emergency Room usage (ER) usage.
- **Hoosier Care Connect** (HCC) provides health coverage for individuals who require similar services but do not qualify for Medicare; these populations include aged, blind, disabled, and/or those receiving Supplemental Security Income (SSI). The program also provides health coverage for many of Indiana's foster children. The program was implemented in April 2015, under a 1915(b)-waiver authority. Members enrolled in the HCC program receive all

Indiana Medicaid-covered benefits in addition to individualized care coordination services based on assessed member needs. The care of Hoosier Care Connect members is managed through a contracted network of primary medical providers (PMPs), specialists, and other care providers.

- **Hoosier Healthwise** (HHW) services Indiana's Children's Health Insurance Program (CHIP) population that provides health insurance programs to children and pregnant women who earn too much to qualify for traditional Medicaid but not enough to purchase private health insurance. The program began in 1994 with members having the option to enroll with an IHCP in 1996, voluntarily. By 2005, enrollment with an IHCP was mandatory for low-income families, pregnant women, and children. The HHW program's objective is to improve the health of Indiana residents by focusing on the healthy growth and development of Indiana children and pregnant women.

Five MCEs are contracted with the state of Indiana:

- Anthem;
- CareSource;
- MDwise;
- MHS; and
- UHC.

Anthem and MHS service the HHW, HIP, and HCC lines of business for risk-based managed care, while CareSource and MDwise service only the HHW and HIP lines of business. UnitedHealthcare services only the HCC line of business.

Enrollees

During CY 2023, the population of individuals enrolled in one of the three programs (HIP, HCC, and HHW) decreased by 152,102 members. With more than one in four Indiana residents currently utilizing benefits from Medicaid and/or CHIP — a net increase of 117% since the first Marketplace Open Enrollment Period and related Medicaid program changes in October 2013.

Table 1 presents enrollment for 2023 by month.

Table 1. Total IHCP Enrollees by Month												
	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Healthy Indiana Plan												
Anthem	382,461	386,552	389,282	391,160	390,655	377,924	367,693	360,767	357,945	350,921	344,799	339,223
CareSource	84,577	86,017	87,169	88,044	88,510	86,286	84,650	83,592	83,568	82,381	81,560	81,126
MDwise	179,207	180,716	181,767	182,550	182,097	176,562	172,328	169,767	169,064	166,198	163,817	161,760
MHS	147,415	149,255	150,532	151,353	151,355	147,403	144,220	142,456	141,936	139,921	138,226	136,843
Total	**846,490**	**856,599**	**55,025**	**868,822**	**869,072**	**844,669**	**825,641**	**813,477**	**810,878**	**797,492**	**787,096**	**778,383**
Hoosier Care Connect												
Anthem	61,290	61,249	60,744	60,660	60,290	59,735	59,254	58,944	58,212	57,672	57,283	56,735
MHS	34,834	34,774	34,466	34,547	34,336	34,119	33,947	33,813	33,412	33,129	32,974	32,758
UHC	5,904	5,962	5,976	6,015	5,983	6,001	6,015	6,022	5,972	6,048	6,116	6,089
Total	**102,028**	**101,985**	**101,186**	**101,222**	**100,609**	**99,855**	**99,216**	**98,779**	**97,596**	**96,849**	**96,373**	**95,582**
Hoosier Healthwise												
Anthem	351,814	354,915	357,890	360,045	359,970	350,296	342,146	335,046	330,880	326,282	320,916	316,365
CareSource	87,291	88,073	88,838	89,425	89,486	87,069	85,148	83,534	82,533	81,392	80,209	79,173
MDwise	241,955	243,272	244,455	245,235	244,386	236,439	230,317	224,790	221,120	217,255	212,786	209,158
MHS	204,211	205,666	207,067	208,064	207,630	201,421	196,538	192,625	190,257	187,802	184,700	182,281
Total	**885,271**	**891,926**	**898,250**	**902,769**	**901,472**	**875,225**	**854,149**	**835,995**	**824,790**	**812,731**	**798,611**	**786,977**

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.

In 2021, Indiana outlined specific quality initiatives for the HHW, HIP, and HCC programs. The initiatives outline global

aims that OMPP has identified that support the objectives for all its programs. The initiatives are shown below.

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 cost-effective medical coverage.
    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 (BH) 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 IHCPs' performance and unmet objectives, and opportunities for improvement identified in the external quality review.

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 MCEs must submit quarterly updates to OMPP about the projects determined in their annual work plan. These reports are shared with the Quality Strategy Committee.

Tables 2, **3**, and **4** present the strategic initiatives for each MCE, with their 2021, 2022, and 2023 achievement results against the OMPP-established goals. Where the MCEs display improvement from CY 2022 to CY 2023, the CY 2023 score is accompanied by a green arrow (↑); where the MCE's scores went down, the score is accompanied by a red arrow (↓). If an arrow does not accompany the score, the score did not change, or the comparison is no longer applicable due to a change in benefits offered by the MCE. A column indicating whether or not each CY2023 result met the established goal is addressed under goal attainment of these tables.

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	Goal	MCE	CY 2021 Baseline	CY 2021 Results	CY 2022 Results	CY 2023 Results	Goal Attainment
Measure: Improvements in Children and Adolescents' Well-Care **Domain: Quality Timeliness of Care**	OMPP utilized HEDIS® measures to track the percentages of well-child services in children and adolescents.	Achieve at or above the 90th percentile of the National Committee for Quality Assurance (NCQA) 2023 Quality Compass improvements in HEDIS® well-child visits for children (W30 rates 1 and 2) and adolescents (WCV rate).	Anthem	At or above 50th percentile.	Above the 50th percentile for well-child visits in the first 30 months of life	Above the 50th percentile for well-child visits in the first 30 months of life	Above the 90th percentile for well-child visits in the first 15 months. ↑	Goal Met
					Above the 50th percentile of adolescent well-care visits for ages 3-21.	Above the 50th percentile of adolescent well-care visits for ages 3-21.	Above the 50th percentile for 15 to 30 months.	Goal Not Met
							Above the 50th percentile adolescent well-care visits for ages 3-21.	Goal Not Met
			CareSource	At or above 50th percentile.	Above the 50th percentile for well-child visits in the first 30 months of life	Above the 50th percentile for well-child visits in the first 30 months of life	Above the 50th percentile for well-child visits in the first 15 months.	Goal Not Met
					Above the 50th percentile of adolescent well-care visits for ages 3-21.	Above the 50th percentile of adolescent well-care visits for ages 3-21.	Above the 50th percentile for 15 to 30 months.	Goal Not Met
							Above the 50th percentile for adolescent well-care visits for ages 3-21.	Goal Not Met

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	Goal	MCE	CY 2021 Baseline	CY 2021 Results	CY 2022 Results	CY 2023 Results	Goal Attainment
			MDwise	At or above 50th percentile.	Above the 50th percentile for well-child visits in the first 30 months of life.	Above the 50th percentile for well-child visits in the first 30 months of life.	Above the 50th percentile for well-child visits in the first 15 months, below the 50th percentile for 15 to 30 months.	Goal Not Met
					Above the 50th percentile of adolescent well-care visits for ages 3-21.	Above the 50th percentile of adolescent well-care visits for ages 3-21.	Above the 50th percentile for adolescent well-care visits for ages 3-21.	Goal Not Met
			MHS	At or above 50th percentile.	Below the 50th percentile for well-child visits in the first 30 months of life.	Above the 50th percentile for well-child visits in the first 30 months of life.	Above the 50th percentile for well-child visits in the first 15 months.	Goal Not Met
					Above the 50th percentile of adolescent well-care visits for ages 3-21	Above the 50th percentile of adolescent well-care visits for ages 3-21.	Above the 75th percentile for 15 to 30 months.	Goal Not Met
							Above the 50th percentile for adolescent well-care visits for ages 3-21.	Goal Not Met
Measure: Improvements	OMPP utilized HEDIS®	Achieve at or above the 50th	Anthem	NA*	New for 2022.	Above the 25th percentile.	Above the 25th percentile.	Goal Not Met

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	Goal	MCE	CY 2021 Baseline	CY 2021 Results	CY 2022 Results	CY 2023 Results	Goal Attainment
in Childhood Immunization Status – Combination 10 **Domain: Quality and Timeliness of Care**	measures to track the percentages of well-child services in children and adolescents.	percentile of the NCQA Quality Compass of member childhood immunization status (Combination 10) during the measurement year.	CareSource	NA	New for 2022.	Above the 25th percentile.	Above the 25th percentile.	Goal Not Met
			MDwise	NA	New for 2022.	Below the 25th percentile.	Below the 25th percentile.	Goal Not Met
			MHS	NA	New for 2022.	Above the 25th percentile.	Above the 25th percentile.	Goal Not Met
Measure: Completion of Health Needs Screen (>65%) **Domain: Quality and Timeliness of Care**	Administrative Reporting	Achieve at or above 65% of all new members completing the health needs screening within 90 days of enrollment.	Anthem	NA	New for 2022.	27.98%	70.23% ↑	Goal Met
			CareSource	NA	New for 2022.	68.61%	100% ↑	Goal Met
			MDwise	NA	New for 2022.	57.41%	98.20% ↑	Goal Met
			MHS	NA	New for 2022.	68.81%	52.77% ↓	Goal Not Met
Measure: Annual Dental Visit **Domain: Quality and Timeliness of Care**	OMPP utilizes HEDIS® to track 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 2023 Quality Compass of member dental visits during the measurement year.	Anthem	At or above 25th percentile	At or above the 50th percentile.	At or below the 50th percentile.	This measure was retired in 2023.	NA
			CareSource	At or above 25th percentile	At or above the 50th percentile.	Below the 50th percentile.		
			MDwise	At or above 25th percentile	At or above the 50th percentile.	At or above the 50th percentile.		
			MHS	At or above 25th percentile	At or above the 50th percentile.	At or below the 50th percentile.		

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	Goal	MCE	CY 2021 Baseline	CY 2021 Results	CY 2022 Results	CY 2023 Results	Goal Attainment
Measure: Lead Screening in Children **Domain: Quality and Timeliness of Care**	OMPP utilized 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 2023 Quality Compass of lead screening in children.	Anthem	At or above 25th percentile.	At or above the 25th percentile.	Above the 50th percentile.	Below the 50th percentile. ↓	Goal Not Met
			CareSource	At or above 25th percentile.	At or above the 25th percentile.	Above the 50th percentile.	Above the 50th percentile.	Goal Not Met
			MDwise	At or above 25th percentile.	At or above the 25th percentile.	Above the 50th percentile.	Above the 50th percentile.	Goal Not Met
			MHS	At or above 25th percentile.	At or above the 25th percentile.	Above the 50th percentile.	Below the 50th percentile. ↓	Goal Not Met
Measure: Asthma Medication Ratio **Domain: Quality and Timeliness of Care**	OMPP utilized HEDIS® to track the percentage of children aged 5-11 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 2023 Quality Compass of asthma medication ratio.	Anthem	At or above 50th percentile.	At or above the 50th percentile.	Above the 75th percentile.	Below the 50th percentile. ↓	Goal Not Met
			CareSource	At or above 50th percentile.	At or above the 75th percentile.	Above the 75th percentile.	Below the 50th percentile. ↓	Goal Not Met
			MDwise	At or above 50th percentile.	At or above the 50th percentile.	Above the 50th percentile.	Below the 25th percentile. ↓	Goal Not Met
			MHS	At or above 50th percentile.	At or above the 75th percentile.	Above the 75th percentile.	Below the 25th percentile. ↓	Goal Not Met
Measure: Prenatal Depression Screening in Pregnant Women	OMPP utilized HEDIS® for tracking the percentage of women receiving prenatal	Achieve at or above the 75th percentile of the NCQA 2023 Quality Compass of prenatal	Anthem	NCQA in process of baselining.	Successful submission of results.	Below the 25th percentile on screening.	Above the 50th percentile on screening. ↑	Goal Not Met
						Above the 50th percentile on follow-up.	Below the 50th percentile on follow-up. ↓	Goal Not Met

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	Goal	MCE	CY 2021 Baseline	CY 2021 Results	CY 2022 Results	CY 2023 Results	Goal Attainment
Domain: Quality and Access to Care	depression screening in pregnant women	depression screening.	CareSource	NCQA in process of baselining.	Successful submission of results.	Above the 75th percentile on screening.	Above the 95th percentile on screening. ↑	Goal Met
						Above the 75th percentile on follow-up.	Below the 25th percentile on follow-up. ↓	Goal Not Met
			MDwise	NCQA in process of baselining.	Successful submission of results.	No rates given for screening or follow-up.	Above the 50th percentile on screening.	Goal Not Met
						No rates given for screening or follow-up.	The denominator was too small to report a valid rate for follow-up.	NA
			MHS	NCQA in process of baselining.	Successful submission of results.	Below the 25th percentile on screening.	Above the 75th percentile on screening. ↑	Goal Met
						Above the 50th percentile on follow-up.	Below the 25th percentile on follow-up. ↓	Goal Not Met

**Not Applicable (NA)*

Table 3. Healthy Indiana Plan Quality Strategy Initiatives

Measure and Domain	Methodology	Goal	IHCP	CY 2021 Baseline	CY 2021 Results	CY 2022 Results	CY 2023 Results	Goal Attainment
Measure: Account Roll-Over (HEDIS® AAP) **Domain: Quality and Access to Care**	OMPP utilized HEDIS® to track the percentage of HIP members who received a qualifying preventive exam.	Achieve rate at or above the 75th percentile of the NCQA 2023 Quality Compass of members who received a preventative exam.	Anthem	At or above the 25th percentile.	At or above the 25th percentile.	Above the 50th percentile.	Above the 50th percentile.	Goal Not Met
			CareSource	At or above the 25th percentile.	Below the 25th percentile.	Above the 50th percentile.	Below the 50th percentile. ↓	Goal Not Met
			MDwise	At or above the 25th percentile.	At or above the 25th percentile.	Above the 50th percentile.	Below the 50th percentile. ↓	Goal Not Met
			MHS	At or above the 25th percentile.	At or above the 25th percentile.	Above the 50th percentile.	Above the 50th percentile.	Goal Not Met
Measure: Prenatal Depression Screening in Pregnant Women	OMPP utilized HEDIS® for tracking the percentage of women receiving	Achieve at or above the 75th percentile of the NCQA 2023 Quality Compass of	Anthem	NCQA in process of baselining.	Successful submission of results.	Below the 25th percentile in screening.	Above the 50th percentile in screening. ↑	Goal Not Met
						Above the 50th percentile in follow-up.	Below the 75th percentile in follow-up. ↑	Goal Not Met

Table 3. Healthy Indiana Plan Quality Strategy Initiatives

Measure and Domain	Methodology	Goal	IHCP	CY 2021 Baseline	CY 2021 Results	CY 2022 Results	CY 2023 Results	Goal Attainment
Domain: Quality and Access to Care	prenatal depression screening in pregnant women.	prenatal depression screening.	CareSource	NCQA in process of baselining.	Successful submission of results.	Above the 75th percentile in screening.	Above the 95th percentile in screening. ↑	Goal Met
						Above the 75th percentile in follow-up.	Below the 25th percentile in follow-up. ↓	Goal Not Met
			MDwise	NCQA in process of baselining.	Successful submission of results.	Below the 25th percentile in screening.	Above the 50th percentile in screening. ↑	Goal Not Met
						Below the 25th percentile in follow-up.	The denominator was too small to report a valid rate for follow-up.	NA
			MHS	NCQA in process of baselining.	Successful submission of results.	Below the 25th percentile in screening.	Above the 50th percentile in screening. ↑	Goal Not Met
						Above the 50th percentile in follow-up.	Below the 25th percentile in follow-up. ↓	Goal Not Met
Measure: Timeliness of Ongoing Prenatal Care **Domain: Quality and Timeliness of Care**	OMPP utilized HEDIS® to track the percentage of women who are receiving timely ongoing prenatal care.	Achieve at or above the 75th percentile of the NCQA 2023 Quality Compass of the timeliness of prenatal care.	Anthem	At or above the 10th percentile.	At or above the 50th percentile.	Above the 75th percentile.	Above the 95th percentile. ↑	Goal Met
			CareSource	At or above the 10th percentile.	At or above the 25th percentile.	Above the 75th percentile.	Below the 50th percentile. ↓	Goal Not Met
			MDwise	At or above the 10th percentile.	At or above the 50th percentile.	Above the 75th percentile.	Below the 50th percentile. ↓	Goal Not Met

Table 3. Healthy Indiana Plan Quality Strategy Initiatives

Measure and Domain	Methodology	Goal	IHCP	CY 2021 Baseline	CY 2021 Results	CY 2022 Results	CY 2023 Results	Goal Attainment
			MHS	At or above the 10th percentile.	At or above the 50th percentile.	Above the 75th percentile.	Below the 50th percentile. ↓	Goal Not Met
Measure: Frequency of Post-partum Care **Domain: Quality and Timeliness of Care**	OMPP utilized HEDIS® to track the percentage of women who receive required post-partum visits.	Achieve at or above the 75th percentile of the NCQA 2023 Quality Compass of required post-partum visits.	Anthem	At or above the 25th percentile.	At or above the 75th percentile.	Above the 75th percentile.	Above the 95th percentile. ↑	Goal Met
			CareSource	At or above the 25th percentile.	Below the 25th percentile.	Above the 75th percentile.	Below the 50th percentile. ↓	Goal Not Met
			MDwise	At or above the 25th percentile.	At or above the 50th percentile.	Above the 75th percentile.	Above the 50th percentile. ↓	Goal Not Met
			MHS	At or above the 25th percentile.	At or above the 50th percentile.	Above the 75th percentile.	Above the 50th percentile. ↓	Goal Not Met
Measure: Completion of Health Needs Screen (>65%) **Domain: Quality**	Administrative reporting	Achieve at or above 65% of all new members completing the health needs screening within 90 days of enrollment.	Anthem	At or above 60%	45.60%	38.50%	99.78% ↑	Goal Met
			CareSource	At or above 60%	35.01%	65.56%	100% ↑	Goal Met
			MDwise	At or above 60%	60.83%	57.42%	96.20% ↑	Goal Met
			MHS	At or above 60%	70.36%	66.35%	63.57% ↓	Goal Not Met
Measure: Follow-Up After Emergency Department Visit for Alcohol and Other Drug	HEDIS® measure using administrative data	Achieve at or above the 75th percentile of the NCQA 2023 Quality Compass.	Anthem	At or above the 25th percentile.	At or above the 50th percentile.	Above the 25th percentile.	Above the 50th percentile. ↑	Goal Not Met
			CareSource	At or above the 25th percentile.	At or above the 50th percentile.	Above the 75th percentile.	Above the 50th percentile. ↓	Goal Not Met

Table 3. Healthy Indiana Plan Quality Strategy Initiatives

Measure and Domain	Methodology	Goal	IHCP	CY 2021 Baseline	CY 2021 Results	CY 2022 Results	CY 2023 Results	Goal Attainment
Abuse Dependence 7 days (FUA) **Domain: Quality and Access to Care**			MDwise	At or above the 25th percentile.	At or above the 50th percentile.	Above the 25th percentile.	Above the 25th percentile.	Goal Not Met
			MHS	At or above the 25th percentile.	At or above the 50th percentile.	Above the 25th percentile.	Above the 50th percentile. ↑	Goal Not Met
Measure: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 30 days (FUA) **Domain: Quality and Access to Care**	HEDIS® measure using administrative data	Achieve at or above the 75th percentile of the NCQA 2023 Quality Compass.	Anthem	At or above the 25th percentile.	At or above the 75th percentile.	Above the 25th percentile.	Above the 50th percentile. ↑	Goal Not Met
			CareSource	At or above the 25th percentile.	At or above the 75th percentile.	Above the 75th percentile.	Above the 50th percentile. ↓	Goal Not Met
			MDwise	At or above the 25th percentile.	At or above the 50th percentile.	Above the 25th percentile.	Above the 25th percentile.	Goal Not Met
			MHS	At or above the 25th percentile.	At or above the 25th percentile.	Above the 25th percentile.	Above the 25th percentile.	Goal Not Met

Table 4. Hoosier Care Connect Quality Strategy Initiatives

Measure and Domain	Methodology	Goal	IHCP	2021 Baseline	2021 Results	2022 Results	2023 Results	Goal Attainment
Measure: Adult Preventive Care (HEDIS®) **Domain: Quality**	OMPP used the adult preventive care HEDIS® measure to track preventive	Achieve at or above the 75th percentile for NCQA 2023 Quality	Anthem	At or above the 25th percentile.	At or above the 75th percentile.	Above the 75th percentile.	Above the 75th percentile.	Goal Met
			MHS	At or above the 25th	At or above the 50th	Above the 75th	Above the 75th	Goal Met

Table 4. Hoosier Care Connect Quality Strategy Initiatives

Measure and Domain	Methodology	Goal	IHCP	2021 Baseline	2021 Results	2022 Results	2023 Results	Goal Attainment
and Access to Care	care.	Compass for members 20 years and older who had a preventive care visit.		percentile.	percentile.	percentile.	percentile.	
			UHC*	At or above the 25th percentile.	NA	At or below the 75th percentile.	Above the 50th percentile. ↓	Goal Not Met
Measure: Completion of Health Needs Screen (≥65%) **Domain: Quality and Timely Access to Care**	Administrative reporting	Achieve a Health Needs Screen completion for >65% of all members during the first 90 days of enrollment.	Anthem	At or above 60%.	44.45%	47.72%	99.75% ↑	Goal Met
			MHS	At or above 60%.	78.08%	70.46%	64.17% ↓	Goal Not Met
			UHC*	At or above 60%	NA	70.65%	67.10% ↓	Goal Met
Measure: Completion of Comprehensive Health Assessment Tool **Domain: Quality and Timely Access to Care**	Administrative reporting	Achieve completion of a comprehensive health assessment of >79% for all members stratified into complex case management or the Right Choice Program following the initial screening, during the first 150 days of enrollment.	Anthem	At or above 73%.	77.60%	73.45%	90.11% ↑	Goal Met
			MHS	At or above 73%.	87.53%	90.11%	89.58% ↓	Goal Met
			UHC*	At or above 73%	NA	82.14%	80.91% ↓	Goal Met
Measure: Annual Dental	OMPP utilizes HEDIS® to	Achieve at or above the	Anthem	NA	New for 2022.	At or above the 50th	This measure was retired in	NA

Table 4. Hoosier Care Connect Quality Strategy Initiatives

Measure and Domain	Methodology	Goal	IHCP	2021 Baseline	2021 Results	2022 Results	2023 Results	Goal Attainment
Visit **Domain: Quality and Timely Access to Care**	track the percentage of members aged 2-20 years who had at least one dental visit during the measurement year.	75th percentile of the NCQA 2023 Quality Compass of member dental visits during the measurement year.				percentile.	2023.	
			MHS	NA	New for 2022.	At or above the 50th percentile.		NA
			UHC*	NA	NA	Below the 50th percentile.		NA
Measure: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 7 Day (FUA) **Domain: Quality and Access to Care**	HEDIS® measure using administrative data	Achieve at or above the 75th percentile of the NCQA 2023 Quality Compass.	Anthem	At or above the 25th percentile.	At or above the 50th percentile.	Below the 50th percentile.	Above the 75th percentile. ↑	Goal Met
			MHS	At or above the 25th percentile.	At or above the 25th percentile.	Below the 50th percentile.	Below the 50th percentile.	Goal Not Met
			UHC*	At or above the 25th percentile.	NA	Below the 50th percentile.	Above the 50th percentile. ↑	Goal Not Met
Measure: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 30 Day (FUA) **Domain: Quality**	HEDIS® measure using administrative data	Achieve at or above the 75th percentile of the NCQA 2023 Quality Compass.	Anthem	At or above the 25th percentile.	At or above the 25th percentile.	At or above the 25th percentile.	Above the 75th percentile. ↑	Goal Met
			MHS	At or above the 25th percentile.	At or above the 25th percentile.	At or above the 25th percentile.	Below the 50th percentile. ↑	Goal Not Met
			UHC*	At or above the 25th percentile.	NA	At or above the 25th percentile.	Above the 50th percentile. ↑	Goal Not Met

Table 4. Hoosier Care Connect Quality Strategy Initiatives								
Measure and Domain	**Methodology**	**Goal**	**IHCP**	**2021 Baseline**	**2021 Results**	**2022 Results**	**2023 Results**	**Goal Attainment**
and Access to Care								

**UHC was not a contracted IHCP in 2021; therefore, there is no data to display.*

Quality Strategy Conclusions

OMPP should continue to work with the MCEs and focus on standards that consistently show no improvement or minimal improvement to ensure quality, timeliness, and access to care for the enrollees. OMPP should ensure that the MCEs review their workflows and provide timely care and reporting of data. OMPP should ensure that all the MCEs are informed of all reporting requirements and reporting timeframes. OMPP should continue to develop quality measures that follow HEDIS® updates, additions, and new guidelines. Based on the static nature of performance measures during year-over-year measurements, there should be considerations to evaluate targets on an annual basis based on each plan's performance; thus, creating an evaluation that is based in improvements and relative to actual performance. Overall, the Quality Strategy was an effective tool for measuring and improving OMPP's managed care services, specifically in improving the quality, timeliness, and access to care for the MCEs' enrollees. The MCEs and the State are progressing towards the Quality Strategy goals and objectives.

EQR Activities

As outlined in Title 42 *Code of Federal Regulations*, Section 438, Part 358 (42 § 438.358), incorporated by 42 CFR § 457.1250, there are four mandated and six optional EQR activities. In addition, a state agency can assign other responsibilities to its designated EQRO. This section summarizes the activities that Qsource performed for OMPP in 2024 (CY 2023), following the CMS *External Quality Review Protocols* (updated in 2023).

EQR Mandatory Activities

Following the CMS Protocols published in February 2023, Qsource conducted the EQR activities shown in **Table 5**.

Table 5. EQR Activities Conducted in 2024 for CY 2023			
Protocol #	**Activity Name**	**Mandatory or Optional**	**Measurement Period**
1	***Validation of Performance Improvement Projects***	Mandatory	January 1, 2023 – December 31, 2023
2	***Validation of Performance Measures***	Mandatory	January 1, 2023– December 31, 2023

Table 5. EQR Activities Conducted in 2024 for CY 2023			
Protocol #	**Activity Name**	**Mandatory or Optional**	**Measurement Period**
3	***Review of Compliance with Medicaid and CHIP Managed Care Regulations***	Mandatory	January 1, 2023–December 31, 2023
4	***Validation of Network Adequacy***	Mandatory	January 1, 2023–December 31, 2023
9	***Focus Studies on Quality of Care***	Optional	January 1, 2023 – December 31, 2023

Under CMS requirements, Protocol 3 requires MCEs to undergo a review at least once every three years to determine MCE compliance with federal standards as implemented by the state. OMPP has chosen to review all applicable standards every three years. Protocol 3 was performed in 2024 (CY 2023), assessing all relevant standards. This protocol will be performed again in 2027 (CY 2026).

Qsource maintained ongoing, collaborative communication with OMPP and provided technical assistance to the MCEs in their EQR activities. The technical assistance, which is also defined by 42 CFR § 438.358, consisted of targeted support through phone calls, webinars, written guides, and training. Finally, Qsource provided each MCE with an information packet explaining the EQR activities in greater detail and indicating the dates for data submission.

CMS National Quality Strategy

Throughout the evaluation and validation of MCE activities, Qsource monitors each MCE's compliance with federally mandated activities and to assess the quality, timeliness and accessibility of services provided by the MCEs. Quality of Care, Timeliness of Care, and Access to Care are three domains of healthcare quality that must be present in all activities.

Quality of Care

CMS describes quality of care as the degree to which preferred enrollee health outcomes are likely to increase through the efforts of MCEs, along with their organizations and operations that provide enrollee services. OMPP required the MCEs to conduct quality improvement projects (QIPs), which included mechanisms to assess the quality and appropriateness of care provided to enrollees. 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 conducted Performance Measure Validation to determine if the MCEs met these quality performance measure targets.

Timeliness of Care

For quality care to be effective, it must be delivered promptly. Thus, various standards for timely care were monitored through MCE compliance with federal and state regulations. All program QIPs validated by Qsource addressed the timeliness of care for enrollees: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA), Health Needs Screening,*

and *Prenatal and Postpartum Timeliness of Care* (CareSource only). Qsource's validation of performance measures evaluated timeliness measures determined by OMPP.

Access to Care

Access to care is equally critical for enrollee health outcomes as quality of care. The MCEs' provider capacity is monitored through Annual Network Adequacy (ANA) evaluation, which assesses the availability of essential provider specialties by time and distance and how quickly enrollees can obtain needed appointments. Network adequacy was analyzed to determine if enrollees' access to care met requirements. Compliance with applicable federal, state, and contractual regulations also addressed access to care requirements, ensuring accessibility for all enrollees, including those with limited English proficiency and physical or mental disabilities. The MCEs' QIPs are evaluated to ensure quality care and access to care for all enrollees.

Technical Report Guidelines

Qsource is responsible for creating and producing this *2024 Annual EQRO Technical Report*, which compiles the results of these EQR activities. 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 2023 EQR Protocols for producing annual technical reports.

The report includes the following EQR-activity-specific sections:

- Protocol 1. Validation of Performance Improvement Projects (MCEs refer to these as Quality Improvement Projects [QIPs], which is the acronym used throughout this report)
- Protocol 2. Validation of Performance Measures (PMV)
- Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations (CA)
- Protocol 4. Validation of Network Adequacy (ANA)
- Protocol 9: Focus Studies on Quality Care

Each EQR activity was conducted by Qsource to monitor each MCE's compliance with federally mandated activities and to assess 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 IHCP in providing healthcare services to enrollees;
4. Recommendations for improving the quality of these services, including how OMPP can target goals and objectives within the quality strategy to support improvement better; and
5. Comparative information regarding the IHCPs, consistent with CMS EQR Protocol guidance.

The *2024 Annual EQRO Technical Report* provides OMPP with substantive, unbiased data on the MCEs and recommendations for action toward far-reaching performance improvement. This

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

The Conclusions and Recommendations section of this report offers recommendations on how to utilize Qsource's findings.

The appendices provide additional EQR activity information:

- Appendix A | ANA Excluded Source Data
- Appendix B | Detailed Analysis of Provider Network Access

EQRO Team

The review team included the following staff:

- Jazzmin Kennedy, Qsource, Indiana EQR Program Manager
- Christa Thompson, Qsource, QI Advisor
- Albert Kennedy, Qsource, Technical Writer
- Courtney Hall, Qsource, Technical Writer
- Fidencio Caballero, Qsource, Healthcare Data Analyst
- Kathy Haley, Myers and Stauffer
- Catherine Snider, Myers and Stauffer
- Emily Brammer, Axon Advisors, LLC

Protocol 1: Quality Improvement Project (QIP) Validation

Objectives

The *Balanced Budget Act of 1997* established certain managed care quality safeguards that were 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." These reviews, described in 42 CFR § 438.358, include four required external quality review activities, one of which is validating quality improvement projects.

As part of its external quality review contract with the Indiana FSSA OMPP, Qsource annually validates the QIPs of the MCEs providing services for Indiana Medicaid members. Qsource's *Annual QIP Validation Reports* present validation findings by MCEs and their corresponding IHCPs.

The primary objective of QIP validation is to determine each QIP's compliance with the requirements outlined in Title 42 of the CFR Section 438.330(d). MCEs must conduct QIPs that are designed to achieve, through remeasurement and interventions, significant and sustained improvement in clinical and nonclinical care areas that are expected to favor health outcomes and enrollee satisfaction. QIP study topics must reflect enrollment in terms of demographic characteristics and, if applicable, in terms of the prevalence and potential consequences (risks) of disease and enrollee needs for specific services. Each QIP must be completed within a timeframe that allows QIP success-related data in the aggregate to produce new information on quality of care every year. QIPs are further defined in 42 CFR § 438.330(d)(2) to include all the following:

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

Technical Methods of Data Collection and Analysis

Each MCE was contractually required to submit QIP studies annually to OMPP as requested. QIPs should include the necessary documentation for submitted data collection, data analysis plans, and an interpretation of all results. MCEs should also address threats to validity regarding data analysis and include an interpretation of study results.

Each MCE submitted a continuation of their established QIPs as QIPs are typically conducted over a three-year period. To validate QIPs, Qsource assembled a validation team of experienced staff specializing in clinical quality improvement and a healthcare data analyst. The validation process included a review of each QIP's study design and approach, an evaluation

of each QIP's compliance with the analysis plan, and an assessment of the effectiveness of interventions.

The QIP validation was based on CMS's EQR *Protocol 1: Validation of Performance Improvement Projects (2023)*. Qsource developed a QIP Summary Form (with accompanying QIP Summary Form Completion Instructions) and a QIP Validation Tool to standardize the process by which each MCE delivers QIP information to OMPP and how the information is assessed. Using Qsource's QIP Summary Form, each MCE submitted its QIP studies and supplemental information in July 2024. The CY for this validation was January 1, 2023, through December 31, 2023.

Each QIP involves nine required steps, and each step consists of elements essential to the successful completion of a QIP. The elements within each step were scored as Met, Not Met, or NA. The first overall validation rating was determined by the percentage score of all elements met, as guided by EQR Protocol 1, and was calculated by dividing the number of elements met by the number of elements assessed. The first validation rating indicates Qsource's overall confidence (ranging from No Confidence to High Confidence) that the QIP adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of QIP results.

Qsource also assigned a second validation rating based on its assessment of whether the QIP produced evidence of improvement. To determine this rating, Qsource reviewed QIP results and processes, their relative strengths and weaknesses, and the extent to which they affected confidence in the generalizability and usefulness of the QIP's findings.

Table 6 presents the rating criteria used for QIP validation based on the CMS EQR Protocol's suggested rating scale.

Table 6. QIP Validation Rating Criteria

Rating	Criteria
Rating 1	
High Confidence	Of all elements assessed, 90–100% were met across all activities.
Moderate Confidence	Of all elements assessed, 80–<90% were met across all activities.
Low Confidence	Of all elements assessed, 70–<80% were met across all activities.
No Confidence	Less than 70% of all elements were met.
Rating 2	
High Confidence	The QIP achieved statistically significant improvement for all performance measures and interventions resulted in demonstrated improvement.
Moderate Confidence	The QIP achieved statistically or non-statistically significant improvement for at least one measure.
Low Confidence	The QIP did not demonstrate statistically or non-statistically significant improvement or none of the interventions resulted in demonstrated improvement.

Table 6. QIP Validation Rating Criteria	
Rating	**Criteria**
No Confidence	The QIP did not follow approved methodology or processes through the end date.

Table 7 lists the nine QIP steps used for assessing the QIP methodology.

Table 7. QIP Steps
1. Review the Selected QIP Topic
2. Review the QIP Aim Statement
3. Review the Identified QIP Population
4. Review the Sampling Method
5. Review the Selected QIP Variables and Performance Measures
6. Review the Data Collection Procedures
7. Review Data Analysis and Interpretation of QIP Results
8. Assess the Improvement Strategies
9. Assess the Likelihood that Significant and Sustained Improvement Occurred

Description of Data Obtained

The MCEs are required to produce QIPs for any Indiana programs administered. This report includes three programs – Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect. Qsource received the MCEs' QIP Summary Forms on July 19, 2024, and assessed them for the following QIP topics, as found in **Table 8**.

The MCEs were assigned two QIP topics conducted across all programs and allowed to include additional QIP topics. Anthem, CareSource, and MHS submitted 6 QIPs, MDwise submitted 4 QIPs, and UHC submitted 2 QIPs. Qsource received and assessed QIP Summary Forms for the following QIP topics:

Table 8. QIP Topics by IHCP

QIP Topic	Anthem			CareSource		MDwise		MHS			UHC
	HIP	HHW	HCC	HIP	HHW	HIP	HHW	HIP	HHW	HCC	HCC
Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)	X	X	X	X	X	X	X	X	X	X	X
Health Needs Screening (HNS)	X	X	X	X	X	X	X	X	X	X	X

Table 8. QIP Topics by IHCP											
QIP Topic	Anthem			CareSource		MDwise		MHS			UHC
	HIP	HHW	HCC	HIP	HHW	HIP	HHW	HIP	HHW	HCC	HCC
Postpartum Care				X	X						

Validation Results CY 2023 QIPs

Table 9 presents each QIP's name, elements met and applicable, overall validation score, and validation ratings.

For the QIP review, 4 of the 11 QIPs received a High Confidence validation rating for Validation Rating 1, while 1 of the applicable QIPs received a High Confidence validation rating for Validation Rating 2.

Table 9. QIP Validation Status and Performance Scores						
IHCP	QIP Name	Elements		Overall Score	Validation Rating 1	Validation Rating 2
		Met	Applicable			
Anthem	QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*	41	49	83.67%	Moderate Confidence	Low Confidence
	QIP 2: *Health Needs Screening*	37	45	82.22%	Moderate Confidence	Moderate Confidence
CareSource	QIP 1: *Improving outcomes for members with substance use disorder (SUD) through timely member engagement in care-case management following an Emergency Department (ED) Visit*	47	47	100%	High Confidence	Moderate Confidence
	QIP 2: *Health Needs Screening*	44	44	100%	High Confidence	High Confidence
	QIP 3: *Improve access to timely Prenatal and Postpartum Care through Care Management (CM) Engagement*	48	48	100%	High Confidence	Moderate Confidence
MDwise	QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*	23	46	50.00%	No Confidence	No Confidence

Table 9. QIP Validation Status and Performance Scores

IHCP	QIP Name	Elements		Overall Score	Validation Rating 1	Validation Rating 2
		Met	Applicable			
	QIP 2: *Health Needs Screening*	20	46	43.48%	No Confidence	No Confidence
MHS	QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*	34	46	73.91%	Low Confidence	No Confidence
	QIP 2: *Health Needs Screening*	34	46	73.91%	Low Confidence	No Confidence
UHC	QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*	41	44	93.18%	High Confidence	Moderate Confidence
	QIP 2: *Health Needs Screening*	35	43	81.40%	Moderate Confidence	Low Confidence

Strengths, Weaknesses, and Recommendations

Table 10 presents strengths and **Table 11** presents weaknesses identified for each MCE during the QIP validation. Strengths for the QIP validation indicate that the MCEs demonstrated proficiency in a given activity and can be recognized regardless of validation rating. The lack of an identified strength should not be interpreted as a shortcoming of an MCE. Areas of noncompliance (AONs), or weaknesses, arise from evaluation elements that receive a Not Met score, indicating that those elements were not fully compliant with CMS EQR Protocols. This information helps determine whether to continue or retire a specific QIP. Qsource also identified suggestions when documentation for an evaluation element included the essential components to meet requirements, but enhanced documentation could demonstrate a stronger understanding of CMS EQR Protocols. The MCEs were not held accountable to address suggestions; therefore, this report did not monitor or include suggestions.

Table 10. QIP Strengths	
CareSource	
Health Needs Screening	
Step 7: Review the Data Analysis and Interpretation of QIP Results	Element 2: The MCE provided tables, graphs, and a run chart depicting annual performance over the life of the QIP and capturing strategies and occurrences that may have led to improvement and/or decline in performance.

Table 11. QIP Weaknesses (AONs) and Recommendations	
Anthem	
Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA) (HIP / HHW / HCC)	
Step 3: Review the Identified QIP Populations	Element 2: The MCE should include all health plans in the population.
Step 6: Review the Data Collection Procedures	Element 10: The MCE should describe the intra- and inter-rater reliability processes in place to ensure valid and reliable data are abstracted during medical record reviews.
	Element 11: The MCE should include guidelines developed specifically for data abstraction staff to ensure valid and reliable data are abstracted during medical record reviews.
Step 7: Review the Data Analysis and Interpretation of QIP Results	Element 1: The MCE should discuss how data analysis and interpretation were conducted in accordance with the data analysis plan.
	Element 2: The MCE should include a detailed discussion of baseline year 2019 and each remeasurement year's performance.
Step 8: Assess the Improvement Strategies	Element 4: The MCE should include how member interactions are culturally and linguistically appropriate.
	Element 5: The MCE should include documentation that details the presence of major confounding factors and how these factors were reflected within improvement strategies.
Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred	Element 4: The MCE should include evidence that any observed improvement is or is not the result of improvement strategies for either all the IHCPs or an overall number for the three combined.

Table 11. QIP Weaknesses (AONs) and Recommendations	
***Health Needs Screening (HNS)* (HIP / HHW / HCC)**	
Step 2: Review the QIP Aim Statement	Element 2: The MCE should clearly define the QIP population in the aim statement.
Step 5: Review the Selected QIP Variables and Performance Measures	Element 3: The MCE should discuss the availability of data.
	Element 4: The MCE should include a discussion of how performance measures were based on current clinical knowledge or health services research.
	Element 10: The MCE should address how performance measures are based on strong evidence that the process being measured is meaningfully associated with outcomes.
Step 7: Review the Data Analysis and Interpretation of QIP Results	Element 1: The MCE should discuss how data analysis and interpretation were conducted in accordance with the data analysis plan.
	Element 2: The MCE should include a detailed discussion of baseline and each remeasurement year's performance.
	Element 3: While the MCE did statistical testing, it should also include a discussion of the statistical significance of any differences between baseline and each repeat measurement(s).
Step 8: Assess the Improvement Strategies	Element 4: The MCE should include an assessment of member-facing improvement strategies for cultural and linguistic appropriateness.
MDwise	
***Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)* (HIP / HHW)**	
Step 2: Review the QIP Aim Statement	Element 3: The MCE should acknowledge the QIP time period within the aim statement (i.e., CY 2023).
	Element 5: The MCE should present the aim statement as a question that is answerable.
Step 6: Review the Data Collection Procedures	Element 4: The MCE should identify the specific data elements collected for QIP performance measures, including numerical definitions and units of measure.
	Element 5: The MCE should include a discussion of the data collection procedures (i.e., data analysis plan) used to monitor and assess performance.
	Element 6: The MCE should include all data instruments used to ensure the accuracy and availability of QIP data over time.
Step 7: Review the Data Analysis and	Element 1: The MCE should provide a data analysis discussion that shows how performance measures were monitored in accordance with the data analysis plan.

Table 11. QIP Weaknesses (AONs) and Recommendations	
Interpretation of QIP Results	Element 2: The MCE should include a discussion of baseline and annual remeasurement(s) data for each performance measure.
	Element 3: The MCE should include a discussion of the statistically significant differences between baseline and repeat measurement(s).
	Element 4: The MCE should identify any factors that may influence comparability of initial and repeat measurements; if no factors were identified it should be explicitly stated.
	Element 5: The MCE should identify factors that threaten internal or external validity of findings; if no factors were identified it should be explicitly stated.
	Element 6: The MCE should include a comparative discussion of results across multiple entities, i.e., a comparison of each IHCP population's results.
	Element 7: The MCE should ensure that the data analysis discussion is presented in a concise and easily understood manner.
	Element 8: The MCE should include a discussion of lessons learned during the current QIP cycle.
Step 8: Assess the Improvement Strategies	Element 1: The MCE should provide a discussion to indicate the QIP improvement strategies as evidence based, i.e., the published or unpublished evidence that each selected intervention is likely to yield the desired improvement.
	Element 2: The MCE should address causes/barriers related to improvement strategies that were identified using data analysis and quality improvement processes.
	Element 3: The MCE should provide evidence that improvement strategies were implemented on a rapid-cycle, Plan-Do-Study-Act (PDSA) basis.
	Element 4: The MCE should include an assessment of cultural and linguistic appropriateness for each of the applied interventions.
	Element 5: The MCE should address how improvement strategies are reflective of major confounding factors (i.e., barriers) that could have an obvious impact on QIP outcomes.
	Element 6: The MCE should provide a detailed discussion of the success of QIP interventions and indicate related follow-up activities planned as a result.
Step 9: Assess the Likelihood that	Element 1: The MCE should specifically state whether the baseline and remeasurement methodologies were the same or describe the change in methodology and the reasons for the change.

Table 11. QIP Weaknesses (AONs) and Recommendations	
Significant and Sustained Improvement Occurred	Element 3: The MCE should provide a detailed discussion to show how improvements made in QIP performance are likely the result of selected improvement strategies.
	Element 4: The MCE should include statistical evidence, such as significance tests, to show how improvements made in QIP performance are likely the result of improvement strategies.
	Element 5: The MCE should include a detailed discussion demonstrating the sustainability of QIP improvement through repeated measurements over time.
***Health Needs Screening (HNS)* (HIP / HHW)**	
Step 2: Review the QIP Aim Statement	Element 2: The MCE should clearly identify the QIP population within the aim statement.
	Element 3: The MCE should clearly specify the current QIP time period within the aim statement.
	Element 5: The MCE should develop the aim statement in the form of an answerable question.
Step 5: Review the Selected QIP Variables and Performance Measures	Element 1a: The MCE should include a variable name, definition, and frequency of measurement for each performance measure.
	Element 3: The MCE should detail how the performance measures are appropriate based on the availability of data and resources to collect the data.
	Element 5: The MCE should address how performance data is monitored, discuss performance measure comparison across programs and to benchmarks, and how the results are used to inform the selection of quality improvement strategies.
	Element 10: The MCE should address how performance measures are based on strong evidence that the process being measured is meaningfully associated with outcomes.
Step 6: Review the Data Collection Procedures	Element 1: The MCE should include a systematic method for collecting valid and reliable data that represent the QIP population.
	Element 3: The MCE should clearly identify data sources.
	Element 4: The MCE should clearly identify data elements to be collected, such as performance measure technical specifications or data element definitions and units.
	Element 5: The MCE should give a detailed description of the data analysis plan and how it is appropriate based on data availability and in accordance with the data collection plan.
	Element 6: The MCE should give detailed information regarding data collection instruments that allow for consistent and accurate data collection over QIP time periods.

Table 11. QIP Weaknesses (AONs) and Recommendations	
	Element 8: The MCE should include an estimated degree of data completeness for administrative data collection and a process description of how it was determined.
Step 7: Review the Data Analysis and Interpretation of QIP Results	Element 1: The MCE should provide a data analysis discussion that shows how performance measures were monitored in accordance with the data analysis plan.
	Element 2: The MCE should include a discussion of baseline and annual remeasurement(s) data for each performance measure.
	Element 3: The MCE should include a discussion of the statistically significant differences between baseline and repeat measurement(s).
	Element 6: The MCE should include a comparative discussion of results across multiple entities, i.e., a comparison of each IHCP population's results.
Step 8: Assess the Improvement Strategies	Element 1: The MCE should include evidence to support the likelihood of success for each improvement strategy implemented.
	Element 2: The MCE should identify causes and/or barriers related to care that resulted in the selection of interventions.
	Element 3: The MCE should document the implementation of interventions within a rapid-cycle, PDSA process.
	Element 4: The MCE should acknowledge the cultural and linguistic appropriateness of selected interventions.
	Element 6: The MCE should include a detailed discussion of each intervention's level of success, and any follow-up activities planned as a result.
Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred	Element 2: The MCE should address quantitative evidence of improvement in processes or outcomes of care.
	Element 3: The MCE should provide a detailed discussion to show how improvements made in QIP performance are likely the result of selected improvement strategies.
	Element 4: The MCE should include statistical evidence, such as significance tests, to show how improvements made in QIP performance are likely the result of improvement strategies.
	Element 5: The MCE should include a detailed discussion demonstrating the sustainability of QIP improvement through repeated measurements over time.

Table 11. QIP Weaknesses (AONs) and Recommendations	
MHS	
***Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)* (HIP / HCC / HHW)**	
Step 5: Review the Selected QIP Variables and Performance Measures	Element 5: The MCE should include a discussion to address performance, including a data comparison of current performance rates against benchmarks and how the performance was used to inform improvement strategies.
Step 7: Review the Data Analysis and Interpretation of QIP Results	Element 1: The MCE should demonstrate and discuss remeasurement data for each program and for the full QIP time period, as indicated in the data collection plan.
	Element 2: The MCE should report and discuss the current year's measurement data compared with prior year's data.
	Element 3: The MCE should identify changes in year-over-year data for all performance measures and each program with the statistical significance of each displayed.
	Element 6: The MCE should include a comparison of each IHCP population's data (rates) for the full QIP time period (one year) in accordance with the QIP's data analysis plan.
	Element 7: The MCE should ensure that the data analysis and interpretation section include documentation for the current QIP year that is data driven, concise, and presented in accordance with the QIP Summary Form Instructions.
	Element 8: The MCE should discuss lessons learned and plans for future activities.
Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred	Element 1: The MCE should indicate whether the remeasurement methodology was the same as the baseline methodology.
	Element 2: The MCE should include quantitative evidence of improvement in processes or outcomes of care.
	Element 3: The MCE should include information on how improvement in performance is likely the result of the selected improvement strategies.
	Element 4: The MCE should include statistical evidence that any observed improvement is the result of the improvement strategies.
	Element 5: The MCE should include a discussion of whether sustained improvement is demonstrated through repeated measurements over time.

Table 11. QIP Weaknesses (AONs) and Recommendations	
***Health Needs Screening (HNS)* (HIP / HHW / HCC)**	
Step 5: Review the Selected QIP Variables and Performance Measures	Element 5: The MCE should include all required elements to address performance of the QIP, such as performance measure results over time, a comparison of performance to benchmarks, and how said performance was used to inform the selection of improvement strategies.
	Element 10: The MCE should detail how process measures are based on strong evidence that the process being measured is meaningfully associated with health outcomes, i.e., demonstrate how the HNS process impacts outcomes.
Step 7: Review the Data Analysis and Interpretation of QIP Results	Element 3: The MCE should include an appropriate discussion of the statistical significance of differences between each remeasurement period in accordance with the performance measure results table.
	Element 5: The MCE should discuss factors that threaten internal or external validity of data findings for the current QIP cycle and avoid the reuse of indistinguishable documentation from prior QIP Summary submissions.
	Element 7: The MCE should ensure that the data analysis and interpretation section include documentation for the current QIP year that is concise and presented in an easily understood manner by explicitly responding to each requirement outlined within the QIP Summary Form Instructions.
	Element 8: The MCE should include a clear discussion of lessons learned about QIP performance and specifically state plans for future activities of the QIP.
Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred	Element 1: The MCE should appropriately describe variations between baseline and the current remeasurement year and avoid the inclusion of identical discussions from prior QIP cycles.
	Element 2: The MCE should discuss how quantitative results are evidence of improvement in care processes and/or outcomes; if no quantitative evidence exists it should be stated as such.
	Element 3: The MCE should provide a clear discussion of how measured improvement is likely to be the result of applied improvement strategies.
	Element 4: The MCE should include the details of statistical testing that show a correlation between observed improvement, if any improvement, is the result of the improvement strategy.
	Element 5: The MCE should address and discuss if repeated measurements, year-to-year, demonstrate sustained improvement over time.

Table 11. QIP Weaknesses (AONs) and Recommendations	
UHC	
***Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)* (HCC)**	
Step 7: Review the Data Analysis and Interpretation of QIP Results	Element 8: The MCE should include what lessons can be gleaned from the reported suboptimal findings.
Step 8: Assess the Improvement Strategies	Element 3: The MCE should include a discussion of how strategies are culturally and linguistically appropriate.
Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred	Element 4: The MCE should address statistical evidence showing improvements or the lack thereof are a result of interventions.
***Heath Needs Screening (HNS)* (HCC)**	
Step 1: Review the Selected QIP Topic	Element 5: The MCE should describe how the QIP topic aligns with CMS or the Department of Health and Human Services (HHS) priorities.
Step 2: Review the QIP Aim Statement	Element 2: The MCE should indicate the QIP population in the QIP aim statement.
Step 5: Review the Selected QIP Variables and Performance Measures	Element 4: The MCE should provide current clinical knowledge and/or health services research to support the selection of the performance measure.
	Element 10: The MCE should address if performance measure is a process measure and furthermore should provide strong evidence that the process being measured is meaningfully associated with outcomes.
Step 6: Review the Data Collection Procedures	Element 8: The MCE should include an estimated degree of data completeness based on data related to the QIP.
Step 7: Review the Data Analysis and Interpretation of QIP Results	Element 8: The MCE should include a discussion of any lessons learned about suboptimal performance.
Step 8: Assess the Improvement Strategies	Element 1: The MCE should cite evidence supporting the improvement activities implemented.
	Element 3: The MCE should be using PDSA rapid cycle process for continuous improvement.

Interventions

Table 12 presents the reported QIP interventions. The table contains direct quotes from the MCEs.

Table 12. CY 2023 QIP Interventions

IHCP	QIP Title	Interventions
Anthem	*Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)* HIP / HHW / HCC	Conduct internal Indiana Health Information Exchange (IHIE) coding query to expand the identification of members who may be eligible for post discharge outreach for FUA.
		Increase FUA-30 compliance by utilizing Community Health Workers (CHWs) for face-to-face outreach.
		Identified a disconnected data flow and worked with our corporate Quality Data Management Team to implement a solution that restored the technical information flow between our case management system and QSHR (Supplemental Data Feed) to allow for Behavioral Health (BH) assessments conducted by Licensed Clinical Social Workers (LCSWs) to count as a follow up visit in alignment with NCQA specifications.
	Health Needs Screening (HNS) HIP / HHW / HCC	Include quick response (QR) code for the HNS in the mailed new member Identification (ID) card.
		Prioritize face-to-face outreach for HCC members and those on the Do Not Call list.
		Commission an end-to-end assessment by a third party of Anthem's current HNS process. The assessment included key stakeholder interviews, review of processes and data flows, analysis of HNS call recordings, and a deep dive discussion with Health Plan subject matter experts (SMEs) about challenges, risks, concerns, and opportunities.
CareSource	*Improving outcomes for members with substance use disorder (SUD) through timely member engagement in care-case management following an ED Visit* HIP / HHW	Use of dedicated CHWs to facilitate timely outreach and CM engagement within 28 days following ED visit for substance use disorder. CHW identifies members through IHIE daily reporting, ED claims, ED facility staff, providers, UM team and referrals. Upon reaching member, CHW assists with arranging appointments, transportation, and referrals for ongoing case management. CM referrals and engagement are analyzed monthly.
		Improve Peer Recovery Specialist (PRS) member notification and handoffs for care-case management within 28 days following a SUD related ED visit. CM referrals and engagement are analyzed monthly to ensure referrals are submitted within 28 days of the ED visit and that the PRS is identifying all eligible members and notifying care-case management. Current facilities with participating Peer Recovery Specialists include Eskenazi Health, Indiana University Health (14 campuses) and Parkview Health Systems, thus this intervention targets 16 ED facilities.

Table 12. CY 2023 QIP Interventions

IHCP	QIP Title	Interventions
		Impact care coordination and handoffs of high-volume ED facilities through use of peer comparison reports. Peer comparison reports on FUA HEDIS® measure compliance rates are used to prompt provider practice change and are shared quarterly to the top 10 high-volume ED facilities. CareSource Behavioral Health initiative Leads meet with providers, at least once per quarter, to provide education on handoffs to care management, outpatient, and treatment providers. CareSource monitors the number of members receiving care through the targeted ED facilities for FUA 7-day compliance. CareSource expects to observe a statistically significant change in FUA 7-day rates from baseline to subsequent reporting periods.
		Impact of value-based reimbursement (VBR) on two ED facilities, Eskenazi Hospital and Community Hospital East, to improve 7-day FUA rates among Black HIP members in Marion County.
	Health Needs Screening HIP / HHW	Implementation of multiple modalities through a staggered approach for timely HNS completion includes telephonic outreach through the member assessment team, use of Pursuant kiosk, use of the web portal, use of mailers, and offering HNS completion through interactive texting option between days 61-90 of plan enrollment.
		Implementation of a standardized member locate strategy for new members identified as unreachable during initial telephonic attempts due to wrong, invalid, or disconnected numbers and/or exhausted attempts. A standardized approach is used to search for updated member contact information using white pages, pharmacy and encounter data, outreach to provider offices, etc. Upon locating members CareSource representatives will attempt to complete the HNS during the outreach call.
	Improve access to timely Prenatal and Postpartum Care through Care Management (CM) Engagement HIP / HHW	Implementation of process redesign to increase pregnant member engagement in care-case management (CM).
		Use of CHWs to drive community-based engagement of Black or African American pregnant members.
		Provides member access to Nurse Practitioners over interactive audio or video, who assess, diagnose and if needed, prescribe medication. It is a convenient and affordable way for members to complete a postpartum visit.
MDwise	*Follow-up after Emergency Department Visit for Drug Abuse or Dependence (FUA)*	Identification and outreach to members with new prescription fill for Benzodiazepines and Suboxone.
		Identification and outreach to members with new prescription fills for Antidepressants, Antipsychotics, Antianxiety drug classes.

Table 12. CY 2023 QIP Interventions

IHCP	QIP Title	Interventions
	HIP / HHW	CM outreach for prior authorization for SUD service request (Inpatient, Detox, Residential SUD, and Intensive Outpatient Program).
		Partner with Emergency Departments in Counties that supports substance use visits as well as rural areas.
	Health Needs Screenings HIP / HHW	Outreach via interactive text to all newly enrolled members with valid mobile.
		Visits by CHWs to newly enrolled member with a valid address but no phone number for HNS completion or Community/Provider partner completion.
MHS	*Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)* HIP / HHW / HCC	Utilize the ED Diversion team, referrals to BH Disease Management, letters to members and member incentives to engage members and encourage them to engage in case management or Intensive Outpatient treatment.
		Utilize additional methods of communication (short message service [SMS] and email) to outreach to HIP members who appear on the IHIE or MHS Pharmacy report following member visit to ED for treatment of SUD diagnosis.
	Health Needs Screening HIP / HHW / HCC	MHS adopted the improvement strategy of Member Engagement & Education through these six member-targeted interventions: ♦ Telephonic outreach by the Community Engagement Team (CET) to members to complete HNS ♦ Email to members with a link to HNS form ♦ Kiosks at Walmart and participating CVS stores ♦ Paper copy in Welcome packet (Second copy of paper HNS mailed in CET unable to connect with member) ♦ Member can send digital copy of completed HNS by email to MHS ♦ Member can complete HNS on MHS member portal
		Utilize Care Engagement Specialists to research new HHW members who: 1) Have phone numbers that have been deemed unreachable according to the dialer disposition; and/or 2) Have not completed the HNS within 30 days of enrollment. Obtain alternate telephone numbers for newly enrolled HHW members with unreachable telephone numbers to facilitate effective member outreach by the CET and improve HNS

Table 12. CY 2023 QIP Interventions		
IHCP	**QIP Title**	**Interventions**
		completion rates. Alternate sources for obtaining another contact number consist of transactional processes and systems including the member Primary Care Physician (PCP) on record, the member's pharmacy on record, and researching by household in MHS systems so the CET can outreach to the family member's phone.
UHC	*Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)* HCC	Member Incentive.
		General Provider Education: To improve FUA HEDIS® measure rates, the quality analyst developed a provider-specific educational flyer on FUA during baseline measurement period. Further educational and training efforts will continue throughout the course of this QIP.
		Internal Process Change: The policy on frequency of member outreach was modified to reflect a 24-hour expectation with a target goal of compliance 85% of the time and a stretch goal of compliance 100% of the time.
	Health Needs Screening HCC	Member Rewards Program: Evidence suggests that providing member incentives would increase the number of members successfully completing a Health Needs Screener. Although, UHC IN did not find that providing the incentive significantly increased the number of completed screeners as evidenced in the results above. However, UHC IN does believe the monetary amount of the incentive may affect the rates/outcomes. If determined successful, administration of member incentives, if continued over time, would have the ability to influence long-term change. This improvement strategy is and was measured on an ongoing basis for efficacy. Members were educated regarding member incentives in both English and Spanish. The mailers containing the gift cards were also mailed in English or Spanish accordingly. No confounding variables that could have an impact on the outcomes were identified.
		Strategic Outreach Campaign: Beginning 4/1/2021, UHC deployed an all-hands-on-deck strategy to capture the member's HNS, regardless of who interacted with the member initially. We address HNS through outbound calls, mail, email outreach, inbound member services calls, and during interactions with care coordinators. We track completions by user, department, and method of completion. As UHC has been reaching members, no specific strategies have addressed completion by a specific method, but UHC does continue to monitor in the event UHC do wish to initiate a new strategy in the future. For now, UHC is confident that telephonic outreach is by far the most effective way to collect HNS and focus our efforts on this method of completion, as it also affords us the greatest opportunity to engage members and help them understand their benefits and coverage. It also allows us to introduce members to care coordination, social determinants of health (SDOH) resources, and initial preventive health education in ways that digital and mail-in options cannot.

Comparison QIP Improvements

Table 13 presents a comparison between QIP validation scores in MY 2022 and MY 2023. Where comparisons were not included, the results either showed no change or were not applicable (NA) in the previous measurement year. Notable improvements from the previous measurement year are indicated using an up arrow (↑) and notable decreases in performance are indicated using a down arrow (↓).

Table 13. QIP Performance Comparison

IHCP	QIP Name	MY 2022 Validation Rating 1	MY 2022 Validation Rating 2	MY 2022 Overall Score	MY 2023 Validation Rating 1	MY 2023 Validation Rating 2	MY 2023 Overall Score
Anthem – HIP/HHW/HCC	*Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*	No Confidence	NA	58.33%	Moderate Confidence	Low Confidence	83.67% ↑
	Health Needs Screening (HNS)	Low Confidence	NA	71.11%	Moderate Confidence	Moderate Confidence	82.22% ↑
CareSource – HIP/HHW	*Improving outcomes for members with substance use disorder (SUD) through timely member engagement in care-case management following an ED Visit*	High Confidence	NA	100%	High Confidence	Moderate Confidence	100%
	Health Needs Screening	High Confidence	NA	100%	High Confidence	High Confidence	100%
	Improve access to timely Prenatal and Postpartum Care through Care Management (CM) Engagement	High Confidence	NA	100%	High Confidence	Moderate Confidence	100%
MDwise – HIP/HHW	*Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*	No Confidence	NA	42.22%	No Confidence	No Confidence	50.00% ↑

Table 13. QIP Performance Comparison							
IHCP	**QIP Name**	**MY 2022 Validation Rating 1**	**MY 2022 Validation Rating 2**	**MY 2022 Overall Score**	**MY 2023 Validation Rating 1**	**MY 2023 Validation Rating 2**	**MY 2023 Overall Score**
	Health Needs Screening	No Confidence	NA	42.55%	No Confidence	No Confidence	43.48% ↑
MHS – HIP/HHW/HCC	*Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*	High Confidence	NA	93.33%	Low Confidence	No Confidence	73.91% ↓
	Health Needs Screening	High Confidence	NA	100%	Low Confidence	No Confidence	73.91% ↓
UHC – HCC	*Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*	Moderate Confidence	NA	84.46%	High Confidence	Moderate Confidence	93.18% ↑
	Health Needs Screening	Moderate Confidence	NA	80.00%	Moderate Confidence	Low Confidence	81.40% ↑

Table 14 displays the rating criteria for the degree to which the plans addressed the previous year's AONs.

Table 14. Improvement Rating Criteria	
Rating	**Criteria**
High	Recommendations were fully addressed.
Medium	Recommendations were partially addressed.
Low	Recommendations were not addressed.
Not Applicable	No comparison was available.

Table 15 presents how the plans addressed recommendations from MY 2022 in MY 2023.

Table 15. MY 2022 Recommendations Addressed in MY 2023

Anthem **MY 2022** **AON**	In MY 2022, Anthem submitted six QIPs for the HHW, HIP, and HCC programs. Upon validation by Qsource, it was determined that AONs occurred within the following steps: ♦ Step 2: Review the QIP Aim Statement ♦ Step 3: Review the identified QIP Population ♦ Step 5: Review the Selected QIP Variables and Performance Measures ♦ Step 6: Review the Data Collection Procedures ♦ Step 7: Review the Data Analysis and Interpretation of QIP Results ♦ Step 8: Assess the Improvement Strategies ♦ Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred Qsource's recommendations included: 1. The MCE should include discussions regarding how performance measures were based on current clinical knowledge or health services research and that the process being measured is meaningfully associated with outcomes. 2. The MCE should address and describe the processes and qualifications associated with the data abstraction role and the intra- and inter-rater reliability review role. 3. The MCE should include discussion on: ♦ Whether QIP improvement strategies are evidence based; ♦ Statistical significance between baseline and repeat measurements; ♦ Any factors that may influence comparability of initial and repeat measurements; ♦ Success of QIP interventions or related, planned follow-up activities; and ♦ How data analysis and interpretation were conducted in accordance with the data analysis plan. 4. The MCE should include a description of the process used to implement improvement strategies that demonstrate rapid-cycle activities implemented on a PDSA basis and an assessment of member-facing improvement strategies for cultural and linguistic appropriateness. 5. The MCE should include an assessment for real improvement that includes: ♦ Whether or not there is quantitative evidence of improvement in processes or outcomes; ♦ Whether improvement is present and if it is the result of implemented strategies; ♦ Whether statistical evidence of improvement is present; ♦ Whether sustained improvement over time is demonstrated; and ♦ Whether the remeasurement methodology is the same as baseline methodology.
Results from MY 2023 Validation	In MY 2023, Anthem improved the combined average QIP score for the FUA and HNS QIPs from 64.72% in MY 2022 to 82.95% in MY 2023. However, Anthem's QIPs continued to lack inclusion of members from all health plans, a detailed explanation of measurement processes, data analysis plans, and performance measures that compromised the

Table 15. MY 2022 Recommendations Addressed in MY 2023	
	QIP results and the validity of the studies. Some of Qsource's recommendations from MY 2022 were implemented, but further work needs to be completed.
Degree to Which the Plan Addressed Recommendation(s)	Medium
CareSource MY 2022 AON	In MY 2022, CareSource achieved an average of 100% for the six QIPs. No recommendations were given by Qsource.
Results from MY 2023 Validation	In MY 2023, CareSource maintained the 100% average for their six QIPs.
Degree to Which the Plan Addressed Recommendation(s)	Not Applicable
MDwise MY 2022 AON	In MY 2022, MDwise submitted four QIPs for the HHW and HIP programs. Upon validation by Qsource, it was determined that AONs occurred within the following steps: ♦ Step 2: Review the QIP Aim Statement ♦ Step 5: Review the Selected QIP Variables and Performance Measures ♦ Step 6: Review the Data Collection Procedures ♦ Step 7: Review the Data Analysis and Interpretation of QIP Results ♦ Step 8: Assess the Improvement Strategies ♦ Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred Qsource's recommendations included: 1. The MCE should ensure that the QIP aim statement is concise, clear, and easily understandable, is in the form of a question and answerable, is measurable with specific criteria, and discuss improvement strategies. 2. The MCE should describe the process of addressing and tracking performance measures at a point in time, indicate how the measures are appropriate based on the availability of data and resources, compare the measures to benchmarks, and give details of how the process being measured was meaningfully associated with outcomes. 3. The MCE should address and describe the processes and qualifications associated with the data abstraction role and the intra- and inter-rater reliability review role. 4. The MCE should ensure data sources and elements are clearly identified, systematic methods for collecting the data are included, and the data collection plan has all applicable details, including the data collection instruments. 5. The MCE should ensure that statistical significance between remeasurement years is noted and explained.

Table 15. MY 2022 Recommendations Addressed in MY 2023	
	6. The MCE should review quality improvement methods that are significant to QIP execution such as rapid-cycle improvement, PDSA, barrier analysis, and the development of a data analysis plan. 7. The MCE should conduct statistical analysis and include a detailed discussion demonstrating the sustainability of QIP improvement through repeated measurements over time.
Results from MY 2023 Validation	In MY 2023, MDwise improved the combined average QIP score for the FUA and HNS QIPs from 42.39% in MY 2022 to 46.74% in MY 2023. However, MDwise's QIPs continued to lack vital information that compromised QIP results and the overall validity of the studies. The majority of Qsource's recommendations from 2022 were not followed.
Degree to Which the Plan Addressed Recommendation(s)	Low
MHS **MY 2022 AON**	In MY 2022, MHS submitted six QIPs for the HHW, HIP, and HCC programs. Upon validation by Qsource, it was determined that AONs occurred within the following steps: ♦ Step 5. Review the Selected QIP Variables and Performance Measures ♦ Step 7. Review the Data Analysis and Interpretation of QIP Results ♦ Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred Qsource's recommendations included: 1. The MCE should detail how process measures are based on strong evidence that the process being measured is meaningfully associated with health outcomes. 2. The MCE should compare results across multiple entities, as applicable, with clear data descriptions that acknowledge the performance measure being discussed. 3. The MCE should include a discussion of whether sustained improvement is demonstrated through repeated measurements over time.
Results from MY 2023 Validation	In MY 2023, MHS decreased the combined average QIP score for the FUA and HNS QIPs from 96.67% in MY 2022 to 73.91% in MY 2023. While some of the recommendations made in MY 2022 were followed, Qsource identified several problems in MY 2023 that were not present in MY 2022.
Degree to Which the Plan Addressed Recommendation(s)	Medium
UHC **MY 2022** **AON**	In MY 2022, UHC submitted two QIPs for the HCC program. Upon validation by Qsource, it was determined that AONs occurred within the following steps: ♦ Step 1. Review the Selected QIP Topic ♦ Step 2. Review the QIP Aim Statement ♦ Step 3. Review the Identified QIP Population

Table 15. MY 2022 Recommendations Addressed in MY 2023	
	♦ Step 5. Review the Selected QIP Variables and Performance Measures ♦ Step 6. Review the Data Collection Procedures Qsource's recommendations included: 1. The MCE should specifically indicate how the QIP topic aligns with priority areas identified by HHS and/or CMS. 2. The MCE should clearly define the QIP population in the QIP aim statement. 3. The MCE should specifically state that performance measure is a process measure, provide strong evidence that links the performance measure to meaningful outcomes, and provide current clinical knowledge and/or health services research to support the selection of the performance measure. 4. The MCE should provide a detailed systemic method for collecting valid and reliable data that represent the QIP population.
Results from MY 2023 Validation	In MY 2023, UHC increased the combined average QIP score for the FUA and HNS QIPs from 82.23% in MY 2022 to 87.29% in MY 2023. However, UHC QIPs lacked detailed explanations of measurement processes, data analysis plans, and performance measures that compromised QIP results and the overall validity of the studies. The majority of Qsource's recommendations from 2022 were not followed.
Degree to Which the Plan Addressed Recommendation(s)	Low

Conclusions and Recommendations

Anthem

Anthem received an overall Validation Rating 1 of Moderate Confidence for the six submitted QIPS for MY 2023. Their *Follow-up within 7 days After Emergency Department Visit for Drug Abuse or Dependence (FUA)* QIP received a Validation Rating 2 of Low Confidence and their *Health Needs Screening (HNS)* QIP received a Validation Rating 2 of Moderate Confidence. Anthem's two OMPP-selected QIP topics, *Follow-up within 7 days After Emergency Department Visit for Drug Abuse or Dependence (FUA)* and *Health Needs Screening (HNS)* were conducted consistently across all three programs.

Each of Anthem's QIP Summary Forms contained varying degrees of missing or incomplete information that could be improved by acknowledging each element according to the QIP Summary Form Instructions. A detailed data analysis and statistical testing were among the missing details for both QIP topics. Additionally, the missing performance measure data, lack of statistical analysis, and absence of two of the three IHCP populations in the FUA QIP compromised QIP results and the validity of both studies. The MCE should refer to CMS guidance, OMPP directives, and the QIP Summary Form

Instructions for clarification and to increase understanding of the protocol requirements.

The FUA QIP topic addresses quality and access to care delivered to members with a principal diagnosis of alcohol or other drug abuse or dependence (AOD) treated in ED given that high rates of ED use by this population can indicate barriers to quality and access to care. The FUA topic incorporates timeliness of care by assessing timely follow-up visits completed within the target population. The HNS topic addresses the timeliness of completing new member assessments, promotes access to care by early identification of enrollee health needs, and improves quality by using HNS assessments to support care coordination.

The validation status and scores for each submitted QIP indicated that Anthem could address the suggestions noted by Qsource to aid in increasing quality of care, timeliness of care and access to care for enrollees.

The following recommendations should be incorporated into Anthem's HIP, HHW and HCC QIP activities:

1. The MCE should clearly define the QIP population within the aim statement.
2. The MCE should include all health plans in the population.
3. The MCE should ensure that performance measures are grounded in strong evidence, demonstrating a meaningful connection between the process being measured and outcomes. The MCE should discuss data availability and how performance measures are informed by current clinical knowledge or health services research.
4. The MCE should describe the intra- and inter-rater reliability processes implemented to ensure valid and reliable data abstraction during medical record reviews. The MCE should also provide specific guidelines for data abstraction staff to guarantee the accuracy and reliability of the data.
5. The MCE should explain how data analysis and interpretation were carried out according to the data analysis plan. This should include a detailed discussion of performance during the baseline year and each remeasurement year, along with an analysis of the statistical significance of any differences between the baseline and subsequent remeasurements.
6. The MCE should address how member interactions are culturally and linguistically appropriate. Additionally, the MCE should assess the cultural and linguistic appropriateness of member-facing improvement strategies and document any major confounding factors, explaining how these were accounted for in the improvement strategies.
7. The MCE should provide evidence demonstrating whether any observed improvements are the result of the improvement strategies, either for individual IHCPs or across the three combined.

Anthem addressed MY 2022 recommendations to a medium degree.

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, sustained study outcomes. Each of the QIPs scored 100%, attaining a Validation Rating 1 of High Confidence. For their

Improving outcomes for members with substance use disorder (SUD) through timely member engagement in care-case management following an Emergency Department (ED) Visit and QIP 3: *Improve access to timely Prenatal and Postpartum Care through Care Management (CM) Engagement* QIPs they received a Validation Rating 2 of Moderate Confidence and for their *Health Needs Screening* QIP they received a Validation Rating 2 of High Confidence.

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 performance measure rates. In general, the MCE utilized appropriate methodology across all the QIPs, which allowed them to maintain the improvement made in MY 2022.

The FUA QIP topic addresses quality and access to care delivered to members with a principal diagnosis of AOD treated in the ED given that high rates of ED use by this population can indicate barriers to quality and access to care. The FUA topic incorporates timeliness of care by assessing timely follow-up visits completed within the target population. The HNS topic addresses the timeliness of completing new member assessments, promotes access to care by early identification of enrollee health needs, and improves quality by using HNS assessments to support care coordination. The Postpartum Care topic addresses the timeliness and access of prenatal and postpartum care delivered to pregnant and postpartum women.

The validation status and scores for each submitted QIP indicate that CareSource suitably designed their QIPs to aid in increasing quality of care, timeliness of care, and access to care for enrollees.

CareSource had no recommendations in MY 2022 therefore the degree of addressing any is not applicable.

MDwise

MDwise's two OMPP-selected Quality Improvement Projects, *Follow-up within 7 days After Emergency Department Visit for Drug Abuse or Dependence (FUA-7)* and *Health Needs Screening* both received Validation Rating 1 of No Confidence and Validation Rating 2 of No Confidence. Although some performance rate improvement was noted, each of the QIP Summary Forms contained varying degrees of missing or incomplete information that could be improved by the MCE acknowledging each element according to the QIP Summary Form Instructions. Data elements, data collection plan, an analysis of results, and statistical testing were among the missing details for both QIPs. The MCE should refer to CMS guidance for clarification and to increase understanding of the protocol requirements.

The FUA QIP topic addresses quality and access to care delivered to members with a principal diagnosis of AOD treated in the ED given that high rates of ED use by this population can indicate barriers to quality and access to care. The FUA topic incorporates timeliness of care by assessing timely follow-up

visits completed within the target population. The HNS topic addresses the timeliness of completing new member assessments, promotes access to care by early identification of enrollee health needs, and improves quality by using HNS assessments to support care coordination.

The scores for each submitted QIP indicated that MDwise could address the suggestions noted by Qsource to aid in increasing quality of care, timeliness of care, and access to care for enrollees.

The following recommendations should be incorporated into MDwise's HIP and HHW QIP activities:

1. The MCE should ensure that the QIP aim statement is concise, clear, and easily understandable, is in the form of a question and answerable, is measurable with specific criteria, and discuss improvement strategies.
2. The MCE should describe the process of addressing and tracking performance measures at a point in time, indicate how the measures are appropriate based on the availability of data and resources, compare the measures to benchmarks, and give details of how the process being measured was meaningfully associated with outcomes.
3. The MCE should ensure data sources and elements are clearly identified, systematic methods for collecting the data are included, and the data collection plan has all applicable details, including the data collection instruments.

MDwise addressed MY 2022 recommendations to a low degree.

MHS

MHS's two OMPP-selected Quality Improvement Projects, FUA-7 and HNS, both received Validation Rating 1 of Low Confidence and a Validation Rating 2 of No Confidence. MHS appropriately conducted and selected the sampling and data collection activities. These activities ensured that MHS properly defined and collected the necessary data to produce accurate study indicator rates. MHS demonstrated sound study designs for its QIPs but failed to achieve real and sustained improvement for the QIPs. In general, MHS utilized appropriate methodology across all the QIPs. The MCE should refer to CMS Protocols, OMPP guidance, and the QIP Summary Form Instructions for clarification to improve understanding of protocol requirements.

The FUA QIP topic addresses quality and access to care delivered to members with a principal diagnosis of AOD treated in the ED given that high rates of ED use by this population can indicate barriers to quality and access to care. The FUA topic incorporates timeliness of care by assessing timely follow-up visits completed within the target population. The HNS topic addresses the timeliness of completing new member assessments, promotes access to care by early identification of enrollee health needs, and improves quality by using HNS assessments to support care coordination.

The validation status and scores for each submitted QIP indicate that MHS suitably designed their QIPs to aid in increasing quality of care, timeliness of care, and access to care for enrollees. However, MHS should ensure that they submit a

single statistically significant number; in all MY 2023 QIPs, there were two reported statistically significant numbers for the same dataset. Due to the conflicting information, Qsource could not verify which analysis to consider. Additionally, MHS only reported one quarter of data for MY 2023 to compare against a full year of data given during the prior QIP Remeasurement (MY 2022) which compounded this discrepancy. MHS should also address the suggestions noted by Qsource to improve the clarity of their quality improvement projects.

The following recommendations should be incorporated into MHS's HIP, HHW and HCC QIP activities:

1. The MCE should ensure that the data analysis and interpretation section include documentation for the current QIP year that is concise and presented in an easily understood manner by explicitly responding to each requirement outlined within the QIP Summary Form Instructions.
2. The MCE should include all required elements to address performance of the QIP, such as performance measure results over time, a comparison of performance to benchmarks, and how said performance was used to inform the selection of improvement strategies.
3. The MCE should appropriately describe variations between baseline and the current remeasurement year and avoid the inclusion of identical discussions from prior QIP cycles.
4. The MCE should discuss how quantitative results are evidence of improvement in care processes and/or outcomes; if no quantitative evidence exists it should be stated as such.

MHS addressed MY 2022 recommendations to a medium degree.

UHC

UnitedHealthcare's two OMPP-selected Quality Improvement Projects, FUA-7 and HNS received Validation Rating 1 of High Confidence and Moderate Confidence, respectively. Additionally, UnitedHealthcare's two OMPP-selected Quality Improvement Projects, FUA-7 and HNS received Validation Rating 2 of Moderate Confidence and Low Confidence, respectively. Detailed explanations of measurement processes, data analysis plans, and performance measures were among the missing details for both QIPs. Overall, the MCE performed and reported QIP activity well and should continue to refer to CMS guidance for clarification and to increase understanding of the protocol requirements.

The FUA QIP topic addresses quality and access to care delivered to members with a principal diagnosis of AOD treated in the ED given that high rates of ED use by this population can indicate barriers to quality and access to care. The FUA topic incorporates timeliness of care by assessing timely follow-up visits completed within the target population. The HNS topic addresses the timeliness of completing new member assessments, promotes access to care by early identification of enrollee health needs, and improves quality by using HNS assessments to support care coordination.

The two validation statuses and overall scores for each submitted QIP indicate that UHC suitably designed their QIPs to aid in increasing quality of care, timeliness of care and access of care for enrollees, but should address the suggestions noted

by Qsource to improve the clarity of their quality improvement projects.

The following recommendations should be incorporated into UnitedHealthcare's Hoosier Care Connect QIP activities:

1. The MCE could present evidence supporting each strategy and provide statistical data to back up improvements, along with more detailed follow-up activities.
2. The MCE should provide current clinical knowledge and/or health services research to justify the performance measure selection. Additionally, the MCE should address whether a performance measure is a process measure and provide strong evidence linking the processes being measured to meaningful outcomes.
3. The MCE should explain how strategies are culturally and linguistically appropriate, cite supporting evidence for the implemented improvement activities, and utilize PDSA or rapid-cycle processes for continuous improvement.
4. The MCE should provide statistical evidence demonstrating whether improvements, or lack thereof, are the result of interventions.

UnitedHealthcare addressed MY 2022 recommendations to a low degree.

Protocol 2: Performance Measure Validation (PMV)

Objectives

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. FSSA OMPP has contracted with Qsource to conduct mandatory EQR activities required by 42 CFR § 438.358. One of the mandatory activities is performance measure validation (PMV) of the MCEs.

The 2024 PMV, which validates performance measures for MY 2023, was conducted virtually. The validation activities for these measures were conducted as outlined in CMS's EQR *Protocol 2: Validation of Performance Measures (February 2023)*. This report includes findings from a review of each MCE's Information Systems Capabilities Assessment Tool (ISCAT) that the EQRO used to validate information systems, processes, data, and MCE-reported results for all performance measure production, including the *0507 Utilization Services Report*. Protocol guidance indicates that the EQRO may review results from a recent comprehensive, independent assessment of the MCE's information systems, such as the HEDIS® Compliance Audit, conducted in the previous two years, provided that the HEDIS® measures were calculated using NCQA HEDIS®-certified software and any non-HEDIS® rates included under the scope of the HEDIS® audit. Validation of HEDIS® measures was conducted by utilizing certified HEDIS® auditor results.

Qsource conducted virtual systems reviews for each MCE, including interviews with key staff involved in producing performance measures, using questions tailored to the processes for producing performance measures, and supported by findings from the ISCAT. Primary source verification was done of data tracking logs used to monitor data transfer and ingestion across all facets of data: claims, enrollment, provider, and ancillary vendors. Qsource observed live demonstrations of the data systems and key processes required for performance measure calculation. Qsource assessed the ability to link data from multiple sources and the extent to which the MCE have created processes to ensure the accuracy of the calculated performance measures. A data file review was conducted as well as a review of all systems contributing to the performance measure calculations including:

1. Claims and Encounter Systems
2. Enrollment Systems
3. Medical Record Data, if applicable

4. Ancillary Vendor Data
5. Provider Systems
6. Data Integration
7. Software Integration and Measure Development
8. Communication Findings and Outstanding Items

Specific findings from the virtual systems reviews and ISCATs for the MCEs are in the *2024 Performance Measure Validation Reports*.

Technical Methods of Data Collection and Analysis

Quality and Performance Measures for Validation

Qsource obtained the list of quality measures and technical specifications for the measures from OMPP's 0507 Utilization Measures Report. Qsource requested measure numerators, denominators, rates, and source data for the selected measures from the MCEs. The validation team completed a line-by-line code review 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. In addition, Qsource reviewed calculated rates and compared them to target rates for the current measurement period. As indicated in Activity 2 of the Protocol, there was no sampling for the validated measures. For the MCEs, all measures reported were calculated from administrative data only; therefore, the medical record review (MRR) mentioned in Activity 1 of the Protocol was not applicable. Qsource verified that NCQA-certified software was used to calculate the HEDIS® measures. Qsource reviewed calculated rates and compared them to national benchmarks for the current measurement period.

Description of Data Obtained

OMPP selected measures for specific primary data source review. Qsource requested source code and source data (claims data) for the selected measures from the MCEs. The source code and source data were used to validate the rates that MCEs provide Qsource. Qsource randomly selected ten numerator positive files from the data with five oversamples for primary source verification. These measures were reviewed for the following elements: 1. Documentation related to the data collection and calculation method; 2. Denominator calculation(s), including adequacy of the data sources to calculate the denominator, operationalization of the measure-specific eligibility criteria, and adherence to the measurement period; 3. Numerator calculation(s), including adequacy of the data sources to calculate the numerator, appropriateness of codes used to identify numerator compliance, avoidance of double counting, and adherence to the measurement period; 4. Sampling methodology; and 5. Reporting of rates and other supporting information, including documentation of deviations (if any). These measures were required-reporting metrics identified by OMPP and system findings were extrapolated to all performance measures required for reporting. Qsource further utilized each MCE's Final Audit Report (FAR) from the

HEDIS® Compliance Audit to ensure measures were validated and support all system's integrity including medical record review activities, if applicable.

The Quality Measures are listed in **Table 16**.

Table 16. Quality Measures

Measure Name	Domain of Care
Physician-Administered Drugs	Quality and Access to Care
Home Health/Home IV Therapy	Quality and Access to Care
Hospice	Quality and Access to Care

Qsource obtained appropriate MCE-specific documentation from OMPP to validate additional performance standards. Annual MY 2023 results for each measure were evaluated and compared to defined targets to assess overall compliance with each performance standard. The additional performance standards are listed in **Table 17**.

Table 17. Performance Measures

Measure Name	Domain of Care
Health Needs Survey (HNS)	Timeliness and Access to Care
Comprehensive Health Needs Assessment Tool (HCC only)	Timeliness and Access to Care

HEDIS® Measures

HEDIS® measures were subject to an NCQA HEDIS® Compliance Audit that must be conducted by an NCQA-certified HEDIS® Compliance Auditor under the auspices of an NCQA-licensed organization. This ensures the integrity of the HEDIS® collection and calculation process through an information systems capabilities assessment (ISCA), followed by an evaluation of the ability to comply with HEDIS® specifications. Each MCE underwent this audit. Qsource reviewed the submitted HEDIS® Roadmap and ISCAT to support findings.

Each MCE noted that NCQA-certified software was used to calculate the measures. Qsource reviewed calculated rates and compared them to national benchmarks for the current measurement period. The MCEs included a designation of one of the following for each measure:

- R—Reportable: A reportable rate was submitted for the measure.
- NA—Not Applicable: The MCE followed the specifications, but the denominator was too small (<30) to report a valid rate; thus, results are not presented.
- NB—No Benefit: The MCE did not offer the health benefit required by the measure.
- NR—Not Reported: The MCE chose not to report the measure.
- NQ—Not Required: The MCE was not required to report the measure.
- BR—Biased Rate: The calculated rate was materially biased.

The number of reportable measures versus not applicable measures varied among the MCEs based on their reported data.

Data Integration, Data Control, and Performance Measure Documentation

Table 18 presents the validation findings across all MCEs.

Table 18. Data Integration, Data Control, and Performance Measure Documentation

Measure	Anthem	CareSource	MDwise	MHS	UHC
Claims/Encounter Data System	No issues identified	No issues identified	No issues identified	No issues identified	No issues identified
Enrollment/Eligibility Data System	No issues identified	No issues identified	No issues identified	No issues identified	No issues identified
Provider Systems	No issues identified	No issues identified	No issues identified	No issues identified	No issues identified
Data Integration, Software Integration, and Measure Development	No issues identified	No issues identified	No issues identified	No issues identified	No issues identified

Claims/Encounter Data System

The organizational infrastructure of claims and encounter data must be verified based on industry standards and business rules. Both paper and electronic claims data must be audited regularly for accuracy, completeness, and timeliness; audits must also be performed on the analysts who perform the audits on claims data. Encounter data must then be extracted from the claims data for submission to the state and timeliness tracking.

Enrollment/Eligibility Data System

The MCE must be able to track enrollment data, including changes in enrollment, name changes, and changes in coverage, and this data needs to be stored safely and securely.

Provider Systems

The MCE must be able to track and store provider data. This can then be used to credential and recredential providers, track changes in provider data, and track providers over time, including across locations and participation.

Data Integration, Software Integration, and Measure Development

The organizational infrastructure for housing both HEDIS® and non-HEDIS® measure data must be verified for standard control procedures and completeness of data. All MCEs were required to provide source code and source data (claims data) for the measures chosen by OMPP as the focus for MY 2023 PMV. The source code and source data were used to validate the rates the MCEs reported. The primary source verification and measure validation results were extrapolated to all measures.

Description of Data Obtained

Information Systems Capabilities Assessment (ISCA)

Table 19 presents the criteria used to assign ISCA ratings.

Table 19. ISCA Validation Rating Criteria

Rating	Criteria
Fully Met	The MCE fully met all the criteria necessary for producing accurate and reliable performance metrics with a well-developed and complete data receipt, integration, and reporting process.
Partially Met	The MCE partially met the criteria necessary for producing accurate and reliable performance metrics.
Not Met	The MCE did not meet the criteria necessary for producing accurate and reliable performance metrics.

Table 20 presents the ISCA findings by MCE. The 2024 Performance Measure Validation Reports contain specific findings from the virtual systems review and ISCATs for each MCE.

Table 20. Information Systems (IS) Capabilities

MCE	Validation Rating
Anthem	Fully met
CareSource	Fully met
MDwise	Fully met
MHS	Fully met
UHC	Fully met

Performance Measures

Throughout the validation activities, Qsource performed primary source verification to ensure that the MCE has processes to manage the data. Once those processes were located, Qsource validated their ability to produce the performance measures chosen by OMPP for a more thorough investigation.

Qsource determined validation results for each performance measure for each MCE. These results are displayed in **Table 21**.

Table 21. Key Performance Measure Review Results

Measure	Anthem	CareSource	MDwise	MHS	UHC
Physician-administered Drugs	No issues found	No issues found	No issues found	No issues found	No issues found
Home Health/Home IV therapy	No issues found	No issues found	No issues found	No issues found	No issues found

Table 21. Key Performance Measure Review Results					
Measure	**Anthem**	**CareSource**	**MDwise**	**MHS**	**UHC**
Hospice	No data was available on this performance measure, as there were no enrollees during the measurement period	No data was available on this performance measure, as there were no enrollees during the measurement period	No data was available on this performance measure, as there were no enrollees during the measurement period	No issues found	No data was available on this performance measure, as there were no enrollees during the measurement period

Table 22 presents the rating criteria for performance measures, and **Table 23** presents the results and ratings for each MCE and its performance measures.

Table 22. Performance Measure Rating Criteria	
Rating	**Criteria**
High Confidence	Met or exceeded OMPP target
Moderate Confidence	Within 10 percentage points of OMPP target
Low Confidence	Within 20 percentage points of OMPP target
No Confidence	Below 20 percentage points of OMPP target

Table 23. Performance Measure Results and Ratings											
Measure Name	**Goal**	**Anthem**		**CareSource**		**MDwise**		**MHS**		**UHC**	
		Annual Results	**Rating**	**Annual Results**	**Rating**	**Annual Results**	**Rating**	**Annual Results**	**Rating**	**Annual Results**	**Rating**
HIP											
Health Needs Assessment: Measure 1 (percent screened within 90 days excluding	≥65%	37.13%	No Confidence	68.88%	High Confidence	56.90%	Moderate Confidence	61.58%	Moderate Confidence		

Table 23. Performance Measure Results and Ratings

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Annual Results	Rating	Annual Results	Rating	Annual Results	Rating	Annual Results	Rating	Annual Results	Rating
terminated and unreachable)											
Health Needs Assessment: Measure 2 (percent screened within 90 days excluding terminated)	≥65%	99.78%	High Confidence	100%	High Confidence	96.20%	High Confidence	63.57%	Moderate Confidence		
HHW											
Health Needs Assessment: Measure 1 (percent screened within 90 days excluding terminated and unreachable)	≥65%	14.65%	No Confidence	72.55%	High Confidence	54.30%	Moderate Confidence	52.53%	Low Confidence		
Health Needs Assessment: Measure 2 (percent screened within 90 days excluding terminated)	≥65%	70.23%	High Confidence	100%	High Confidence	98.20%	High Confidence	52.77%	Low Confidence		

Table 23. Performance Measure Results and Ratings

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Annual Results	Rating	Annual Results	Rating	Annual Results	Rating	Annual Results	Rating	Annual Results	Rating
HCC											
Health Needs Assessment: Measure 1 (percent screened within 90 days excluding terminated and unreachable)	≥65%	50.29%	Low Confidence					63.79%	Moderate Confidence	67.10%	High Confidence
Health Needs Assessment: Measure 2 (percent screened within 90 days excluding terminated)	≥65%	99.75%	High Confidence					64.17%	Moderate Confidence	67.10%	High Confidence
Comprehensive Health Needs Assessment Tool	≥79%	90.11%	High Confidence					89.58%	High Confidence	80.91%	High Confidence

HEDIS® Measures

HEDIS® measures were subject to an NCQA HEDIS® Compliance Audit, which must be conducted by an NCQA-certified HEDIS® Compliance Audit under the auspices of an NCQA-licensed organization. This audit ensures the integrity of the HEDIS® collection and calculation process through an ISCA, followed by an evaluation of the ability to comply with HEDIS® specifications. Each MCE underwent this audit. Qsource reviewed the submitted HEDIS® Roadmap and ISCAT to support findings.

Table 24 provides the color and measure designation used in this report. Per NCQA HEDIS® Measurement Year 2023 Volume 5; HEDIS® Compliance Audit: Standards, Policies and Procedures, rates are not reported if the denominator is too small (<30).

Table 24. 2024 PMV: HEDIS® Color and Measure Designations	
Color Designation	**National Percentile Achieved**
■	Greater than or equal to the goal rate
□	Rate is NA or NB
■	Less than the goal rate
Measure Designation	**Definition**
R	Reportable: a reportable rate was submitted for the measure.
NA	Not Applicable: the MCE followed the specifications, but the denominator was too small (<30) to report a valid rate; thus, results are not presented.
NB	No Benefit: the MCE did not offer the health benefit required by the measure.
NR	Not Reported: the MCE chose not to report the measure.
NQ	Not Required: the MCE was not required to report the measure.
BR	Biased Rate: the calculated rate was materially biased.
UN	Un-Audited: the MCE chose to report a measure that is not required to be audited. This result applies to only a limited set of measures.

OMPP designated specific goals for different HEDIS® measures for each MCE based upon the population the MCE serves. **Table 25** presents the HEDIS® measures for each MCE with which HIP contracts. **Table 26** presents the HEDIS® measures for each MCE with whom HHW contracts. **Table 27** presents the HEDIS® measures for each MCE whom HCC contracts. **Table 28** presents the HEDIS® performance measures for each plan that includes the applicable program and a validation status of compliant or noncompliant, based on Qsource validations and the results of HEDIS® Compliance Audits completed for measurement year 2023.

Table 25. 2024 PMV: HIP HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Adults' Access to Preventive/ Ambulatory Health Services	75th percentile (78.08%)	75.89%	R	69.86%	R	71.01%	R	73.69%	R		
Breast Cancer Screening	33.34%	52.46%	R	50.67%	R	48.02%	R	51.57%	R		
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (FUA) (Total)	75th percentile (42.67%)	40.73%	R	38.03%	R	33.59%	R	34.94%	R		
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (FUA) (Total)	75th percentile (29.98%)	28.97%	R	25.81%	R	22.63%	R	25.32%	R		
Prenatal Depression Screening and Follow-Up – Depression Screening	75th percentile (8.81%)	7.40%	R	51.26%	R	0.83%	R	12.29%	R		

Table 25. 2024 PMV: HIP HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Prenatal and Postpartum Care - Timeliness of Prenatal Care	75th percentile (88.33%)	91.97%	R	82.24%	R	82.29%	R	79.81%	R		
Prenatal and Postpartum Care - Postpartum Care	75th percentile (82.00%)	87.10%	R	81.51%	R	79.86%	R	79.32%	R		

Table 26. 2024 PMV: HHW HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Annual Dental Visits Ages 2-20 Years of Age	75th percentile (56.36%)		Retired Measure		Retired Measure		Retired Measure		Retired Measure		
Asthma Medication Ratio (5-11 years)	90th percentile (85.33%)	72.68%	R	74.55%	R	64.86%	R	67.17%	R		
Breast Cancer Screening	33.34%	47.58%	R		NA	NA	R		NA		
Childhood Immunization Status - Combo 10	50th percentile (30.90%)	25.06%	R	26.76%	R	21.41%	R	27.01%	R		

Table 26. 2024 PMV: HHW HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (FUA) (Total)	15.12%	23.97%	R	24.64%	R	13.59%	R	20.60%	R		
Lead Screening in Children	75th percentile (70.07%)	62.42%	R	69.34%	R	64.55%	R	56.45%	R		
Prenatal Depression Screening and Follow-Up – Depression Screening	75th percentile (8.81%)	6.54%	R	56.13%	R	0.39%	R	13.46%	R		
Child and Adolescent Well-Care Visits (Total)	90th percentile (61.15%)	54.16%	R	52.18%	R	48.52%	R	54.89%	R		
Well-Child Visits in the First 30 Months of Life (First 15 Months)	90th percentile (68.09%)	69.03%	R	61.19%	R	62.09%	R	61.80%	R		

Table 26. 2024 PMV: HHW HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	90th percentile (77.78%)	70.84%	R	70.55%	R	66.65%	R	71.87%	R		

Table 27. 2024 PMV: HCC HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Adults' Access to Preventive/ Ambulatory Health Services	75th percentile (78.08%)	81.73%	R					78.36%	R	74.19%	R
Annual Dental Visits Ages 2-20 Years of Age	75th percentile (56.36%)		Retired Measure						Retired Measure		Retired Measure
Breast Cancer Screening	33.34%	47.58%	R					47.87%	R	50.43%	R
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 days (FUA)	75th percentile (42.67%)	46.33%	R					32.12%	R	40.48%	R

Table 27. 2024 PMV: HCC HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
(Total)											
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 days (FUA) (Total)	75th percentile (29.98%)	32.37%	R					21.17%	R	28.57%	R

Table 28. NCQA HEDIS® Compliance Audit Results

Measure Name	Anthem		CareSource		MDwise		MHS		UHC	
	Program	Validation Result	Program	Validation Result	Program	Validation Result	Program	Validation Result	Program	Validation Result
Adults' Access to Preventive/ Ambulatory Health Services	HIP HCC	Compliant	HIP	Compliant	HIP	Compliant	HIP HCC	Compliant	HCC	Compliant
Annual Dental Visits Ages 2-20 Years of Age	Retired Measure	Retired Measure	Retired Measure	Retired Measure	Retired Measure	Retired Measure	Retired Measure	Retired Measure	Retired Measure	Retired Measure
Asthma Medication Ratio (5-11 years)	HHW	Compliant	HHW	Compliant	HHW	Compliant	HHW	Compliant		
Breast Cancer Screening	HIP HHW HCC	Compliant	HIP	Compliant	HIP	Compliant	HIP HCC	Compliant	HCC	Compliant
Child and Adolescent Well-Care Visits (Total)	HHW	Compliant	HHW	Compliant	HHW	Compliant	HHW	Compliant		

Table 28. NCQA HEDIS® Compliance Audit Results

Measure Name	Anthem		CareSource		MDwise		MHS		UHC	
	Program	Validation Result	Program	Validation Result	Program	Validation Result	Program	Validation Result	Program	Validation Result
Childhood Immunization Status - Combo 10	HHW	Compliant	HHW	Compliant	HHW	Compliant	HHW	Compliant		
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (FUA) (Total)	HIP HCC	Compliant	HIP HHW	Compliant	HIP HHW	Compliant	HIP HHW HCC	Compliant	HCC	Compliant
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (FUA) (Total)	HIP HHW HCC	Compliant	HIP	Compliant	HIP	Compliant	HIP HCC	Compliant	HCC	Compliant
Lead Screening in Children	HHW	Compliant	HHW	Compliant	HHW	Compliant	HHW	Compliant		
Prenatal Depression Screening and Follow-Up – Depression Screening	HIP HHW	Compliant	HIP HHW	Compliant	HIP HHW	Compliant	HIP HHW	Compliant		
Prenatal and Postpartum Care - Timeliness of Prenatal Care	HIP	Compliant	HIP	Compliant	HIP	Compliant	HIP	Compliant		
Prenatal and Postpartum Care - Postpartum Care	HIP	Compliant	HIP	Compliant	HIP	Compliant	HIP	Compliant		
Well-Child Visits in the First 30 Months of Life	HHW	Compliant	HHW	Compliant	HHW	Compliant	HHW	Compliant		

Table 28. NCQA HEDIS® Compliance Audit Results

Measure Name	Anthem		CareSource		MDwise		MHS		UHC	
	Program	Validation Result	Program	Validation Result	Program	Validation Result	Program	Validation Result	Program	Validation Result
(First 15 Months)										
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	HHW	Compliant	HHW	Compliant	HHW	Compliant	HHW	Compliant		

Strengths, Weaknesses, and Improvements

Qsource did not identify any areas for improvement related to the MCE's data collection and performance measure reporting processes during the MY 2023 PMV protocol; however, Qsource did find some recommendations that the plans could address. Each MCE was independently deemed fully compliant with all NCQA-defined Information System Standards for HEDIS®-applied data and processes.

No weaknesses were identified for the MCEs in the MY 2022 PMV review; therefore, the degree to which the plans addressed a recommendation could not be made as there are no improvements to report in the MY 2023 review. Although the plans were determined to be deficiency-free overall, it was noted that Anthem was not properly prepared for the audit and required the use of a secondary sampling for review to complete the audit process.

Conclusions

Qsource found no issues throughout the protocol while validating the MCEs' ISCA, Claims/Encounter Data Systems, Enrollment/Eligibility Data System, Provider Systems, Data Integration, Software Integration, and Measure Development, and Performance Data Validation. The ISCA found that all MCEs fully met requirements, indicating that its systems can provide quality and timely care. Qsource validated data systems and ensured performance measure documentation was complete and sufficient to support validation activities. The MCEs' claims encounter data system had criteria for 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. These results indicated a high confidence in The MCEs' ability to provide quality and timely care for its enrollees.

Anthem

Qsource made the following recommendations for Anthem:

- To improve the quality, access, and timeliness of care, Anthem should continue to focus on HEDIS® measures where performance fell below national benchmarks.
- To improve timeliness and access to care, Anthem should review its process for collecting HNS from patients, as it did not meet the goal for the OMPP HNS measure.
- To improve the audit process, adequate preparation in accordance with the EQR protocols prior to the virtual systems review should be implemented.

CareSource

Qsource made the following recommendations for CareSource:

- To improve the quality, access, and timeliness of care, CareSource should continue to focus on HEDIS® measures where performance fell below national benchmarks.

MDwise

Qsource made the following recommendations for MDwise:

- To improve the quality, access, and timeliness of care, MDwise should continue to focus on HEDIS® measures where performance fell below national benchmarks.
- MDwise should review its process for collecting HNS from patients, as it did not meet the goal for the OMPP HNS measure.

MHS

Qsource made the following recommendations for MHS:

- To improve the quality, access, and timeliness of care, MHS should continue to focus on HEDIS® measures where performance fell below national benchmarks.
- To improve timeliness and access to care, MHS should review its process for collecting HNS from patients, as it did not meet the goal for the OMPP HNS measure.

UHC

Qsource made the following recommendations for UHC:

- To improve care quality, access, and timeliness, UHC should continue to focus on HEDIS® measures where performance fell below national benchmarks.

Protocol 3: Compliance Assessment (CA)

Objectives

Qsource conducted the Compliance Assessment (CA) under the requirements in 42 CFR § 438 Subparts D and F, 42 CFR § 438.330 Subparts D and E, as incorporated by 42 CFR § 457 Subpart L; CMS EQR *Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations (2023)*; and the agreement between the MCEs and OMPP. The survey team consisted of staff with expertise in quality improvement.

As required by 42 CFR § 438.358, one of the mandatory EQR activities is a review within the previous three-year period to determine each MCE's compliance with federal and state EQR regulations, as noted in **Table 29**. Qsource last reviewed these standards in 2021; those scores are compared in **Table 34**. CMS introduced three new standards in its 2023 EQR Protocol: Disenrollment Requirements and Limitation, Emergency and Post-Stabilization Services, and Enrollee Rights Requirements. The current three-year cycle is 2024–2026. The current measurement year in which Qsource conducted activities for this report was MY 2023.

Table 29. Compliance Standards

CFR Citation	2024 Standard	Domain of Care
42 CFR § 438.206	Availability of Services	Access to Care
42 CFR § 438.207	Assurances of Adequate Capacity and Services	Access to Care
42 CFR § 438.208	Coordination and Continuity of Care	Quality of Care
42 CFR § 438.210	Coverage and Authorization of Services	Access to Care/Quality of Care
42 CFR § 438.114	Emergency and Poststabilization	Access to Care/Quality of Care/Timeliness of Care
42 CFR § 438.214	Provider Selection	Access to Care
42 CFR § 438.224	Confidentiality	Quality of Care
42 CFR § 438.228	Grievance and Appeals System	Quality of Care
42 CFR § 438.230	Subcontractual Relationships and Delegation	Quality of Care
42 CFR § 438.236	Practice Guidelines	Quality of Care
42 CFR § 438.242	Health Information Systems	Quality of Care
42 CFR § 438.330	Quality Assessment and Performance Improvement	Quality of Care

Table 29. Compliance Standards		
CFR Citation	**2024 Standard**	**Domain of Care**
42 CFR § 438.56	Disenrollment Requirements and Limitations	Access to Care
42 CFR § 438.100	Enrollee Rights Requirements	Quality of Care
42 CFR § 438.10	Information Requirements	Access to Care/Quality of Care/Timeliness of Care
42 CFR § 441.56	Early and Periodic Screening, Diagnostic, and Treatment	Access to Care/Quality of Care/Timeliness of Care

Technical Methods for Data Collection and Analysis

The CA was conducted in three phases: pre-virtual reviews, a virtual review, and post-virtual analyses. Protocols for the 2024 CA review were guided by *CMS's EQR Protocol 3 (2023)*.

Qsource worked closely with OMPP and the MCEs throughout the process, developing the CA tools to be used during the virtual review, and ensuring all tools were approved by OMPP before the review. The tools and a list of documents needed to support compliance were forwarded to the MCEs during the pre-virtual review phase. This allowed Qsource and the MCEs to ask confirmation questions, complete documentation reviews, and prepare for the virtual review.

The reviews took place from June to July 2024. During the review, MCE staff answered questions and provided information to help surveyors determine the degree of compliance with federal and agreement/contract requirements, explore any issues not fully addressed in the document review, and increase overall understanding of the operations. Qsource surveyors used the tools, along with interviews with MCE staff, system demonstrations, and file/document reviews, to facilitate analyses and compilation of findings. Each MCE also provided additional documentation as needed for surveyors during the review.

The compliance rating was determined by the percentage score of all elements met, as guided by EQR Protocol 3, and was calculated by dividing the number of elements met by the number of elements assessed. The compliance rating indicates Qsource's confidence (ranging from No Compliance to High Compliance) that the MCE met the elements in terms of the standards reviewed.

Table 30 presents the rating criteria used in the CA validation.

Table 30. Compliance Rating Criteria	
Status	**Criteria**
High Compliance	Of all elements assessed, 90–100% were met.
Moderate Compliance	Of all elements assessed, 80–<90% were met.
Low Compliance	Of all elements assessed, 70–<80% were met.
No Compliance	Less than 70% of the elements were met.

Description of Data Obtained

Throughout the documentation review and assessment processes, Qsource reviewers used the survey tools to collect information and document findings regarding compliance with regulatory and contractual standards by reviewing Policies and Procedures (P&Ps), quality studies, reports, medical records/files, and other related MCE documentation. Each standard element has an assigned point value of one, 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 zero to one. Scores for each standard were calculated by dividing the total points earned for all elements in the standard by the total points possible.

In addition, the CA included file reviews that assessed primary source compliance for the following types of files:

- Utilization Management (UM) Denials
- Grievances
- Appeals
- Credentialing
- Recredentialing

Table 31 presents overall compliance scores for all standards by MCE evaluated for the 2024 CA.

Table 31. 2024 Compliance Standard Scores										
Standards	**Anthem**		**CareSource**		**MDwise**		**MHS**		**UHC**	
	Score	**Compliance Rating**	**Score**	**Compliance Rating**	**Score**	**Compliance Rating**	**Score**	**Compliance Rating**	**Score**	**Compliance Rating**
Availability of Services	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Assurances of Adequate Capacity and Services	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Coordination and Continuity of Care	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance

Table 31. 2024 Compliance Standard Scores

Standards	Anthem		CareSource		MDwise		MHS		UHC	
	Score	Compliance Rating	Score	Compliance Rating	Score	Compliance Rating	Score	Compliance Rating	Score	Compliance Rating
Coverage and Authorization of Services	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Emergency and Poststabilization	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Confidentiality	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Grievance and Appeals System	100%	High Compliance	94.74%	High Compliance	100%	High Compliance	97.37%	High Compliance	100%	High Compliance
Subcontractual Relationships and Delegation	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Practice Guidelines	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Health Information Systems	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Quality Assessment and Performance Improvement	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Disenrollment Requirements and Limitations	0.00%	No Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	0.00%	No Compliance
Enrollee Rights Requirements	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Information Requirements	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Early and Periodic Screening, Diagnostic, and Treatment	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Provider Selection	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Overall Compliance Standard Score	**99.20%**	**High Compliance**	**98.40%**	**High Compliance**	**100%**	**High Compliance**	**99.20%**	**High Compliance**	**99.20%**	**High Compliance**

Table 32 presents the file review score for each MCE.

Table 32. 2024 File Review Score

File	Anthem		CareSource		MDwise		MHS		UHC	
	Score	Compliance Rating	Score	Compliance Rating	Score	Compliance Rating	Score	Compliance Rating	Score	Compliance Rating
UM Denials	97.50%	High Compliance	100%	High Compliance	95.45%	High Compliance	100%	High Compliance	100%	High Compliance
Grievances	97.14%	High Compliance	100%	High Compliance	90.00%	High Compliance	98.57%	High Compliance	98.57%	High Compliance
Appeals	98.57%	High Compliance	100%	High Compliance	100%	High Compliance	97.14%	High Compliance	97.14%	High Compliance
Credentialing	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Recredentialing	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Overall File Review Score	**98.97%**	**High Compliance**	**100%**	**High Compliance**	**97.77%**	**High Compliance**	**99.26%**	**High Compliance**	**99.25%**	**High Compliance**

Strengths and Weaknesses

Table 33 provides strengths by compliance standard or file review for the CA, while the AONs, or weaknesses, are identified in **Table 34**. 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, this report did not monitor or include suggestions. If an MCE was not listed, it had no identified strengths or weaknesses in those areas.

Table 33. CA Strengths by Standard

Standard Title	Strength
Anthem	
Availability of Services #10: Access and Cultural Considerations	The MCE included documentation of their cultural competency strategic plan. There is a dedicated website with multiple trainings available.

Table 33. CA Strengths by Standard	
Standard Title	**Strength**
Grievance and Appeals System #31: Provider Information	The MCE took a proactive approach by exceeding the requirement of the criteria by not only informing the providers about the grievance and OMPP appeal procedures and filing timeframes upon entering the network, but also annually through provider newsletter, the provider website, and the provider manual.
MDwise	
Availability of Services #10: Access and Cultural Considerations	The MCE sent additional documentation including a website with Health Equity resources for providers, policies for training, training curriculum, and a reference to a policy for recruiting providers to increase ethnic diversity.
Grievance and Appeals System #25: Format of Grievance Notice	The MCE provides 16 different languages for interpretation services.
UHC	
Practice Guidelines #1: Adoption of Practice Guidelines	The MCE has a webpage on their provider site specifically for Medical Policy Updates for a given timeframe.

Table 34. CA Weaknesses (AONs) by Standard	
Standard Title	**AON**
Anthem	
Disenrollment Requirements and Limitations #1: Notification for Disenrollment	The MCE should create documentation addressing each of the enumerated reasons for disenrollment, and this documentation will need to be provided to OMPP within 30 days from receipt of report.
File Review: UM Denials	The MCE should ensure appropriate review criteria are used and documented on all UM Denial cases.
File Review: Grievance	The MCE should ensure that all grievance acknowledgments are sent to the enrollee within the established timeframe.
	The MCE should ensure that all grievances are investigated and documented as part of the grievance process.
File Review: Appeals	The MCE should ensure that all appeal acknowledgments are sent to the enrollee within the established timeframe.

Table 34. CA Weaknesses (AONs) by Standard	
Standard Title	**AON**
	The MCE should include verbiage regarding appeals and the precise verbiage, "resolution at each level of the appeal or grievance, if applicable," into the policy.
CareSource	
Grievance and Appeals System #30: Expedited Resolution of Appeals Requirements	The MCE should include the verbiage "makes reasonable efforts to give the member prompt oral notice of the delay" within their Grievance and Appeals policy regarding expedited resolution requests.
Grievance and Appeals System #33: Recordkeeping Requirements – Information	The MCE should include verbiage regarding appeals and the precise verbiage, "resolution at each level of the appeal or grievance, if applicable," into the policy.
MDwise	
File Review: UM Denials	The MCE should ensure that all enrollees are notified of the denial decisions within the established timeframe.
	The MCE should ensure that appropriate review criteria are used for all denials.
File Review: Grievances	The MCE should ensure that all grievances are acknowledged, and the acknowledgement standards are met. This discrepancy was observed in two files.
	The MCE should ensure that all grievances are investigated properly. This discrepancy was observed in three files.
	The MCE should ensure that resolution standards are met on all Grievances. This discrepancy was observed in one file.
	The MCE should ensure that enrollees are notified of the resolution of their grievances within the established timeframe and notification standards are met. This discrepancy was observed in one file.
MHS	
Grievance and Appeals System #13: Exceptions from Advance Notice	The MCE should have a policy that acknowledges exceptions from Advance Notice.
File Review: Appeals	The MCE should ensure that the acknowledgement is sent in a timely fashion for all Appeals.
File Review: Grievances	The MCE should ensure that the acknowledgement is sent in a timely fashion for all Grievances.

Table 34. CA Weaknesses (AONs) by Standard	
Standard Title	**AON**
UHC	
Disenrollment Requirement and Limitations #1: Notification for Disenrollment	The MCE should create a policy that addresses each of the enumerated reasons for disenrollment in this element, and this policy should be provided to OMPP within 30 days of receipt of report unless otherwise provided.
File Review: Grievances	The MCE should ensure that all Grievances are investigated properly.
File Review: Appeals	The MCE should ensure that notifications of resolutions are sent for all Appeals cases.
	The MCE should ensure that all Appeal acknowledgment letters are sent within the stipulated timeframe.

Performance Improvement

Table **35** compares the CA scores in MY 2024 and MY 2021. Where comparisons were not included, the results either showed no change or were not applicable in MY 2021. Improvements from the last MY in which these standards were assessed are indicated using an upward arrow (↑), and decreases in performance are indicated using a downward arrow (↓).

Table 35. 2024 Compliance Standard Scores									
Standards	**Anthem**		**CareSource**		**MDwise**		**MHS**		**UHC***
	2021	**2024**	**2021**	**2024**	**2021**	**2024**	**2021**	**2024**	**2024**
Availability of Services	100%	100%	84.60%	↑ 100%	100%	100%	100%	100%	100%
Assurances of Adequate Capacity and Services	50.00%	↑ 100%	50.00%	↑ 100%	50.00%	↑ 100%	50.00%	↑ 100%	100%
Coordination and Continuity of Care	100%	100%	100%	100%	100%	100%	100%	100%	100%
Coverage and Authorization of Services	100%	100%	95.90%	↑ 100%	99.40%	↑ 100%	98.00%	↑ 100%	100%
Emergency and Poststabilization		100%		100%		100%		100%	100%
Confidentiality	100%	100%	100%	100%	100%	100%	100%	100%	100%
Grievance and Appeals System	100%	100%	100%	↓ 94.74%	100%	100%	97.70%	↓ 97.37%	100%

Table 35. 2024 Compliance Standard Scores									
Standards	**Anthem**		**CareSource**		**MDwise**		**MHS**		**UHC***
	2021	**2024**	**2021**	**2024**	**2021**	**2024**	**2021**	**2024**	**2024**
Subcontractual Relationships and Delegation	100%	100%	100%	100%	93.80%	↑ 100%	100%	100%	100%
Practice Guidelines	100%	100%	100%	100%	100%	100%	100%	100%	100%
Health Information Systems	100%	100%	100%	100%	100%	100%	100%	100%	100%
Quality Assessment and Performance Improvement	100%	100%	100%	100%	100%	100%	100%	100%	100%
Disenrollment Requirements and Limitations		0.00%		100%		100%		100%	0.00%
Enrollee Rights Requirements		100%		100%		100%		100%	100%
Information Requirements		100%		100%		100%		100%	100%
Early and Periodic Screening, Diagnostic, and Treatment		100%		100%		100%		100%	100%
Provider Selection	100%	100%	100%	100%	100%	100%	100%	100%	100%
Overall Compliance Standard Score	**95.45%**	**93.75%**	**93.68%**	**99.67%**	**94.84%**	**100%**	**95.06%**	**99.84%**	**93.75%**

**UHC was not a contracted IHCP in 2021; therefore, no comparative data exists.*

Table 36 displays the rating criteria for how the plan addressed the recommendations given the last time these CA standards were assessed.

Table 36. Improvement Rating Criteria	
Rating	**Criteria**
High	Recommendations were fully addressed.
Medium	Recommendations were partially addressed.
Low	Recommendations were not addressed.
Not Applicable	No comparison was available.

Recommendations

Table 37 displays the degree to which the plan addressed the recommendations given in 2021. It includes only plans that received recommendations the last year in which these standards were assessed.

Table 37. 2021 Recommendations Addressed in 2024

Recommendations	2024 Results	Degree to Which Plan Addressed Recommendation(s)
Anthem		
Assurances of Adequate Capacity and Services: a. The MCE should have sufficient access to specialty services for enrollees.	Anthem was fully compliant with the Assurances of Adequate Capacity and Services standard.	High
CareSource		
Availability of Services: a. CareSource should have policies and procedures on maintaining and monitoring an appropriate provider network, along with a policy and procedures stating that CareSource has agreements. b. CareSource should also include how they maintain and monitor an appropriate provider network 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. c. CareSource 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 CareSource for payment.	CareSource was fully compliant with the Availability of Services standard.	High

Table 37. 2021 Recommendations Addressed in 2024

Recommendations	2024 Results	Degree to Which Plan Addressed Recommendation(s)
Assurances of Adequate Capacity and Services: a. CareSource should have a policy and procedure discussing how they monitor and ensure the network has sufficient coverage. b. CareSource should have sufficient access to specialty services for enrollees.	CareSource was fully compliant with the Assurances of Adequate Capacity and Services standard.	High
Coverage and Authorization of Services: a. CareSource 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." b. CareSource 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. c. CareSource should have a policy that states, "The MCE will provide written notice of termination of a contracted provider to each enrollee who received their primary care from, or was seen regularly 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.	CareSource was fully compliant with the Coverage and Authorization of Services standard.	High
MDwise		
Assurances of Adequate Capacity and Services:	MDwise was fully compliant with the Assurances of Adequate Capacity and Services standard.	High

Table 37. 2021 Recommendations Addressed in 2024

Recommendations	2024 Results	Degree to Which Plan Addressed Recommendation(s)
a. MDwise should have sufficient access to specialty services for enrollees.		
Coverage and Authorization of Services: a. Include "font size no smaller than 12 points" in the "Readability, Accuracy and Translation of Member Materials Policy and Procedure" document. b. 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."	MDwise was fully compliant with the Coverage and Authorization of Services standard.	High
Subcontractual Relationships and Delegation: a. 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 completion date of any audit, whichever is later.	MDwise was fully compliant with the Subcontractual Relationships and Delegation standard.	High
MHS		
Assurances of Adequate Capacity and Services: a. MHS should have sufficient access to specialty services for enrollees.	MHS was fully compliant with the Assurances of Adequate Capacity and Services standard.	High
Coverage and Authorization of Services: a. MHS 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 five 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 required in paper format.	MHS was fully compliant with the Coverage and Authorization of Services standard.	High

Table 37. 2021 Recommendations Addressed in 2024		
Recommendations	**2024 Results**	**Degree to Which Plan Addressed Recommendation(s)**
b. 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."		
UHC		
UHC was not contracted in MY 2021.		Not Applicable

Conclusions

Anthem

Anthem maintained 100% on 10 of the 11 standards measured in 2021, increasing the score on the Assurances of Adequate Capacity and Services standard from 50.00% in 2021 to 100% in 2024 to a high degree**.**

In the 2024 CA, Anthem appropriately addressed the AON recommendations in Assurances of Adequate Capacity and Services from 2021 regarding access to specialty services for enrollees.

Anthem's rating of High Compliance in 15 of the 16 compliance standards and all of the file reviews indicated that the MCE aligned with Goal 1, Quality, of OMPP's Quality Strategy: Encourage quality, continuity, and appropriateness of medical care. Additionally, Anthem's score of 100% for Emergency and Poststabilization, Information Requirements, and Early and Periodic Screening, Diagnostic, and Treatment demonstrate a commitment to providing timely care to enrollees. Anthem's score of 100% for Availability of Services, Assurances of Adequate Capacity and Services, and Coordination and Continuity of Care aligned with Goal 2 of OMPP's Quality Strategy: Promote primary and preventative care.

CareSource

CareSource achieved a higher score on three of the standards reviewed in 2021, going from 50.00% in 2021 to 100% in 2024 on Assurances of Adequate Capacity and Services, from 84.60% in 2021 to 100% in 2024 for AOS and from 95.90% in 2021 to 100% in 2024 on Coverage and Authorization of Services. However, CareSource went from 100% in 2021 to 94.74% in 2024 for Grievance and Appeals System. CareSource

consistently scored 100% on seven standards in both 2021 and in 2024.

In the 2024 CA, CareSource addressed the AON for Assurances of Adequate Capacity and Services it received during the 2021 CA relating to how CareSource monitors the overall network and specific enrollees to ensure everyone has access to sufficient services. Likewise, CareSource addressed the Availability of Services AONs regarding out-of-network payments and maintaining appropriate provider networks, and three AONs for Coverage and Authorization of Services regarding provider termination notices, advance directives, and electronic information. CareSource addressed MY 2021 recommendations to a high degree.

CareSource's rating of High Compliance in all compliance standards and all file reviews indicated that the MCE aligned with Goal 1, Quality, of OMPP's Quality Strategy: Encourage quality, continuity, and appropriateness of medical care. Additionally, CareSource's score of 100% for Emergency and Poststabilization, Information Requirements, and Early and Periodic Screening, Diagnostic, and Treatment demonstrate a commitment to providing timely care to enrollees. CareSource's score of 100% of Availability of Services, Assurances of Adequate Capacity and Services, and Coordination and Continuity of Care aligned with Goal 2 of OMPP's Quality Strategy: Promote primary and preventative care.

MDwise

MDwise consistently scored 100% on eight standards in both 2021 and 2024. On the Assurances of Adequate Capacity and Services standard, it improved from 50.00% in 2021 to 100% in 2024, on the Coverage and Authorization of Services, from 99.40% in 2021 to 100% in 2024, and on the Subcontractual Relationships and Delegation standard, from 93.80% in 2021 to 100% in 2024.

In the 2024 CA, MDwise addressed the three AONs it received in the 2021 CA. Previously, MDwise received one AON for Assurances of Adequate Capacity and Services regarding enrollee access to specialty services, one AON for Coverage and Authorization of Services regarding written material requirements, and one AON for Subcontractual Relationships and Delegation regarding the language in subcontractor contracts surrounding the right to audit. These results reflect a marked improvement in scores for the CA standards between the 2021 and 2024 evaluations. MDwise addressed MY 2021 recommendations to a high degree.

MDwise's rating of High Compliance in all compliance standards and all file reviews indicated that the MCE aligned with Goal 1, Quality, of OMPP's Quality Strategy: Encourage quality, continuity, and appropriateness of medical care. Additionally, MDwise's score of 100% for Emergency and Poststabilization, Information Requirements, and Early and Periodic Screening, Diagnostic, and Treatment demonstrate a commitment to providing timely care to enrollees. MDwise's

score of 100% of Availability of Services, Assurances of Adequate Capacity and Services, and Coordination and Continuity of Care aligned with Goal 2 of OMPP's Quality Strategy: Promote primary and preventative care.

MHS

MHS achieved a higher score on two of the standards reviewed in 2021, going from 50.00% in 2021 to 100% in 2024 for Assurances of Adequate Capacity and Services and from 98.00% in 2021 to 100% in 2024 for Coverage and Authorization of Services. While the table shows the Grievance and Appeals System score from 2024 to be lower than 2021 at 97.37% and 97.70% respectively, MHS had one AON in that standard during both assessments. MHS consistently scored 100% on eight standards in both 2021 and in 2024.

For the 2024 CA, MHS appropriately addressed the four AONs identified in the 2021 CA. In the Grievance and Appeals System standard, Qsource identified one AON relating to an enrollee filing a grievance at any time. Qsource also identified one AON for Assurances of Adequate Capacity and Services regarding enrollee access to specialty services and two AONs for Coverage and Authorization of Services regarding electronic information and provider termination notices. While there were two new recommendations for MY 2023 MHS addressed MY 2021 recommendations to a high degree.

MHS's rating of High Compliance in all compliance standards and all file reviews indicated that the MCE aligned with Goal 1, Quality, of OMPP's Quality Strategy: Encourage quality, continuity, and appropriateness of medical care. Additionally, MHS's score of 100% for Emergency and Poststabilization, Information Requirements, and Early and Periodic Screening, Diagnostic, and Treatment demonstrate a commitment to providing timely care to enrollees. MHS's score of 100% of Availability of Services, Assurances of Adequate Capacity and Services, and Coordination and Continuity of Care aligned with Goal 2 of OMPP's Quality Strategy: Promote primary and preventative care.

UHC

UHC was not a contracted MCE in the delivery of coverage of HCC for OMPP during 2021; therefore, there is no comparison data available to display. The degree to which UHC addressed recommendations in MY 2021 is not applicable.

UHC's rating of High Compliance in 15 of the 16 compliance standards and all of the file reviews indicated that the MCE aligned with Goal 1, Quality, of OMPP's Quality Strategy: Encourage quality, continuity, and appropriateness of medical care. Additionally, UHC's score of 100% for Emergency and Poststabilization, Information Requirements, and Early and Periodic Screening, Diagnostic, and Treatment demonstrate a commitment to providing timely care to enrollees. UHC's score of 100% of Availability of Services, Assurances of Adequate Capacity and Services, and Coordination and Continuity of Care aligned with Goal 2 of OMPP's Quality Strategy: Promote primary and preventative care.

Protocol 4: Annual Network Adequacy (ANA) Overview

Objectives

CMS EQR *Protocol 4: Validation of Network Adequacy (2023)* outlines activities for validation of network adequacy. Per the Protocol, this includes validating data to determine whether the network standards, as defined by the state, were met. The Protocol dictates that the MCEs must conduct activities to assess the adequacy of their networks. States have flexibility in determining the strategies used to assess network adequacy. 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 ANA review. It describes the review methodologies, the findings for each task, and MSLC's recommendations for improvement.

Per 42 CFR 438.68, states must ensure that MCEs maintain provider networks that are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services. In addition, 42 CFR 438.68 requires states to set quantitative network adequacy standards that account for regional factors and the needs of the state's managed care program populations.

The 2024 ANA review covered the period of January 1 to December 31, 2023, and measured member access to provider service types. MSLC analyzed the following:

- Ratio of providers to members;
- Member access to providers based on given accessibility standards;
- Accuracy of ANA reports submitted to the State;
- Completeness of provider directories issued to MCE members;
- Accuracy of provider directories issued to MCE members; and
- Accuracy of appointment wait time based on MCE wait time standards.

As a guide for conducting the ANA validation, *Protocol 4: Validation of Network Adequacy (February 2023)* was used. EQR Protocol 4 includes six activities:

- Activity 1: Define the Scope of Validation
- Activity 2: Identify Data Sources for Validation
- Activity 3: Review Information Systems Underlying Network Adequacy Monitoring (ISCA)
- Activity 4: Validate Network Adequacy Assessment Data, Methods, and Results
- Activity 5: Communicate Preliminary Findings to Each Managed Care Plan
- Activity 6: Submit Findings to State

Geographic Network Adequacy Analysis

Objectives

The contract between OMPP, the MCEs, and their IHCPs establishes minimum requirements for services to be provided to enrollees. The contracts refer to the geographical access distance standards for primary care, specialty care, facility, organizational, and ancillary providers.

The calculation of network adequacy involves Geomapping at a particular point in time. Geomapping involved obtaining data as of October 1, 2023. For this report, the findings from the specified point in time were aggregated to the previous 12 months. 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 provider, factoring in any patient restrictions reported for providers.

Results were validated and further analyzed in Structured Query Language (SQL) in a Microsoft SQL Server database. Results were summarized by county and program to identify potential issues. Underserved members were measured by count and by percentage of members impacted within analysis groupings. Provider service type was determined from the MCE-supplied IHCP Provider Type and IHCP Provider Specialty. Provider taxonomy was also used for applicable service types.

MSLC evaluated the methods and processes used by the MCEs to meet OMPP distance standards. MSLC reviewed and evaluated network adequacy policies and processes as well as network contracting.

Qsource conducted an ISCA as required by Activity 3 during the virtual systems review as part of *Protocol 2: Performance Measure Validation*. ISCATs were reviewed by Qsource for general information, the integrity of all systems capabilities including administrative data (medical claims), enrollment data systems, provider data, data completeness, integration of data for performance measure calculation, and ancillary data and integration processes. The complete findings from the virtual systems review are located in the *2024 Performance Measure Validation Reports*.

Technical Methods of Data Collection and Analysis

Postal addresses of providers' service locations and enrollees' residences were necessary to measure adherence to provider network accessibility standards. Other provider data necessary for the analysis were provider type, provider specialty, and providers' patient restrictions, if any, regarding age or gender. Accordingly, each enrollee's gender and date of birth were also required for the analysis.

Qsource requested and received from each MCE a roster of the providers and members under the MCE's purview for the following programs, when applicable:

- HIP
- HHW

- 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 providers who were eligible on October 1, 2023. The written request also specified that the provider listings should include a separate record for each location at which the individual practitioner was eligible to perform services for the plan on that date. Additionally, the written request specified the MCE provider types and specialties that qualify as providers.

Analysis

All analyses were conducted based on a specified point in time, October 1, 2023. Results were based on the assumption that all variables utilized in the analyses were consistent across the entire period being reviewed.

Description of Data Obtained

All MCEs were requested to submit copies of the annual reports regarding provider networks submitted to the State as of the assessment time period (October 2023), specifically *Report 0902 (Count of Providers)* and *Report 0903 (Member Access to Providers)*.

Additionally, all MCEs were asked to submit copies of the provider directories issued to the MCE members as of the assessment period (October 2023).

Findings are presented in Summary Form, with highlights regarding areas of concern and a summary of strengths, suggestions for improvement, and AONs.

Table 38 presents the network adequacy rating criteria for the MCEs. Qsource developed the network adequacy rating to present comparative findings from the analysis.

Table 38. Annual Network Adequacy Validation Score

Rating	Criteria
High Confidence	90.00–100%
Moderate Confidence	50.00–89.99%
Low Confidence	10.00–49.99%
No Confidence	0.00–9.99%

Table 39 presents the network adequacy ratings for each MCE.

Table 39. Annual Network Adequacy Validation Score

Review	Program	Percentage Met	Validation Rating
Anthem			
ISCA	HHW/HIP/HCC	100%	High Confidence

Table 39. Annual Network Adequacy Validation Score

Review	Program	Percentage Met	Validation Rating
Provider to Member Ratio	HHW/HIP/HCC	100%	High Confidence
Member Access to Providers	HHW	98.06%	High Confidence
	HIP	98.11%	High Confidence
	HCC	98.06%	High Confidence
Appointment Wait Time	HHW	26.67%	Low Confidence
	HIP	44.44%	Low Confidence
	HCC	25.93%	Low Confidence
CareSource			
ISCA	HHW/HIP	100%	High Confidence
Provider to Member Ratio	HHW/HIP	100%	High Confidence
Member Access to Providers	HHW	96.36%	High Confidence
	HIP	96.38%	High Confidence
Appointment Wait Time	HHW	52.38%	Moderate Confidence
	HIP	22.22%	Low Confidence
MDwise			
ISCA	HHW/HIP	100.00%	High Confidence
Provider to Member Ratio	HHW	96.15%	High Confidence
	HIP	96.15%	High Confidence
Member Access to Providers	HHW	93.63%	High Confidence
	HIP	93.42%	High Confidence
Appointment Wait Time	HHW	58.33%	Moderate Confidence
	HIP	84.62%	Moderate Confidence

Table 39. Annual Network Adequacy Validation Score			
Review	**Program**	**Percentage Met**	**Validation Rating**
MHS			
ISCA	HHW, HIP, HCC	100%	High Confidence
Provider to Member Ratio	HHW/HIP/HCC	100%	High Confidence
Member Access to Providers	HHW/HIP	97.90%	High Confidence
	HCC	98.10%	High Confidence
Appointment Wait Time	HHW	80.60%	Moderate Confidence
	HIP	64.30%	Moderate Confidence
	HCC	60.00%	Moderate Confidence
UHC			
ISCA	HCC	100%	High Confidence
Provider to Member Ratio	HCC	92.31%	High Confidence
Member Access to Providers	HCC	91.10%	High Confidence
Appointment Wait Time	HCC	77.63%	Moderate Confidence

Provider Network Adequacy by Geography

Figures in this section graphically illustrate the MCEs' member population by county and program or illustrate the Indiana counties by provider service type where members do not have sufficient access to providers. Figures 1, 2, and 3 illustrate Anthem's member population; Figures 27 and 28 illustrate CareSource's member population; Figures 47 and 48 illustrate MDwise' s member population; Figures 66, 67, and 68 illustrates MHS's member population; Figure 97 illustrate UHC's member population. **Table 40** provides the accessibility standards and adequacy results for all provider service types for HHW, HIP, and HCC as well as links to the figures that illustrate where members do not have sufficient access to providers.

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Anthem										
Acute Care Hospitals	Urban - 1 within 30 miles Rural - 1 within 60 miles	Not Met	Not Met	Not Met	2	2	1	Figure 4	Figure 12	Figure 20
Anesthesiologists	2 within 60 miles	Met	Met	Met	0	0	0			
Behavioral Health Providers	Urban -1 within 30 miles Rural - 1 within 45 miles	Not Met	Not Met	Not Met	1	1	1	Figure 5	Figure 13	Figure 21
Cardiologists	2 within 60 miles	Met	Met	Met	0	0	0			
Cardiothoracic Surgeons	1 within 90 miles	Met	Met	Met	0	0	0			
Cardiovascular Surgeons	1 within 90 miles	Met	Met	Met	0	0	0			
Oral Surgeons	2 within 60 miles	Met	Met	Met	0	0	0			
Dermatologists	1 within 90 miles	Met	Met	Met	0	0	0			
Diagnostic Testing	2 within 60 miles	Not Met	Not Met	Not Met	32	34	29	Figure 6	Figure 14	Figure 22
DME	2 per county	Not Met	Not Met	Not Met	67	66	67	Figure 7	Figure 15	Figure 23
Endocrinologists	2 within 60 miles	Met	Met	Met	0	0	0			

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
End-Stage Renal Disease (ESRD) Clinic	1 within 60 miles	Met	Met	Met	0	0	0			
Gastroenterologists	2 within 60 miles	Met	Met	Met	0	0	0			
General Surgeons	2 within 60 miles	Met	Met	Met	0	0	0			
Dentists	1 within 30 miles	Not Met	Not Met	Met	2	1	0	Figure 8	Figure 16	
Hematologists	2 within 60 miles	Met	Met	Met	0	0	0			
Home Health Providers	2 per county	Not Met	Not Met	Not Met	62	62	62	Figure 9	Figure 17	Figure 24
Infectious Disease Specialists	1 within 90 miles	Met	Met	Met	0	0	0			
Inpatient Psychiatric Facilities	1 within 60 miles	Not Met	Not Met	Not Met	21	8	18	Figure 10	Figure 18	Figure 25
Interventional Radiologists	1 within 90 miles	Met	Met	Met	0	0	0			
Nephrologists	2 within 60 miles	Met	Met	Met	0	0	0			
Neurological Surgeons	1 within 90 miles	Met	Met	Met	0	0	0			
Neurologists	2 within 60 miles	Met	Met	Met	0	0	0			
Nonhospital based Anesthesiologists	1 within 90 miles	Met	Met	Met	0	0	0			

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
OB/GYN	2 within 60 miles	Met	Met	Met	0	0	0			
Occupational Therapists	2 within 60 miles	Met	Met	Met	0	0	0			
Oncologists	2 within 60 miles	Met	Met	Met	0	0	0			
Ophthalmologists	2 within 60 miles	Met	Met	Met	0	0	0			
Optometrists	2 within 60 miles	Met	Met	Met	0	0	0			
Orthodontists	2 within 60 miles	Not Met	Not Met	Not Met	54	56	53	Figure 11	Figure 19	Figure 26
Orthopedic Surgeons	2 within 60 miles	Met	Met	Met	0	0	0			
Otolaryngologists	2 within 60 miles	Met	Met	Met	0	0	0			
Pathologists	1 within 90 miles	Met	Met	Met	0	0	0			
Pharmacy	2 within 30 miles	Met	Met	Met	0	0	0			
Physical Therapists	2 within 60 miles	Met	Met	Met	0	0	0			
PMPs-Physicians	1 within 30 miles	Met	Met	Met	0	0	0			
Prosthetic Suppliers	1 within 90 miles	Met	Met	Met	0	0	0			

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Psychiatrists	2 within 60 miles	Met	Met	Met	0	0	0			
Pulmonologists	2 within 60 miles	Met	Met	Met	0	0	0			
Radiation Oncologists	1 within 90 miles	Met	Met	Met	0	0	0			
Radiologists	1 within 90 miles	Met	Met	Met	0	0	0			
Rheumatologists	1 within 90 miles	Met	Met	Met	0	0	0			
Speech Therapists	2 within 60 miles	Met	Met	Met	0	0	0			
Urologists	2 within 60 miles	Met	Met	Met	0	0	0			
CareSource										
Acute Care Hospitals	Urban - 1 within 30 miles Rural - 1 within 60 miles	Met	Met		0	0				
Anesthesiologists	2 within 60 miles	Met	Met		0	0				
Behavioral Health Providers	Urban -1 within 30 miles Rural - 1 within 45 miles	Met	Met		0	0				
Cardiologists	2 within 60 miles	Met	Met		0	0				

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Cardiothoracic Surgeons	1 within 90 miles	Met	Met		0	0				
Cardiovascular Surgeons	1 within 90 miles	Met	Met		0	0				
Oral Surgeons	2 within 60 miles	Not Met	Not Met		2	6		Figure 29	Figure 38	
Dermatologists	1 within 90 miles	Met	Met		0	0				
Diagnostic Testing	2 within 60 miles	Not Met	Not Met		67	67		Figure 30	Figure 39	
DME	2 per county	Not Met	Not Met		66	66		Figure 31	Figure 40	
Endocrinologists	2 within 60 miles	Not Met	Not Met		2	2		Figure 32	Figure 41	
ESRD Clinic	1 within 60 miles	Met	Met		0	0				
Gastroenterologists	2 within 60 miles	Met	Met		0	0				
General Surgeons	2 within 60 miles	Met	Met		0	0				
Dentists	1 within 30 miles	Not Met	Not Met		6	6		Figure 33	Figure 42	
Hematologists	2 within 60 miles	Met	Met		0	0				
Home Health Providers	2 per county	Not Met	Not Met		79	79		Figure 34	Figure 43	
Infectious Disease Specialists	1 within 90 miles	Met	Met		0	0				

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Inpatient Psychiatric Facilities	1 within 60 miles	Not Met	Not Met		4	5		Figure 35	Figure 44	
Interventional Radiologists	1 within 90 miles	Met	Met		0	0				
Nephrologists	2 within 60 miles	Met	Met		0	0				
Neurological Surgeons	1 within 90 miles	Met	Met		0	0				
Neurologists	2 within 60 miles	Met	Met		0	0				
Nonhospital based Anesthesiologists	1 within 90 miles	Met	Met		0	0				
OB/GYN	2 within 60 miles	Met	Met		0	0				
Occupational Therapists	2 within 60 miles	Met	Met		0	0				
Oncologists	2 within 60 miles	Met	Met		0	0				
Ophthalmologists	2 within 60 miles	Met	Met		0	0				
Optometrists	2 within 60 miles	Met	Met		0	0				
Orthodontists	2 within 60 miles	Not Met	Not Met		63	62		Figure 36	Figure 45	
Orthopedic Surgeons	2 within 60 miles	Met	Met		0	0				

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Otolaryngologists	2 within 60 miles	Met	Met		0	0				
Pathologists	1 within 90 miles	Met	Met		0	0				
Pharmacy**	2 within 30 miles	Not Met	Not Met		41	46		Figure 37	Figure 46	
Physical Therapists	2 within 60 miles	Met	Met		0	0				
PMPs-Physicians	1 within 30 miles	Met	Met		0	0				
Prosthetic Suppliers	1 within 90 miles	Met	Met		0	0				
Psychiatrists	2 within 60 miles	Met	Met		0	0				
Pulmonologists	2 within 60 miles	Met	Met		0	0				
Radiation Oncologists	1 within 90 miles	Met	Met		0	0				
Radiologists	1 within 90 miles	Met	Met		0	0				
Rheumatologists	1 within 90 miles	Met	Met		0	0				
Speech Therapists	2 within 60 miles	Met	Met		0	0				
Urologists	2 within 60 miles	Met	Met		0	0				

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
MDwise										
Acute Care Hospitals	Urban - 1 within 30 miles Rural - 1 within 60 miles	Met	Not Met		0	1			Figure 57	
Anesthesiologists	2 within 60 miles	Met	Met		0	0				
Behavioral Health Providers	Urban -1 within 30 miles Rural - 1 within 45 miles	Met	Met		0	0				
Cardiologists	2 within 60 miles	Met	Met		0	0				
Cardiothoracic Surgeons	1 within 90 miles	Met	Met		0	0				
Cardiovascular Surgeons	1 within 90 miles	Met	Met		0	0				
Oral Surgeons	2 within 60 miles	Not Met	Not Met		67	68		Figure 49	Figure 58	
Dermatologists	1 within 90 miles	Met	Met		0	0				
Diagnostic Testing	2 within 60 miles	Not Met	Not Met		49	49		Figure 50	Figure 59	
DME	2 per county	Not Met	Not Met		71	71		Figure 51	Figure 60	
Endocrinologists	2 within 60 miles	Met	Met		0	0				
ESRD Clinic	1 within 60 miles	Met	Met		0	0				

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Gastroenterologists	2 within 60 miles	Not Met	Not Met		1	1		Figure 52	Figure 61	
General Surgeons	2 within 60 miles	Met	Met		0	0				
Dentists	1 within 30 miles	Not Met	Not Met		82	83		Figure 53	Figure 62	
Hematologists	2 within 60 miles	Met	Met		0	0				
Home Health Providers	2 per county	Not Met	Not Met		81	81		Figure 54	Figure 63	
Infectious Disease Specialists	1 within 90 miles	Met	Met		0	0				
Inpatient Psychiatric Facilities	1 within 60 miles	Not Met	Not Met		11	11		Figure 55	Figure 64	
Interventional Radiologists	1 within 90 miles	Met	Met		0	0				
Nephrologists	2 within 60 miles	Met	Met		0	0				
Neurological Surgeons	1 within 90 miles	Met	Met		0	0				
Neurologists	2 within 60 miles	Met	Met		0	0				
Nonhospital based Anesthesiologists	1 within 90 miles	Met	Met		0	0				
OB/GYN	2 within 60 miles	Met	Met		0	0				

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Occupational Therapists	2 within 60 miles	Met	Met		0	0				
Oncologists	2 within 60 miles	Met	Met		0	0				
Ophthalmologists	2 within 60 miles	Met	Met		0	0				
Optometrists	2 within 60 miles	Met	Met		0	0				
Orthodontists	2 within 60 miles	Not Met	Not Met		92	92		Figure 56	Figure 65	
Orthopedic Surgeons	2 within 60 miles	Met	Met		0	0				
Otolaryngologists	2 within 60 miles	Met	Met		0	0				
Pathologists	1 within 90 miles	Met	Met		0	0				
Pharmacy	2 within 30 miles	Met	Met		0	0				
Physical Therapists	2 within 60 miles	Met	Met		0	0				
PMPs-Physicians	1 within 30 miles	Met	Met		0	0				
Prosthetic Suppliers	1 within 90 miles	Met	Met		0	0				
Psychiatrists	2 within 60 miles	Met	Met		0	0				

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Pulmonologists	2 within 60 miles	Met	Met		0	0				
Radiation Oncologists	1 within 90 miles	Met	Met		0	0				
Radiologists	1 within 90 miles	Met	Met		0	0				
Rheumatologists	1 within 90 miles	Met	Met		0	0				
Speech Therapists	2 within 60 miles	Met	Met		0	0				
Urologists	2 within 60 miles	Met	Met		0	0				
MHS										
Acute Care Hospitals	Urban - 1 within 30 miles Rural - 1 within 60 miles	Not Met	Not Met	Met	1	1	0	Figure 69	Figure 79	
Anesthesiologists	2 within 60 miles	Met	Met	Met	0	0	0			
Behavioral Health Providers	Urban -1 within 30 miles Rural - 1 within 45 miles	Met	Met	Met	0	0	0			
Cardiologists	2 within 60 miles	Met	Met	Met	0	0	0			
Cardiothoracic Surgeons	1 within 90 miles	Met	Met	Met	0	0	0			

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Cardiovascular Surgeons	1 within 90 miles	Met	Met	Met	0	0	0			
Oral Surgeons	2 within 60 miles	Not Met	Not Met	Not Met	9	5	6	Figure 70	Figure 80	Figure 89
Dermatologists	1 within 90 miles	Met	Met	Met	0	0	0			
Diagnostic Testing	2 within 60 miles	Not Met	Not Met	Not Met	51	51	49	Figure 71	Figure 81	Figure 90
DME	2 per county	Not Met	Not Met	Not Met	35	35	37	Figure 72	Figure 82	Figure 91
Endocrinologists	2 within 60 miles	Not Met	Not Met	Not Met	4	3	3	Figure 73	Figure 83	Figure 92
ESRD Clinic	1 within 60 miles	Met	Met	Met	0	0	0			
Gastroenterologists	2 within 60 miles	Met	Met	Met	0	0	0			
General Surgeons	2 within 60 miles	Met	Met	Met	0	0	0			
Dentists	1 within 30 miles	Not Met	Not Met	Not Met	6	5	3	Figure 74	Figure 84	Figure 93
Hematologists	2 within 60 miles	Met	Met	Met	0	0	0			
Home Health Providers	2 per county	Not Met	Not Met	Not Met	58	60	51	Figure 75	Figure 85	Figure 94
Infectious Disease Specialists	1 within 90 miles	Met	Met	Met	0	0	0			

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Inpatient Psychiatric Facilities	1 within 60 miles	Not Met	Not Met	Not Met	1	1	0	Figure 76	Figure 86	
Interventional Radiologists	1 within 90 miles	Met	Met	Met	0	0	0			
Nephrologists	2 within 60 miles	Met	Met	Met	0	0	0			
Neurological Surgeons	1 within 90 miles	Met	Met	Met	0	0	0			
Neurologists	2 within 60 miles	Met	Met	Met	0	0	0			
Nonhospital based Anesthesiologists	1 within 90 miles	Met	Met	Met	0	0	0			
OB/GYN	2 within 60 miles	Met	Met	Met	0	0	0			
Occupational Therapists	2 within 60 miles	Met	Met	Met	0	0	0			
Oncologists	2 within 60 miles	Met	Met	Met	0	0	0			
Ophthalmologists	2 within 60 miles	Met	Met	Met	0	0	0			
Optometrists	2 within 60 miles	Met	Met	Met	0	0	0			
Orthodontists	2 within 60 miles	Not Met	Not Met	Not Met	52	55	52	Figure 77	Figure 87	Figure 95
Orthopedic Surgeons	2 within 60 miles	Met	Met	Met	0	0	0			

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Otolaryngologists	2 within 60 miles	Not Met	Not Met	Not Met	2	1	1	Figure 78	Figure 88	Figure 96
Pathologists	1 within 90 miles	Met	Met	Met	0	0	0			
Pharmacy	2 within 30 miles	Met	Met	Met	0	0	0			
Physical Therapists	2 within 60 miles	Met	Met	Met	0	0	0			
PMPs-Physicians	1 within 30 miles	Met	Met	Met	0	0	0			
Prosthetic Suppliers	1 within 90 miles	Met	Met	Met	0	0	0			
Psychiatrists	2 within 60 miles	Met	Met	Met	0	0	0			
Pulmonologists	2 within 60 miles	Met	Met	Met	0	0	0			
Radiation Oncologists	1 within 90 miles	Met	Met	Met	0	0	0			
Radiologists	1 within 90 miles	Met	Met	Met	0	0	0			
Rheumatologists	1 within 90 miles	Met	Met	Met	0	0	0			
Speech Therapists	2 within 60 miles	Met	Met	Met	0	0	0			
Urologists	2 within 60 miles	Met	Met	Met	0	0	0			

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
UHC										
Acute Care Hospitals	Urban - 1 within 30 miles Rural - 1 within 60 miles			Not Met			39			Figure 98
Anesthesiologists	2 within 60 miles			Met			0			
Behavioral Health Providers	Urban -1 within 30 miles Rural - 1 within 45 miles			Met			0			
Cardiologists	2 within 60 miles			Met			0			
Cardiothoracic Surgeons	1 within 90 miles			Met			0			
Cardiovascular Surgeons	1 within 90 miles			Met			0			
Oral Surgeons	2 within 60 miles			Not Met			62			Figure 99
Dermatologists	1 within 90 miles			Met			0			
Diagnostic Testing	2 within 60 miles			Not Met			73			Figure 100
DME	2 per county			Not Met			92			Figure 101
Endocrinologists	2 within 60 miles			Met			0			

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
ESRD Clinic	1 within 60 miles			Met			0			
Gastroenterologists	2 within 60 miles			Met			0			
General Surgeons	2 within 60 miles			Met			0			
Dentists	1 within 30 miles			Not Met			8			Figure 102
Hematologists	2 within 60 miles			Met			0			
Home Health Providers	2 per county			Not Met			92			Figure 103
Infectious Disease Specialists	1 within 90 miles			Met			0			
Inpatient Psychiatric Facilities	1 within 60 miles			Not Met			7			Figure 104
Interventional Radiologists	1 within 90 miles			Met			0			
Nephrologists	2 within 60 miles			Met			0			
Neurological Surgeons	1 within 90 miles			Met			0			
Neurologists	2 within 60 miles			Met			0			
Nonhospital based Anesthesiologists	1 within 90 miles			Met			0			

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
OB/GYN	2 within 60 miles			Met			0			
Occupational Therapists	2 within 60 miles			Not Met			1			Figure 105
Oncologists	2 within 60 miles			Met			0			
Ophthalmologists	2 within 60 miles			Met			0			
Optometrists	2 within 60 miles			Met			0			
Orthodontists	2 within 60 miles			Not Met			52			Figure 106
Orthopedic Surgeons	2 within 60 miles			Met			0			
Otolaryngologists	2 within 60 miles			Met			0			
Pathologists	1 within 90 miles			Met			0			
Pharmacy	2 within 30 miles			Met			0			
Physical Therapists	2 within 60 miles			Met			0			
PMPs-Physicians	1 within 30 miles			Met			0			
Prosthetic Suppliers	1 within 90 miles			Not Met			92			Figure 107

Table 40. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Psychiatrists	2 within 60 miles			Met			0			
Pulmonologists	2 within 60 miles			Met			0			
Radiation Oncologists	1 within 90 miles			Met			0			
Radiologists	1 within 90 miles			Met			0			
Rheumatologists	1 within 90 miles			Not Met			2			Figure 108
Speech Therapists	2 within 60 miles			Not Met			1			Figure 109
Urologists	2 within 60 miles			Met			0			

**Orthodontic procedures for IHCP programs are covered only for members younger than 21 years old.*
***CareSource appeared to send a large number of organizational National Provider Identifiers (NPIs) in their pharmacy provider data which reduced their total pharmacy provider count for this analysis.*

Anthem Member Population

Figure 1. HHW – Member Population

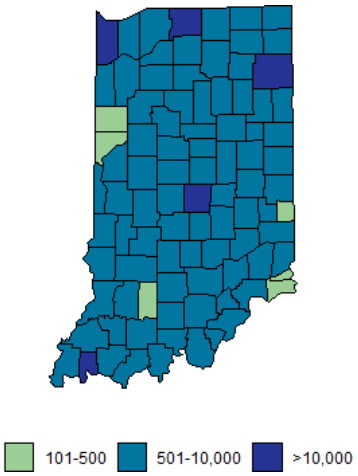


Figure 2. HIP – Member Population

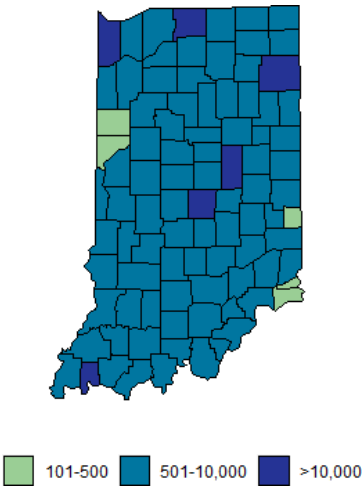
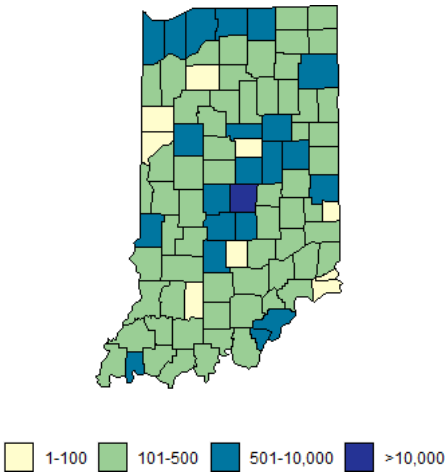


Figure 3. HCC – Member Population



Anthem HHW Accessibility by Provider Type

Figure 4. HHW Acute Care Hospitals

Figure 5. HHW Behavioral Health Providers

Figure 6. HHW Diagnostic Testing

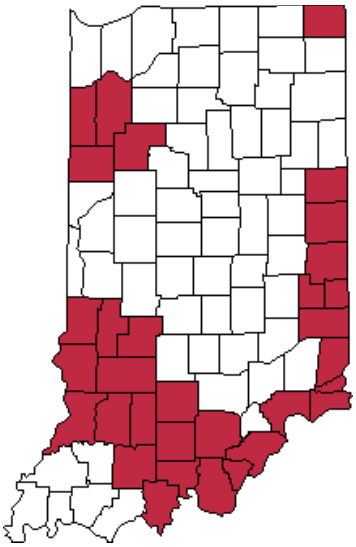


Figure 7. HHW DME

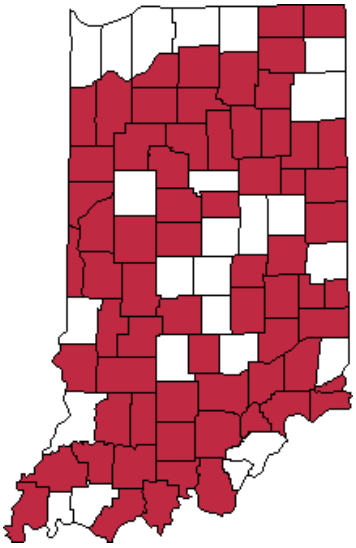


Figure 8. HHW Dentists

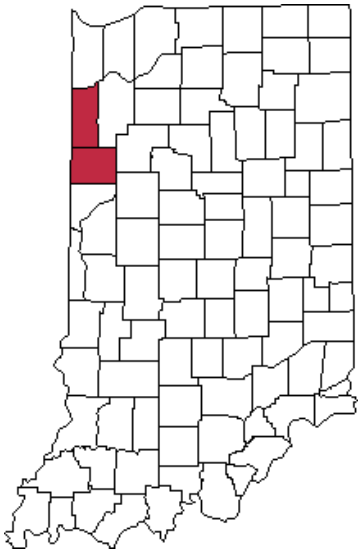


Figure 9. HHW Home Health Providers

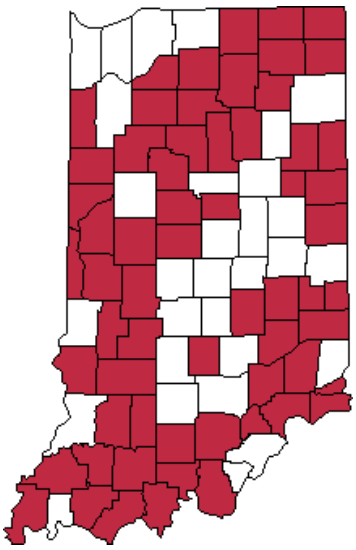


Figure 10. HHW Inpatient Psychiatric Facilities

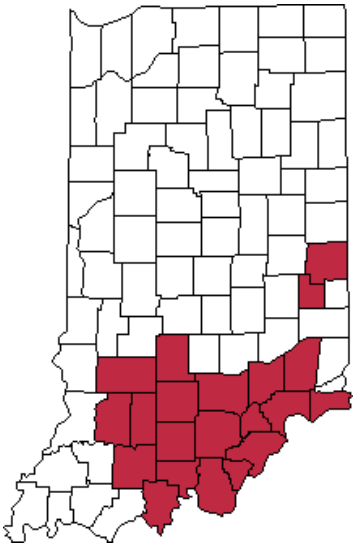
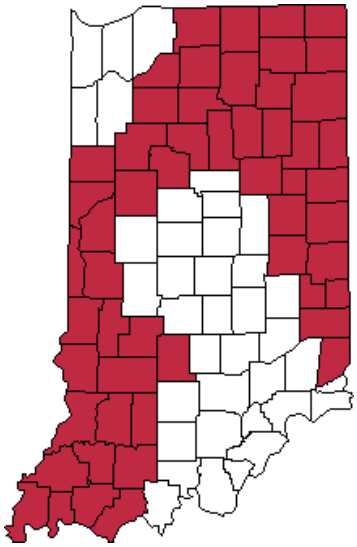


Figure 11. HHW Orthodontists



Anthem HIP Accessibility by Provider Type

Figure 12. HIP Acute Care Hospital

Figure 13. HIP Behavioral Health Providers

Figure 14. HIP Diagnostic Testing

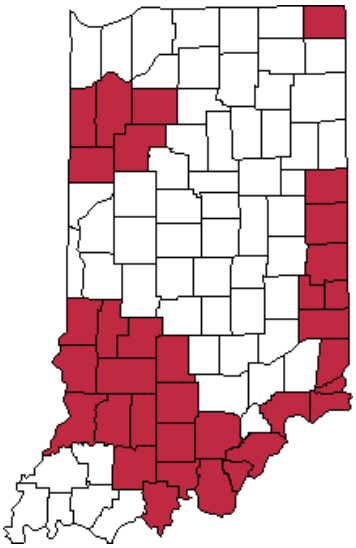


Figure 15. HIP DME

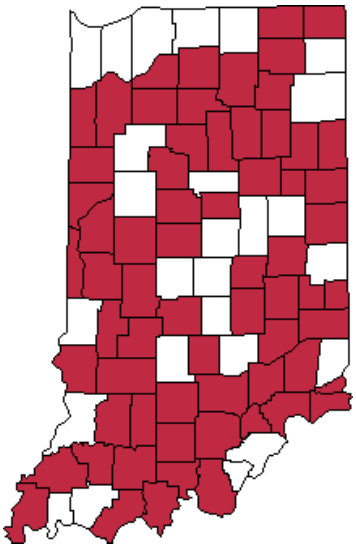


Figure 16. HIP Dentists

Figure 17. HIP Home Health Providers

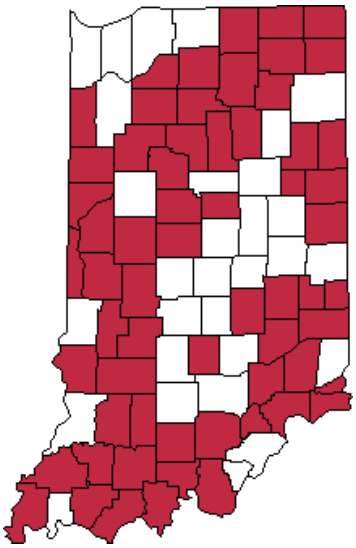


Figure 18. HIP Inpatient Psychiatric Facilities

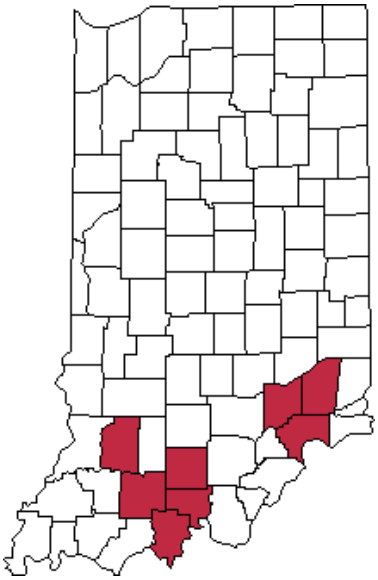
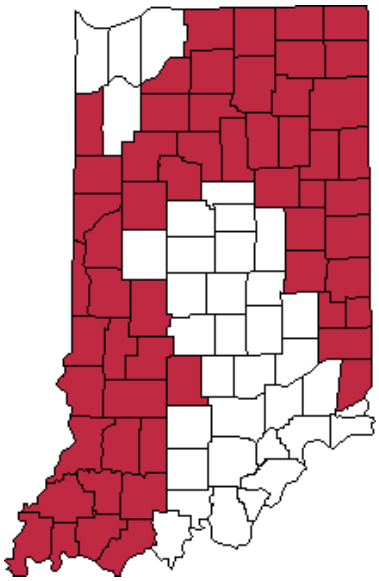


Figure 19. HIP Orthodontists



Anthem HCC Accessibility by Provider Type

Figure 20. HCC Acute Care Hospitals

Figure 21. HCC Behavioral Health Providers

Figure 22. HCC Diagnostic Testing

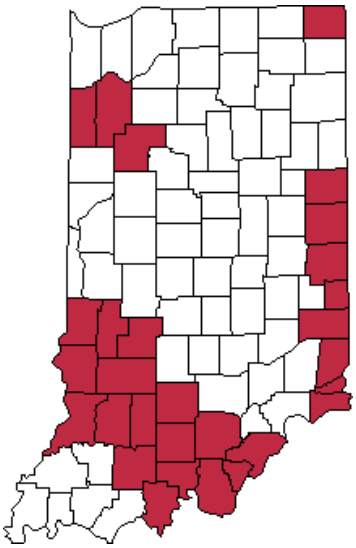


Figure 23. HCC DME

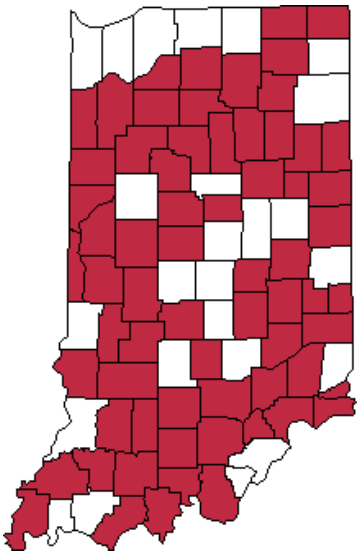


Figure 24. HCC Home Health Providers

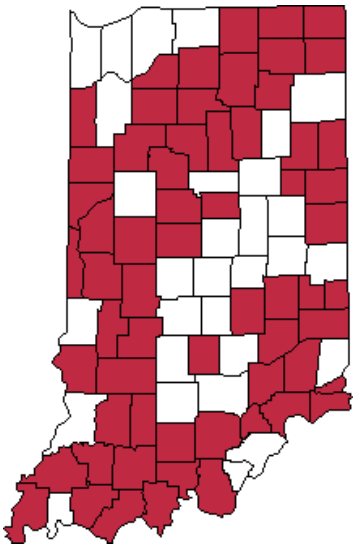


Figure 25. HCC Inpatient Psychiatric Facilities

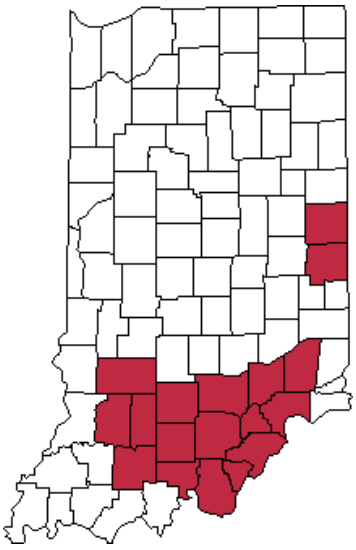
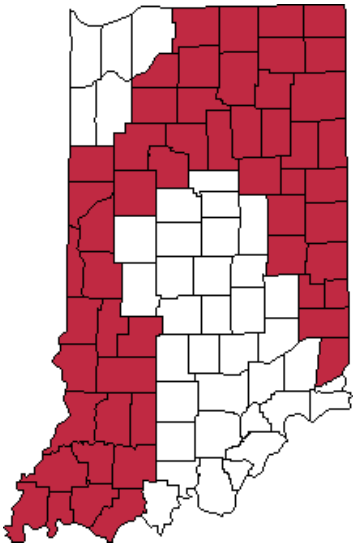


Figure 26. HCC Orthodontists



CareSource Member Populations

Figure 27. HHW Member Population

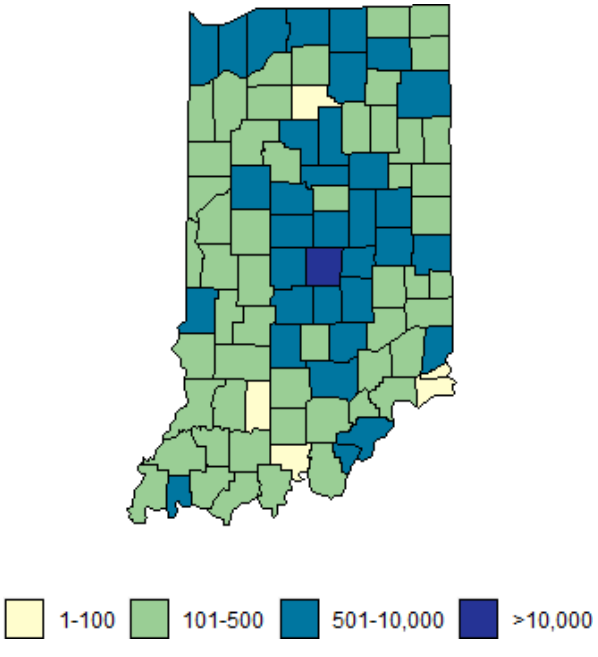
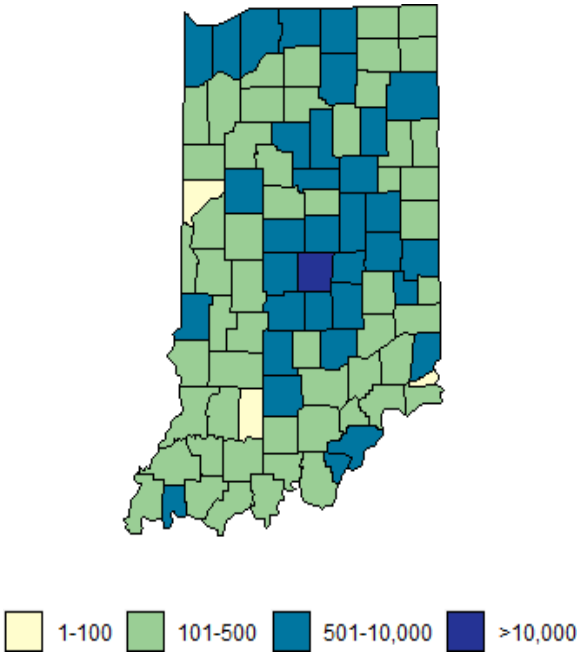


Figure 3. HIP Member Population



CareSource HHW Accessibility by Provider Service Type

Figure 29. HHW Oral Surgeons

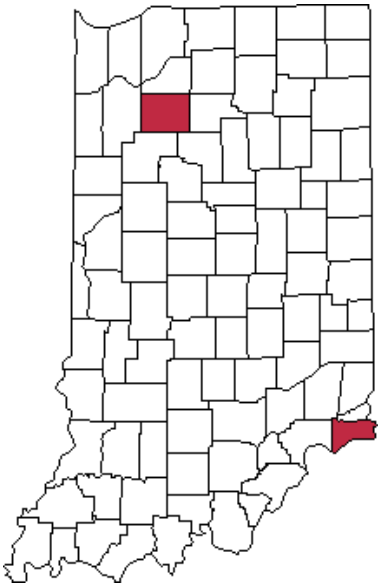


Figure 30. HHW Diagnostic Testing

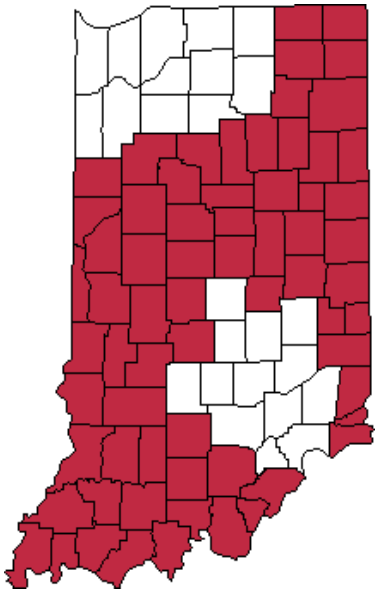


Figure 31. HHW DME

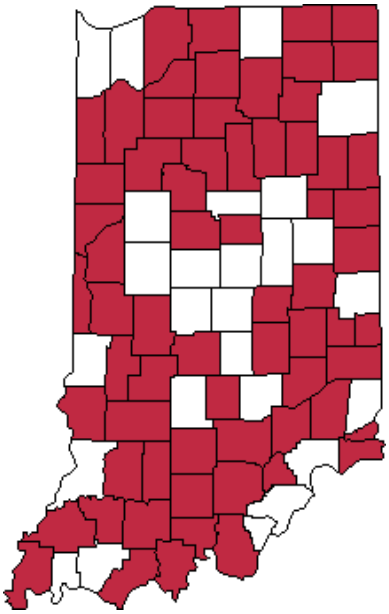


Figure 32. HHW Endocrinologists

Figure 33. HHW Dentists

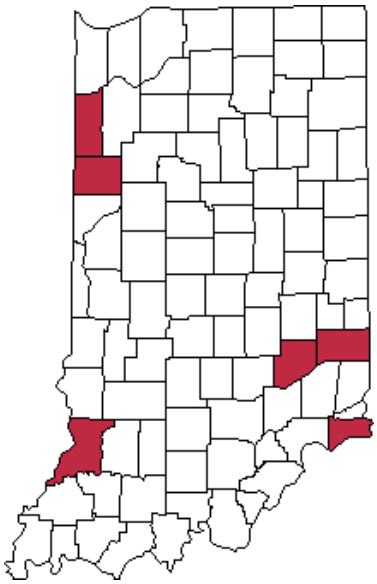


Figure 34. HHW Home Health Providers

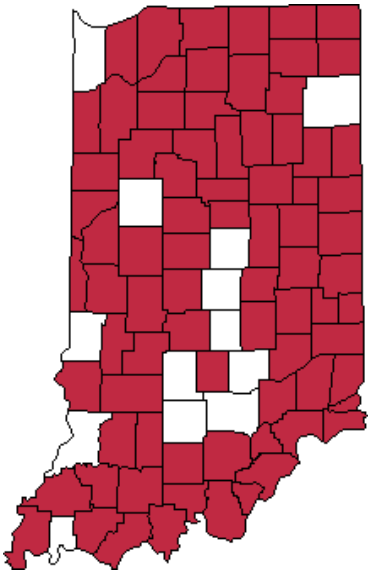


Figure 35. HHW Inpatient Psychiatric Facilities

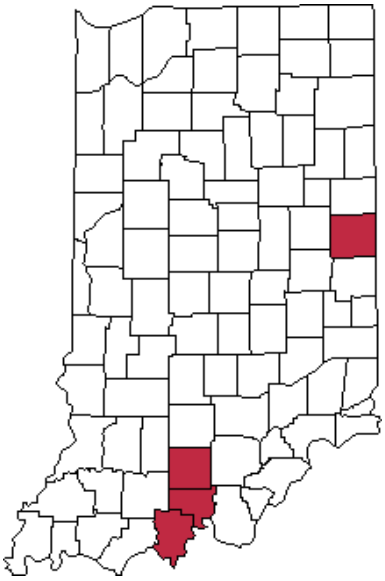


Figure 36. HHW Orthodontists

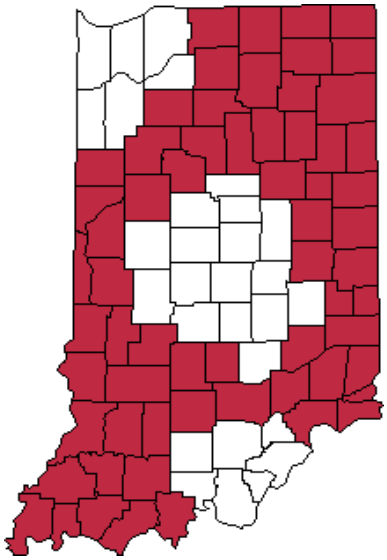
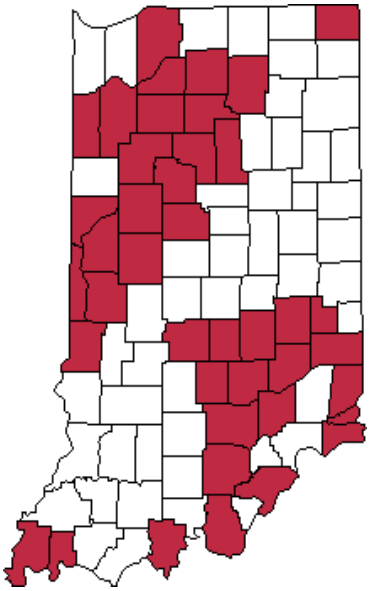


Figure 37. HHW Pharmacy



CareSource HIP Accessibility by Provider Type

Figure 38. HIP Oral Surgeons

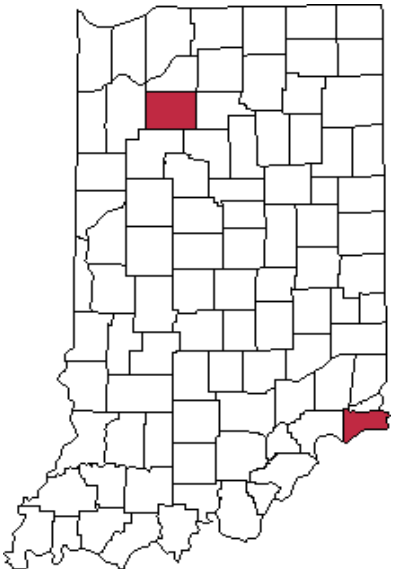


Figure 39. HIP Diagnostic Testing

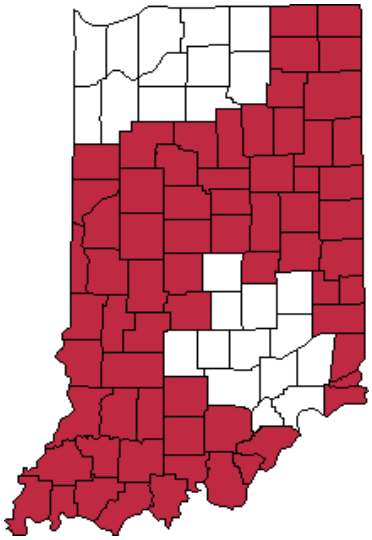


Figure 40. HIP DME

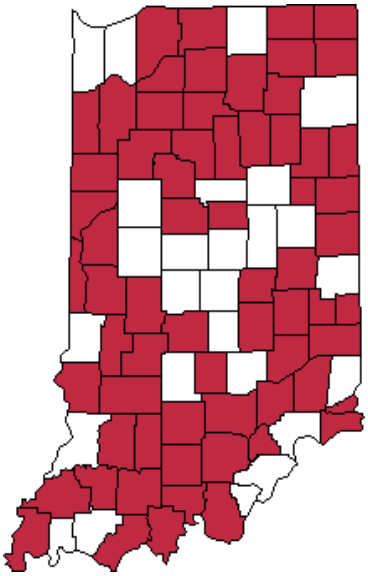


Figure 41. HIP Endocrinologists

Figure 42. HIP Dentists

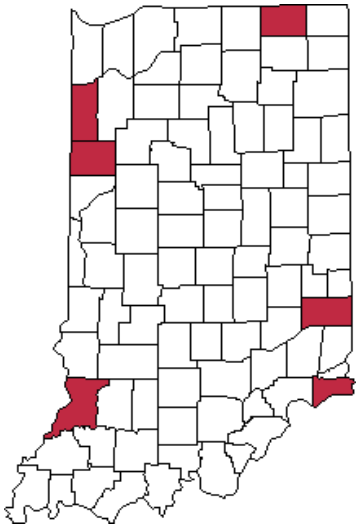


Figure 43. HIP Home Health Providers

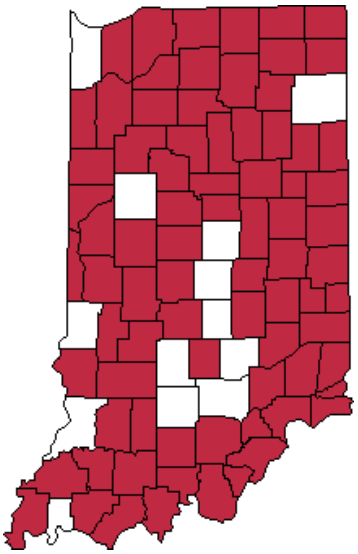


Figure 44. HIP Inpatient Psychiatric Facilities

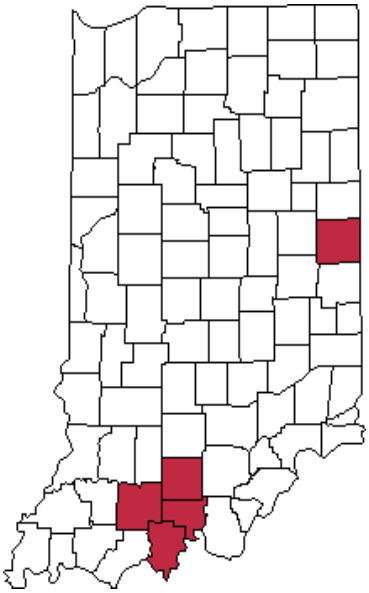
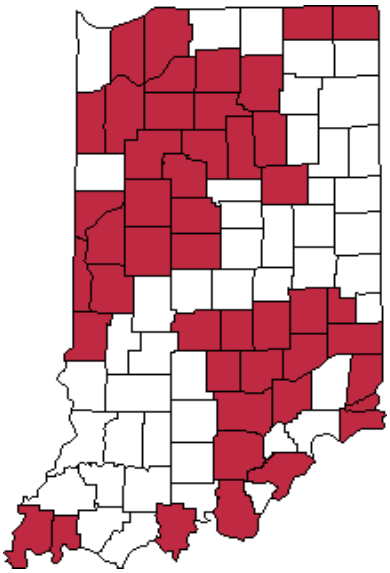


Figure 45. HIP Orthodontists

Figure 46. HIP Pharmacy



MDwise Member Population

Figure 47. HHW Member Population

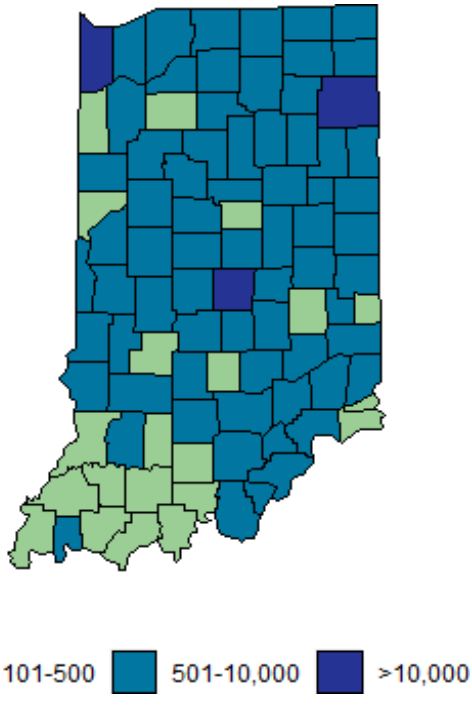
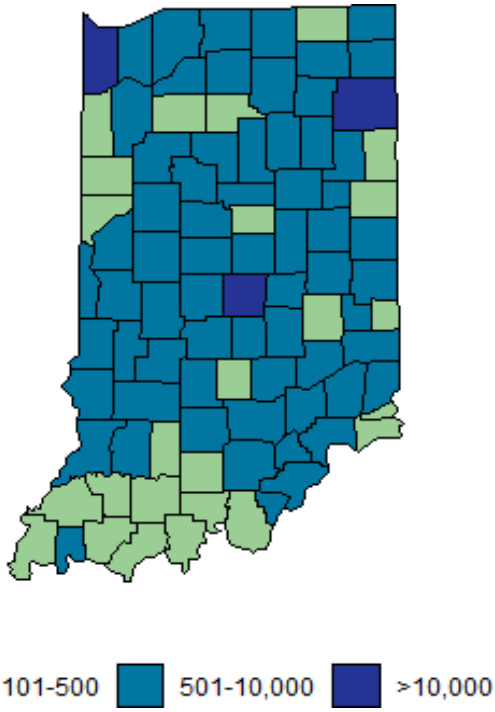


Figure 48. HIP Member Population



MDwise HHW Accessibility by Provider Service Type

Figure 49. HHW Oral Surgeons

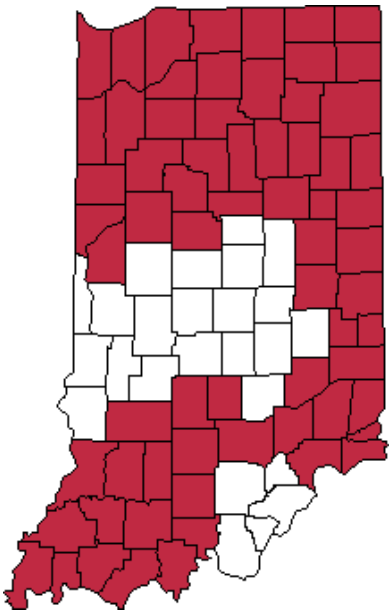


Figure 50. HHW Diagnostic Testing

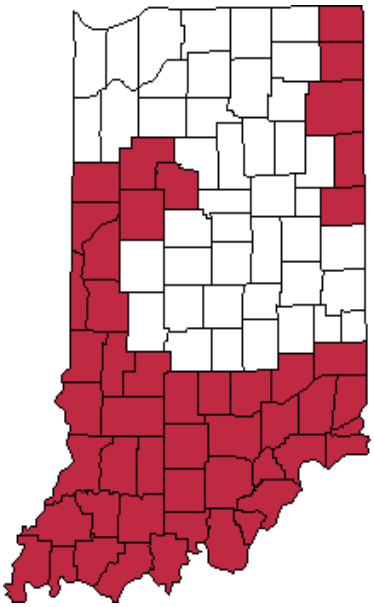


Figure 51. HHW DME

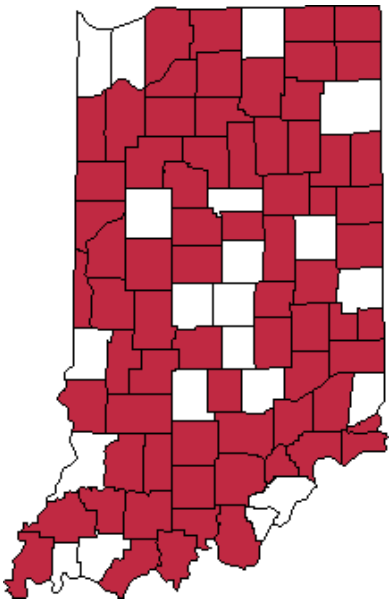


Figure 52. HHW Gastroenterologists

Figure 53. HHW Dentists

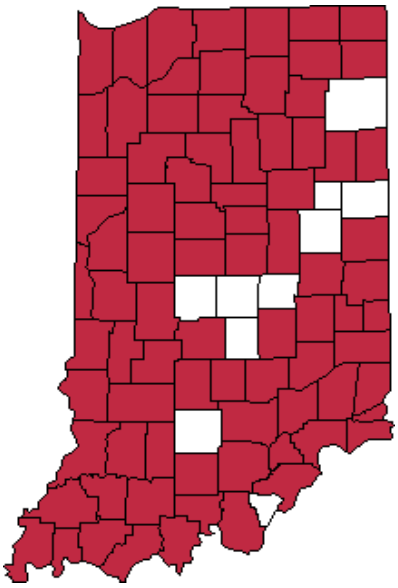


Figure 54. HHW Home Health Providers

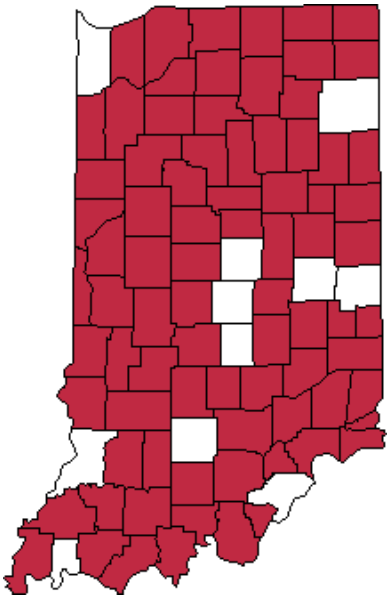


Figure 55. HHW Inpatient Psychiatric Facilities

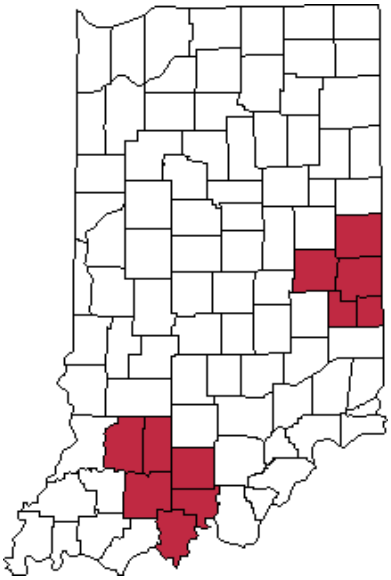
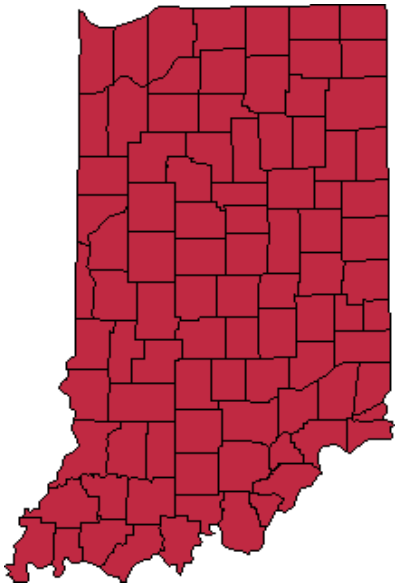


Figure 56. HHW Orthodontists



MDwise HIP Accessibility by Provider Service Type

Figure 57. HIP Acute Care Hospitals

Figure 58. HIP Oral Surgeons

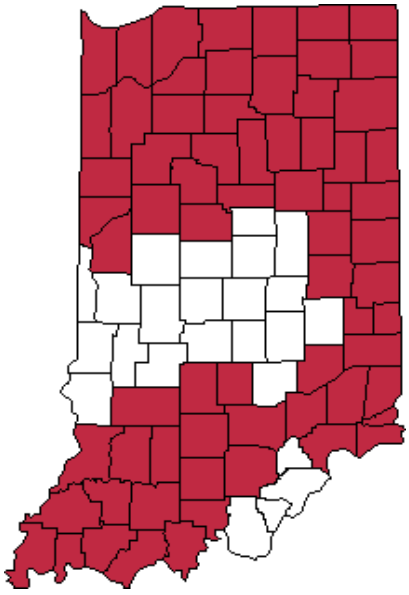


Figure 59. HIP Diagnostic Testing

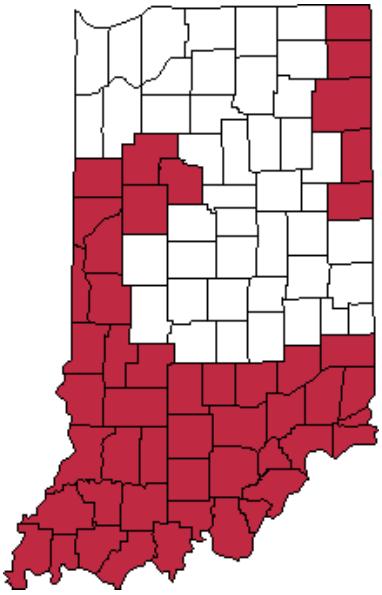


Figure 60. HIP DME

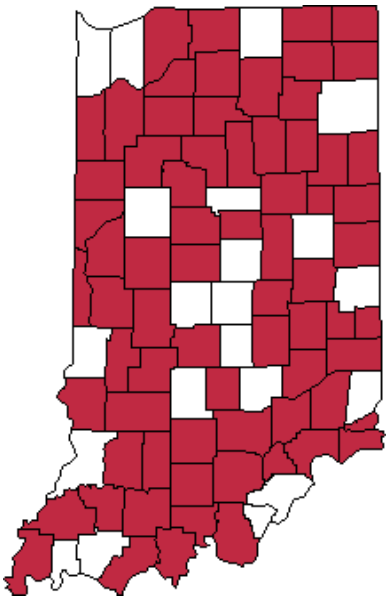


Figure 61. HIP Gastroenterologists

Figure 62. HIP Dentists

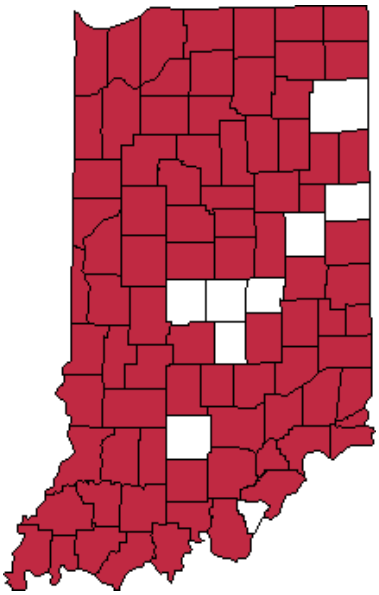


Figure 63. HIP Home Health Providers

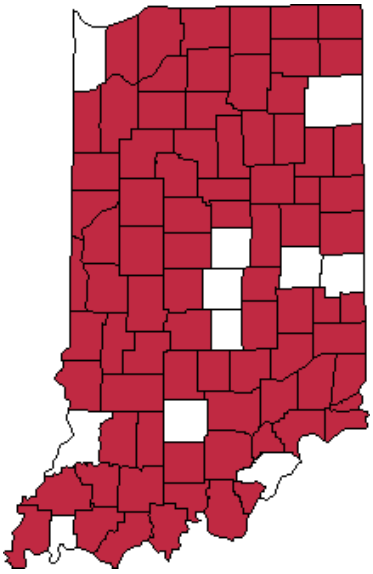


Figure 64. HIP Inpatient Psychiatric Facilities

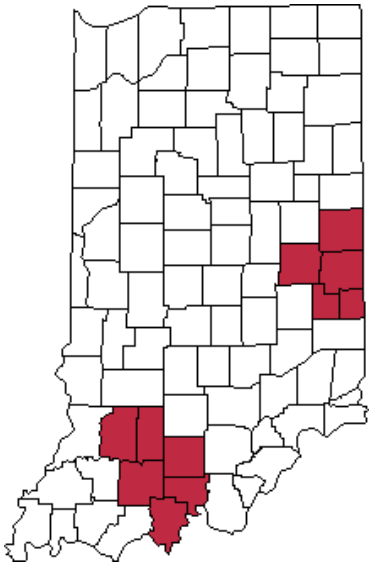
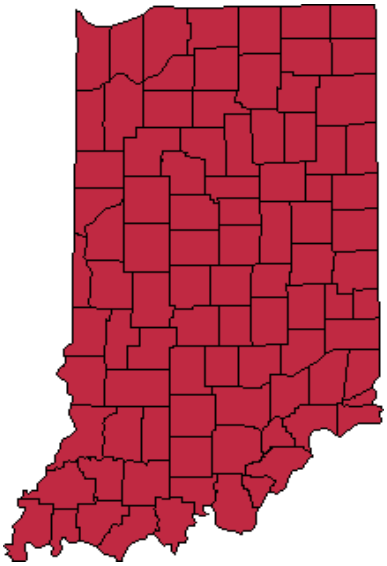


Figure 65. HIP Orthodontists



MHS Member Population

Figure 66. HHW Member Population

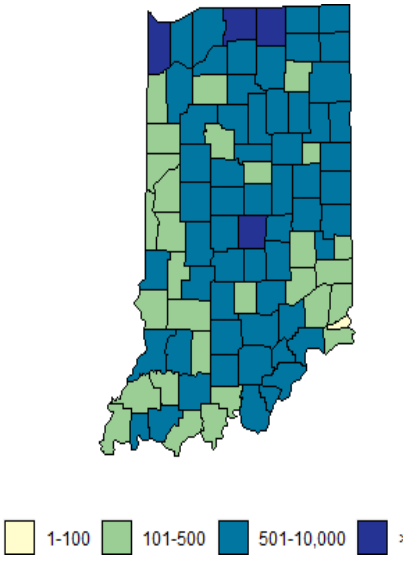


Figure 67. HIP Member Population

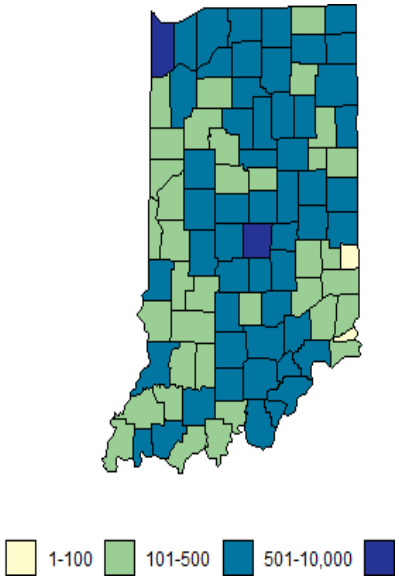
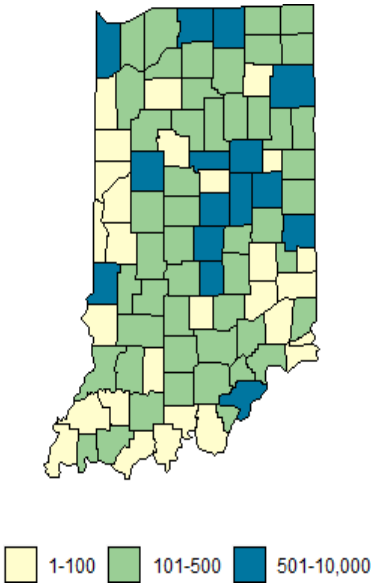


Figure 68. HCC Member Population



MHS HHW Accessibility by Provider Service Type

Figure 69. HHW Acute Care Hospitals

Figure 70. HHW Oral Surgeons

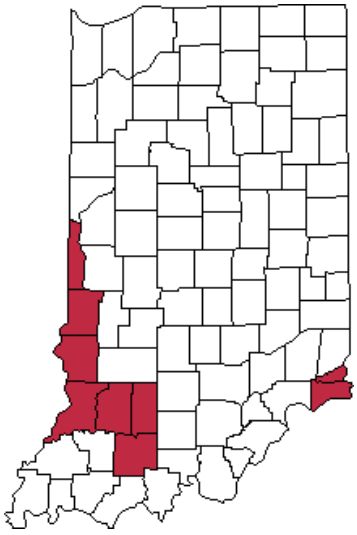


Figure 71. HHW Diagnostic Testing

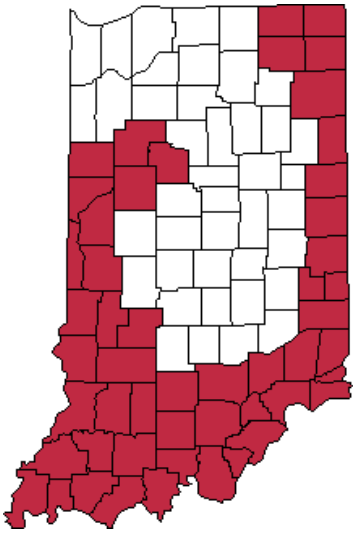


Figure 72. HHW DME

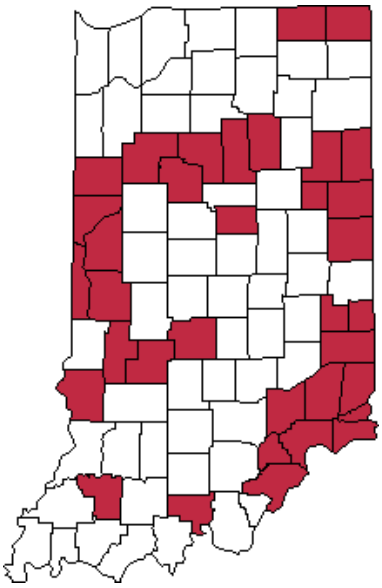


Figure 73. HHW Endocrinologists

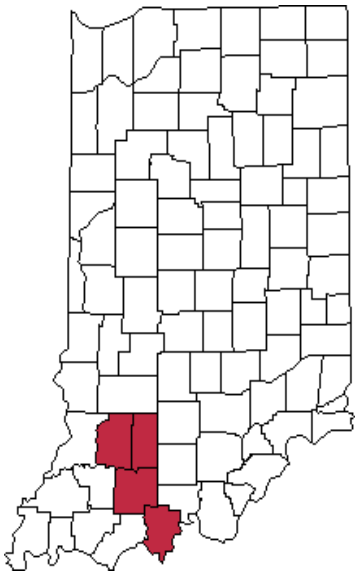


Figure 74. HHW Dentists

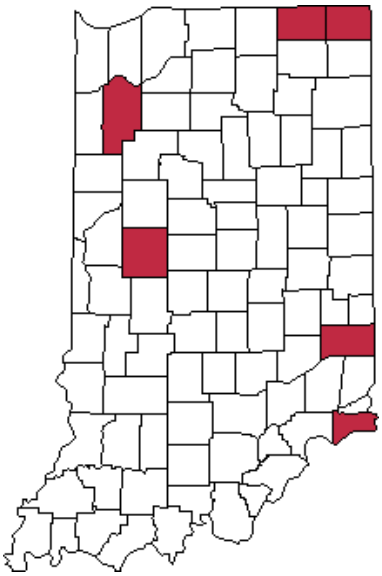


Figure 75. HHW Home Health Providers

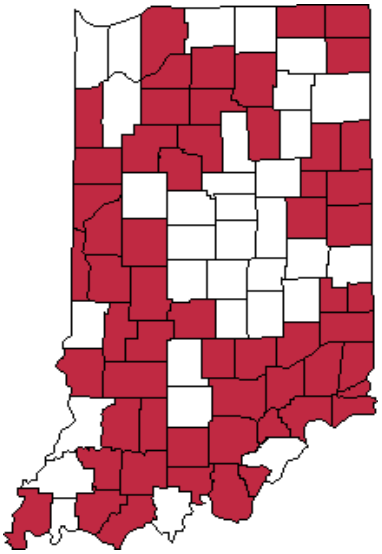


Figure 76. HHW Inpatient Psychiatric Facilities

Figure 77. HHW Orthodontists

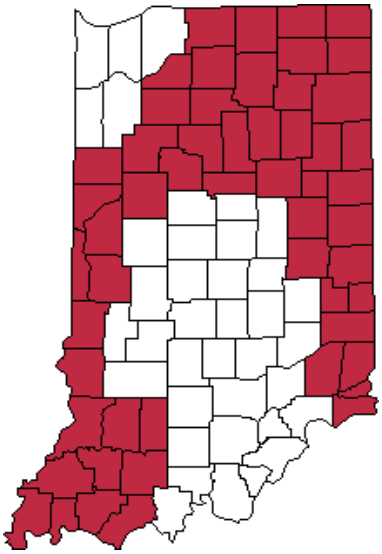


Figure 78. HHW Otolaryngologists

MHS HIP Accessibility by Provider Service Type

Figure 79. HIP Acute Care Hospitals

Figure 80. HIP Oral Surgeons

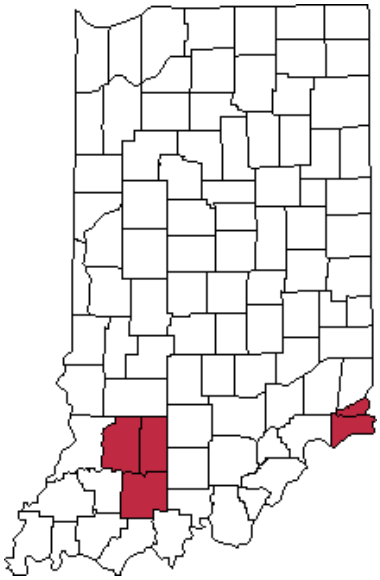


Figure 81. HIP Diagnostic Testing

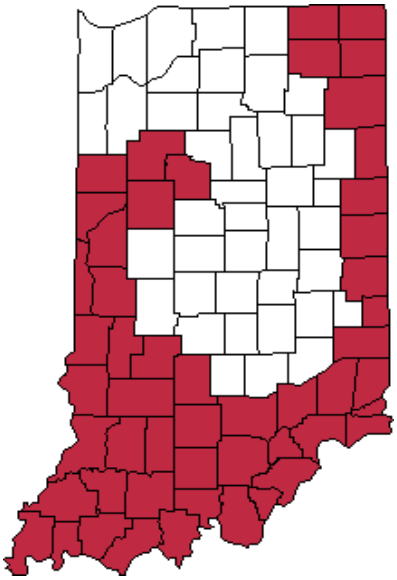


Figure 82. HIP DME

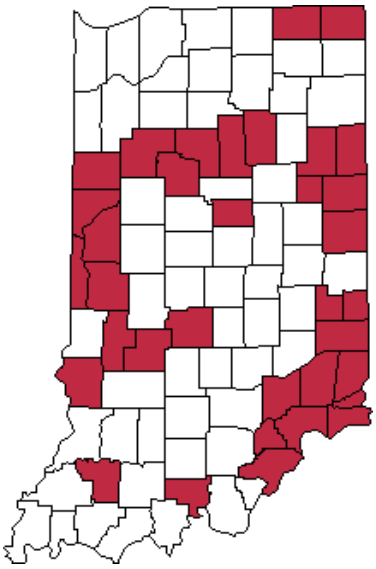


Figure 83. HIP Endocrinologists

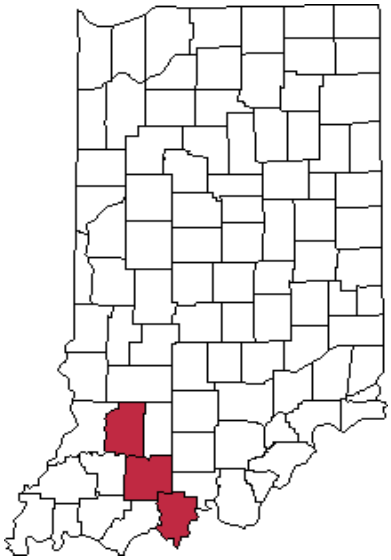


Figure 84. HIP Dentists

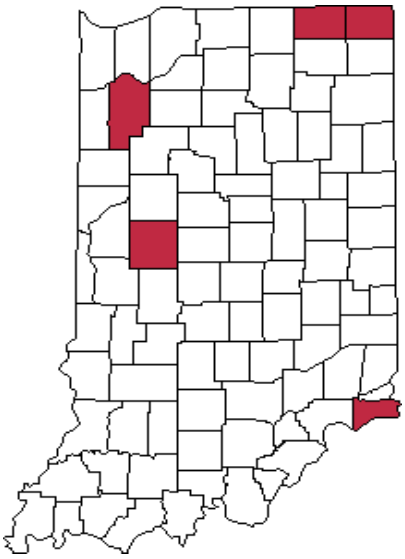


Figure 85. HIP Home Health Providers

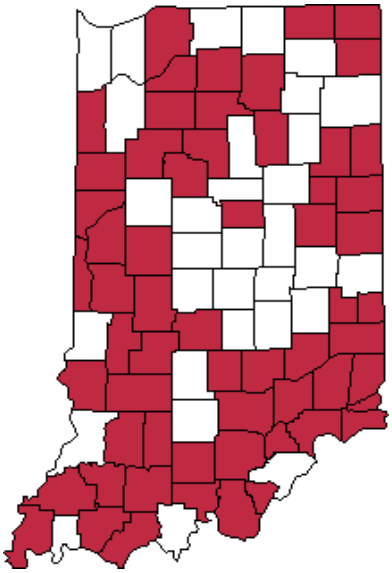


Figure 86. HIP Inpatient Psychiatric Facilities

Figure 87. HIP Orthodontists

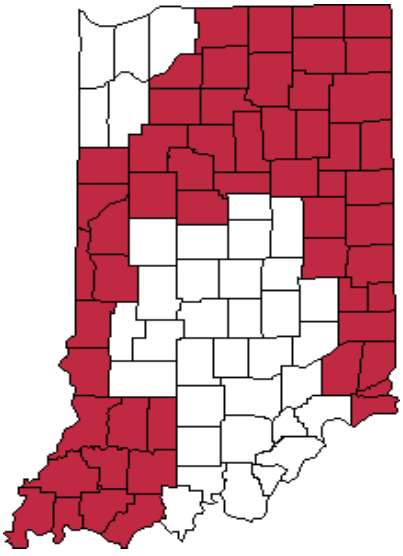


Figure 88. HIP Otolaryngologists

MHS HCC Accessibility by Provider Service Type

Figure 89. HCC Oral Surgeons

Figure 90. HCC Diagnostic Testing

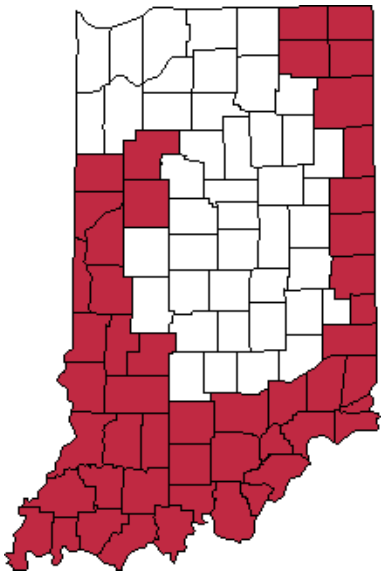


Figure 91. HCC DME

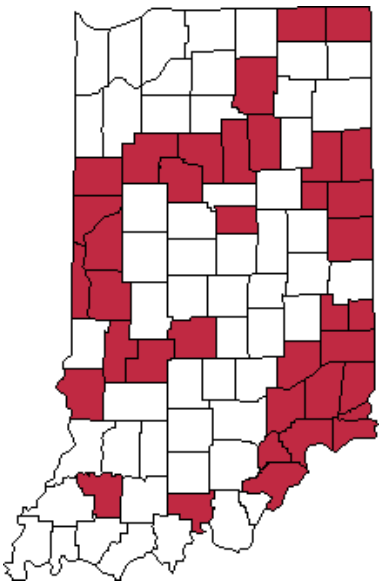


Figure 92. HCC Endocrinologists

Figure 93. HCC Dentists

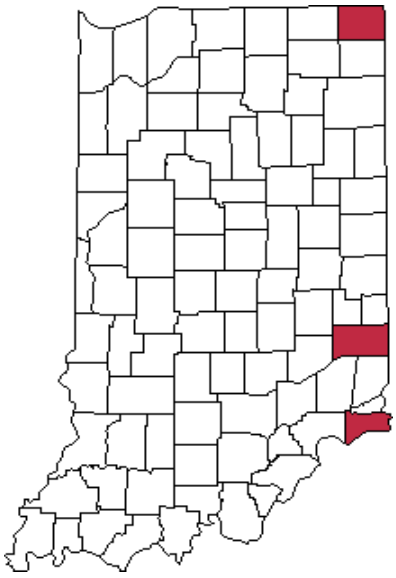


Figure 94. HCC Home Health Providers

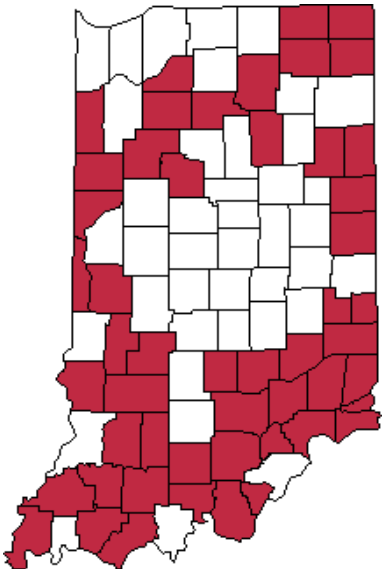


Figure 95. HCC Orthodontists

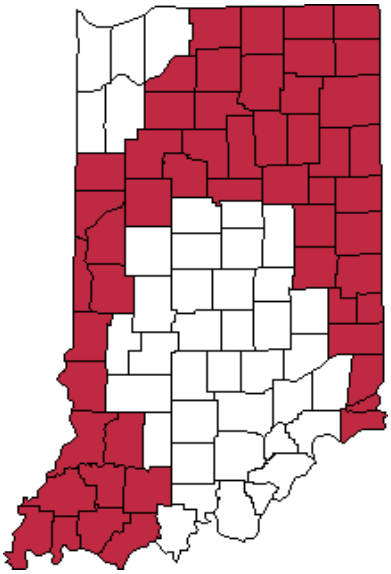
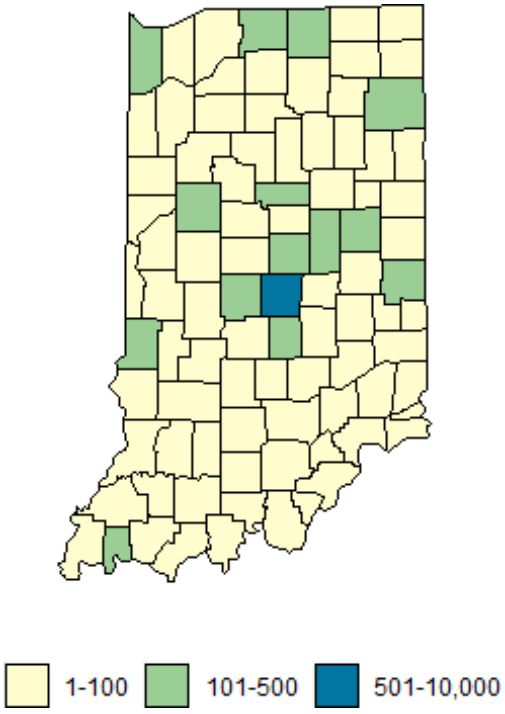


Figure 96. HCC Otolaryngologists

UHC Member Population

Figure 97. HCC Member Population



UHC HCC Accessibility by Provider Service Type

Figure 98. HCC Acute Care Hospitals

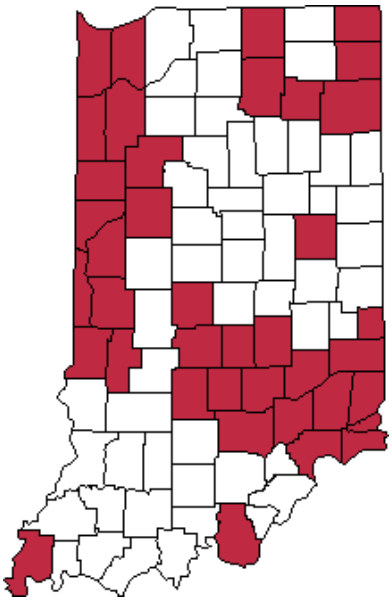


Figure 99. HCC Oral Surgeons

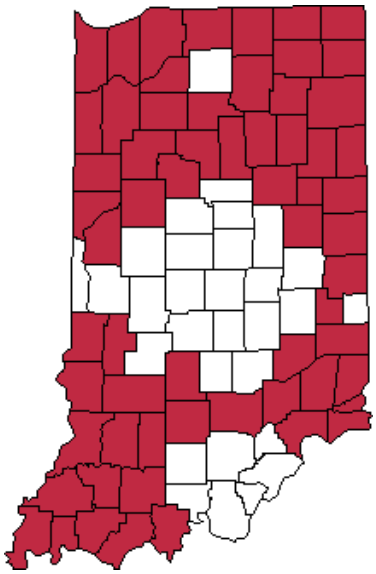


Figure 100. HCC Diagnostic Testing

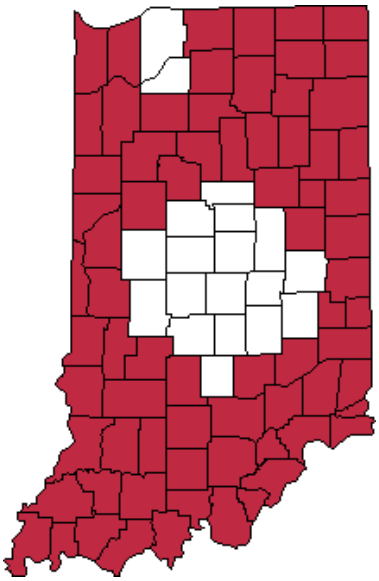


Figure 101. HCC DME

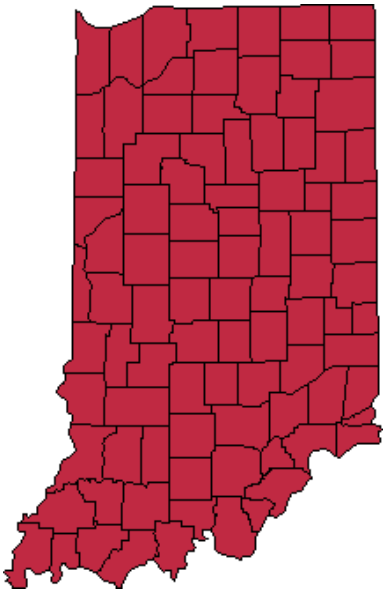


Figure 102. HCC Dentists

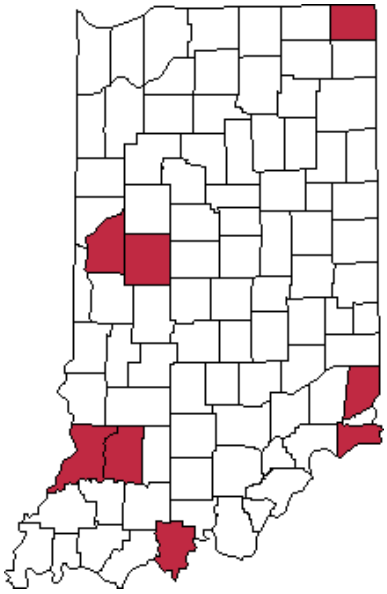


Figure 103. HCC Home Health Providers

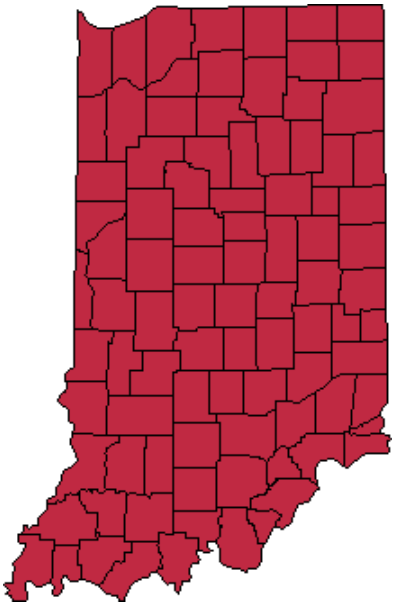


Figure 104. HCC Inpatient Psychiatric Facilities

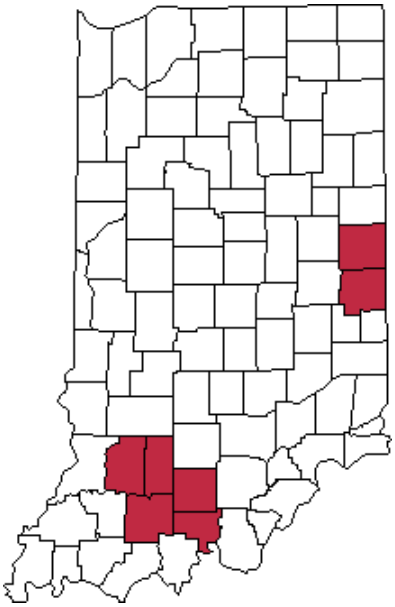


Figure 105. HCC Occupational Therapists

Figure 106. HCC Orthodontists

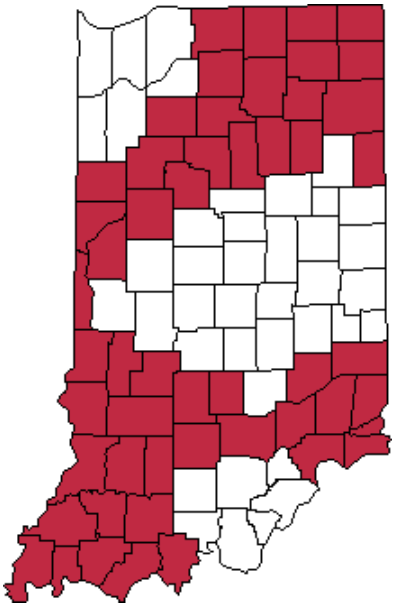


Figure 107. HCC Prosthetic Suppliers

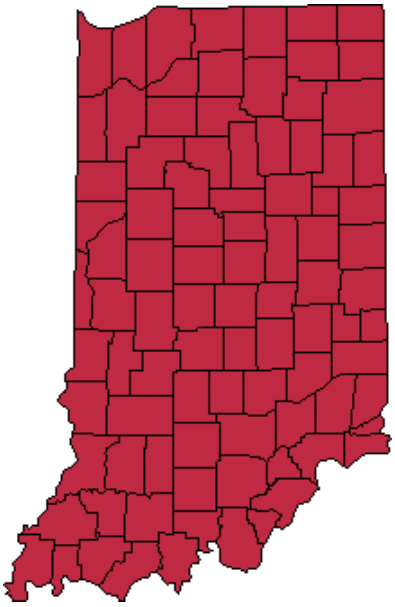


Figure 108. HCC Rheumatologists

Figure 109. HCC Speech Therapists

Assessment of Annual Reports 0902 and 0903 Issued to the State

The MCE's annual *Report 0902 (Count of Providers)* was compared to the State, comparing provider counts per county to the provider rosters the MCEs submitted for analysis (see Appendix A, "Geographic Considerations Regarding the Calculation of Provider-to-Member Ratios").

Table 41. Count of Providers – Verification of Report 0902

IHCP	Program	All Provider Service Types		
		Report 0902	Calculated	Over (Under) Reported
Anthem	HHW	29,016	41,862	(12,846)
	HIP	28,201	40,805	(12,604)
	HCC	29,544	42,033	(12,489)
CareSource	HHW	60,831	34,953	25,878
	HIP	58,752	33,365	23,387
MDwise	HHW	33,768	26,175	7,593
	HIP	33,926	26,180	7,746
MHS	HHW	19,850	21,345	(1,495)
	HIP	19,623	21,098	(1,475)
	HCC	20,068	20,971	(903)
UHC	HCC	25,047	24,756	291

Counts of providers tended to be slightly lower in Anthem's and MHS's Report 0902 than those calculated for the submitted provider rosters, while counts were significantly higher in CareSource's Report, and slightly higher in MDwise's and UHC's Report.

The MCEs' *Report 0903 (Member Access to Providers)* was compared to the State's counts of members lacking sufficient access to providers by county to the results of provider network assessments (Appendix B).

Table 42. Member Access to Providers – Verification of Report 0903							
Program	Service Type	Number of Enrolled Members			Members Without Sufficient Access		
		MCE Report 0903	Calculated	Over (Under)	MCE Report 0903	Calculated	Over (Under)
Anthem							
HHW	Acute Care Hospitals	314,049	317,186	(3,137)	0	25	(25)
	Oral Surgeons	314,049	317,186	(3,137)	3	0	3
	Behavioral Health Providers	314,049	317,186	(3,137)	0	2	(2)
	Diagnostic Testing	314,049	317,186	(3,137)	0	19,673	(19,673)
	DME	314,049	317,186	(3,137)	3,067	82,713	(79,646)
	Dentists	314,049	317,186	(3,137)	0	3	(3)
	Home Health Providers	314,049	317,186	(3,137)	5,906	73,747	(67,841)
	IP Psychiatric Facilities	314,049	317,186	(3,137)	0	7,437	(7,437)
	Orthodontists	314,049	317,186	(3,137)	87,619	96,473	(8,854)
	Radiologists	314,049	317,186	(3,137)	19,918	0	19,918
HIP	Acute Care Hospitals	338,035	351,306	(13,271)	0	8	(8)
	Oral Surgeons	338,035	351,306	(13,271)	251	0	251
	Behavioral Health Providers	338,035	351,306	(13,271)	0	3	(3)
	Diagnostic Testing	338,035	351,306	(13,271)	0	23,175	(23,175)
	DME	338,035	351,306	(13,271)	4,471	91,768	(87,297)
	Dentists	338,035	351,306	(13,271)	0	1	(1)
	Home Health Providers	338,035	351,306	(13,271)	5,950	81,416	(75,466)

Table 42. Member Access to Providers – Verification of Report 0903

Program	Service Type	Number of Enrolled Members			Members Without Sufficient Access		
		MCE Report 0903	Calculated	Over (Under)	MCE Report 0903	Calculated	Over (Under)
	IP Psychiatric Facilities	338,035	351,306	(13,271)	0	246	(246)
	Orthodontists	338,035	351,306	(13,271)	92,012	105,689	(13,677)
	Radiologists	338,035	351,306	(13,271)	22,406	0	22,406
HCC	Acute Care Hospitals	56,174	56,392	(218)	0	4	(4)
	Behavioral Health Providers	56,174	56,392	(218)	0	1	(1)
	Diagnostic Testing	56,174	56,392	(218)	0	4,041	(4,041)
	DME	56,174	56,392	(218)	784	14,799	(14,015)
	Home Health Providers	56,174	56,392	(218)	1,003	12,880	(11,877)
	Inpatient Psychiatric Facilities	56,174	56,392	(218)	0	368	(368)
	Orthodontists	56,174	56,392	(218)	16,284	17,644	(1,360)
	Radiologists	56,174	56,392	(218)	3,332	0	3,332
CareSource							
HHW	Oral Surgeons	82,030	78,696	3,334	98	10	88
	Diagnostic Testing	82,030	78,696	3,334	0	33,988	(33,988)
	DME	82,030	78,696	3,334	0	23,566	(23,566)
	Endocrinologists	82,030	78,696	3,334	0	97	(97)
	Dentists	82,030	78,696	3,334	111	272	(161)
	Home Health Providers	82,030	78,696	3,334	0	37,538	(37,538)

Table 42. Member Access to Providers – Verification of Report 0903

Program	Service Type	Number of Enrolled Members			Members Without Sufficient Access		
		MCE Report 0903	Calculated	Over (Under)	MCE Report 0903	Calculated	Over (Under)
	IP Psychiatric Facilities	82,030	78,696	3,334	0	21	(21)
	Orthodontists	82,030	78,696	3,334	16,587	23,994	(7,407)
	Pharmacy	82,030	78,696	3,334	0	5,276	(5,276)
HIP	Oral Surgeons	81,381	82,524	(1,143)	602	665	(63)
	Diagnostic Testing	81,381	82,524	(1,143)	0	35,885	(35,885)
	DME	81,381	82,524	(1,143)	0	23,613	(23,613)
	Endocrinologists	81,381	82,524	(1,143)	0	73	(73)
	Dentists	81,381	82,524	(1,143)	178	348	(170)
	Home Health Providers	81,381	82,524	(1,143)	0	39,308	(39,308)
	IP Psychiatric Facilities	81,381	82,524	(1,143)	0	39	(39)
	Orthodontists	81,381	82,524	(1,143)	17,611	24,418	(6,807)
	Pharmacy	81,381	82,524	(1,143)	0	5,618	(5,618)
MDwise							
HHW	Acute Care Hospitals	217,393	212,362	5,031	12	0	12
	Behavioral Health Providers	217,393	212,362	5,031	19	0	19
	Oral Surgeons	217,393	212,362	5,031	0	94,061	(94,061)
	Diagnostic Testing	217,393	212,362	5,031	36,743	32,712	4,031
	DME	217,393	212,362	5,031	0	69,954	(69,954)
	ESRD Clinic	217,393	212,362	5,031	71	0	71

Table 42. Member Access to Providers – Verification of Report 0903

Program	Service Type	Number of Enrolled Members			Members Without Sufficient Access		
		MCE Report 0903	Calculated	Over (Under)	MCE Report 0903	Calculated	Over (Under)
	Endocrinologists	217,393	212,362	5,031	6,828	0	6,828
	Gastroenterologists	217,393	212,362	5,031	0	6	(6)
	Dentists	217,393	212,362	5,031	0	97,457	(97,457)
	Home Health Providers	217,393	212,362	5,031	3,666	103,865	(100,199)
	IP Psychiatric Facilities	217,393	212,362	5,031	7,567	4,821	2,746
	Interventional Radiologists	217,393	212,362	5,031	2,177	0	2,177
	Orthodontists	217,393	212,362	5,031	56,806	212,362	(155,556)
	Pharmacy	217,393	212,362	5,031	6	0	6
	Prosthetic Suppliers	217,393	212,362	5,031	14	0	14
HIP	Acute Care Hospitals	164,835	166,454	(1,619)	16	1	15
	Behavioral Health Providers	164,835	166,454	(1,619)	19	0	19
	Oral Surgeons	164,835	166,454	(1,619)	0	74,977	(74,977)
	Diagnostic Testing	164,835	166,454	(1,619)	30,099	29,216	883
	DME	164,835	166,454	(1,619)	0	58,143	(58,143)
	ESRD Clinic	164,835	166,454	(1,619)	56	0	56
	Endocrinologists	164,835	166,454	(1,619)	5,516	0	5,516
	Gastroenterologists	164,835	166,454	(1,619)	0	6	(6)
	Dentists	164,835	166,454	(1,619)	0	79,948	(79,948)

Table 42. Member Access to Providers – Verification of Report 0903

Program	Service Type	Number of Enrolled Members			Members Without Sufficient Access		
		MCE Report 0903	Calculated	Over (Under)	MCE Report 0903	Calculated	Over (Under)
	Home Health Providers	164,835	166,454	(1,619)	3,304	87,085	(83,781)
	IP Psychiatric Facilities	164,835	166,454	(1,619)	6,461	4,252	2,209
	Interventional Radiologists	164,835	166,454	(1,619)	2,308	0	2,308
	Orthodontists	164,835	166,454	(1,619)	44,760	166,454	(121,694)
	Pharmacy	164,835	166,454	(1,619)	6	0	6
	Prosthetic Suppliers	164,835	166,454	(1,619)	18	0	18
MHS							
	Acute Care Hospitals	187,083	183,439	3,644	0	7	(7)
	Oral Surgeons	187,083	183,439	3,644	139	198	(59)
	Diagnostic Testing	187,083	183,439	3,644	106,137	29,866	76,271
	Durable Medical Equipment	187,083	183,439	3,644	0	22,356	(22,356)
HHW	Endocrinologists	187,083	183,439	3,644	0	89	(89)
	Dentists	187,083	183,439	3,644	0	136	(136)
	Home Health Providers	187,083	183,439	3,644	0	45,146	(45,146)
	IP Psychiatric Facilities	187,083	183,439	3,644	0	3	(3)
	Orthodontists	187,083	183,439	3,644	52,034	76,805	(24,771)
	Otolaryngologists	187,083	183,439	3,644	0	232	(232)
HIP	Acute Care Hospitals	140,108	136,502	3,606	0	3	(3)

Table 42. Member Access to Providers – Verification of Report 0903

Program	Service Type	Number of Enrolled Members			Members Without Sufficient Access		
		MCE Report 0903	Calculated	Over (Under)	MCE Report 0903	Calculated	Over (Under)
	Oral Surgeons	140,108	136,502	3,606	155	78	77
	Diagnostic Testing	140,108	136,502	3,606	76,343	24,623	51,720
	Durable Medical Equipment	140,108	136,502	3,606	0	17,429	(17,429)
	Endocrinologists	140,108	136,502	3,606	0	43	(43)
	Dentists	140,108	136,502	3,606	0	114	(114)
	Home Health Providers	140,108	136,502	3,606	0	35,779	(35,779)
	IP Psychiatric Facilities	140,108	136,502	3,606	0	4	(4)
	Orthodontists	140,108	136,502	3,606	34,819	51,247	(16,428)
	Otolaryngologists	140,108	136,502	3,606	0	8	(8)
HCC	Oral Surgeons	33,051	32,579	472	59	32	27
	Diagnostic Testing	33,051	32,579	472	17,252	5,799	11,453
	Durable Medical Equipment	33,051	32,579	472	0	4,851	(4,851)
	Endocrinologists	33,051	32,579	472	0	15	(15)
	Dentists	33,051	32,579	472	0	19	(19)
	Home Health Providers	33,051	32,579	472	0	6,241	(6,241)
	Orthodontists	33,051	32,579	472	7,436	11,740	(4,304)
	Otolaryngologists	33,051	32,579	472	0	2	(2)

Table 42. Member Access to Providers – Verification of Report 0903

Program	Service Type	Number of Enrolled Members			Members Without Sufficient Access		
		MCE Report 0903	Calculated	Over (Under)	MCE Report 0903	Calculated	Over (Under)
UHC							
HCC	Acute Care Hospitals	5,812	5,667	145	0	822	(822)
	Oral Surgeons	5,812	5,667	145	846	635	211
	Diagnostic Testing	5,812	5,667	145	0	2,681	(2,681)
	DME	5,812	5,667	145	0	5,667	(5,667)
	Dentists	5,812	5,667	145	7	21	(14)
	Home Health Providers	5,812	5,667	145	0	5,667	(5,667)
	IP Psychiatric Facilities	5,812	5,667	145	4	143	(139)
	Occupational Therapists	5,812	5,667	145	7	2	5
	Orthodontists	5,812	5,667	145	1,851	1,610	241
	Prosthetic Suppliers	5,812	5,667	145	0	5,667	(5,667)
	Rheumatologists	5,812	5,667	145	0	15	(15)
	Speech Therapists	5,812	5,667	145	0	2	(2)

The MCEs submitted their annual *Report 0903 (Member Access to Providers)*. Each report was reviewed, comparing count of members lacking sufficient access to providers by service type and county to the results of the provider network assessments (see Appendix B). All MCEs' Report 0903 showed no noted differences between the report and the verification.

Assessment of Provider Directories Issued to Members

For the assessment, each MCE submitted provider directories in Portable Document Format (PDF) format that was issued for each program (HHW, HCC and HIP) by region.

A random sample of providers was selected from each MCE's submitted roster of all providers (100 from Anthem, 102 from

CareSource, 80 from MDwise, 102 from MHS, and 94 from UHC), consisting of two observations for each provider service type across all programs. These providers were then traced to the provider directory submitted by the MCE.

A systematic comparison process was performed to assess the completeness and accuracy of the provider service location addresses of enrolled providers within the members' provider directories as of October 1, 2023. The addresses in the provider directory were extracted and geocoded, resulting in a list of standardized address coordinates. These coordinates were compared to the existing provider address coordinates used in the provider network accessibility analysis. This method showed the percentage of enrolled provider addresses matching across all provider service types and programs as 99.60% for Anthem, 96.15% for CareSource, 99.80% for MDwise, 99.80% for MHS, and 99.92% for UHC.

The overall provider directory completeness for each IHCP and MCE are displayed in **Table 43**, as is the percentage of locations matching that of the random sampling of Provider Directory Service Locations.

Table 43. Provider Directory Completeness

MCE	IHCP	Percentage of Providers Found	Percentage of Locations Matching
Anthem	HHW	58.06%	99.61%
	HIP	67.65%	99.61%
	HCC	57.14%	99.59%
	All Programs	61.00%	99.60%
CareSource	HHW	70.91%	99.86%
	HIP	65.96%	82.93%
	All Programs	68.63%	96.15%
MDwise	HHW	90.00%	99.80%
	HIP	90.00%	99.80%
	All Programs	90.00%	99.80%
MHS	HHW	32.40%	99.80%
	HIP	31.00%	99.80%
	HCC	66.70%	99.80%
	All Programs	44.10%	99.80%

Table 43. Provider Directory Completeness			
MCE	IHCP	Percentage of Providers Found	Percentage of Locations Matching
UHC	HCC	60.64%	99.92%

Secret Shopper Survey

Objectives

In an upcoming proposed rule by CMS, it notes that surveys of providers can add a greater level of validity and accuracy to the validation of network adequacy and access. Based on the 2024 Managed Care proposed rule, CMS states that while calls can be either secret, meaning the caller does not identify who they are performing the survey for, or revealed, meaning the caller identifies the entity for which they are performing the survey, it proposes that a secret shopper call can result in unbiased and credible findings. To that end, OMPP requested Qsource conduct a Secret Shopper Survey as a part of ANA to ensure accuracy of the following type of MCE's reporting:

- **Network Directory Accuracy:** Verifying if the provider contact details, address, in-network status, and other information listed in the directory are correct.
- **Provider Availability:** If the provider is accepting new patients and has open appointment date/time slots available.
- **Appointment Wait Times:** The earliest available appointment time offered.

Description of Data Obtained

Secret shopper activities are conducted against established network adequacy standards set by the MCE and/or regulatory agencies, which typically include maximum acceptable wait times for appointments. The data collected from secret shopper calls are analyzed to identify areas where the MCE's provider network may be lacking in accessibility and to take corrective actions, such as adding more providers or addressing issues with provider directories.

Technical Methods of Data Collection and Analysis

A non-statistical randomized oversampling of 100 PMPs and 50 obstetrics and gynecology physicians (OB/GYNs) were selected from each MCE's submitted roster of all providers. The physicians selected were based on provider type, provider specialty, location (city/county), and program type. To ensure the secret shopper calls were based on current information, the MCE's online provider directory was searched during September 2024 to verify the address, phone number, group/practice affiliation, provider availability, program/in-network status, provider type/specialty, and office hours for the providers selected for sampling.

Secret shopper calls were performed by Axon Advisors, LLC (Axon), Qsource's subcontractor. MSLC prepared a Secret Shopper Training Guide and conducted orientation and training meetings with Axon personnel. Caller scripts, data entry forms, contact details and information for the sampled providers were

also provided by MSLC for Axon's use in completing the secret shopper calls.

The PMPs were called to inquire about routine, in-person, non-urgent, appointments for a new patient, or child, if the provider was a pediatrician. The OB/GYNs were called to obtain routine, in-person, appointments for a new, not pregnant patient. Once the OB/GYN calls were completed, the OB/GYN providers were called a second time, requesting in-person appointments for a new patient in a first-trimester pregnancy.

Callers attempted to reach providers a maximum of three times during standard business hours. Each call was categorized as follows:

- **Invalid Phone Number:** The phone number was disconnected, or the phone number was for a business entity other than the physician's office, practice, or hospital/healthcare system.
- **Non-Responsive Provider:** A provider representative was not reached after attempting the call three separate times. This included being placed on hold and/or reaching a voicemail box. The caller was instructed to wait up to five minutes if placed on hold and told not to leave a voicemail if a voicemail box was reached, in order to remain anonymous as a secret shopper.
- **Completed Call:** A provider representative or other individual was reached, regardless of whether the phone number or other provider information on the caller worksheet was noted as inaccurate during the call.

The survey results were documented for each completed call using the fields and definitions set by MSLC in the Secret Shopper Training Guide and caller worksheets. The data reported reflects the status of the individual provider sampled and does not take into account other providers within the group/practice associated with the sampled provider.

The objective of the survey was to obtain an offer for the next available appointment from the provider. If an appointment date was not offered, the caller was to note the main reason for not being offered an appointment. Callers not receiving an appointment date were unable to schedule an appointment for the following reasons:

- **Provider No Longer with Group/Practice**: The provider representative stated that the provider is no longer with the medical group/practice, the provider does not serve patients at the location contacted, the provider is retired/retiring, or the stated office/practice location is closed.
- **Not Accepting Patients or Insurance**: The provider representative indicated that the provider is not accepting new patients, Medicaid, the MCE's insurance, or patients for the specified program.
- **No Routine Appointments or by Referral Only**: The provider is not scheduling routine appointments as it may be a hospitalist, oncology specialist, see OB or GYN patients only, or see patients on a case-by-case basis. The facility/practice is a walk-in clinic or urgent care facility, or the provider accepts patients by referral only.
- **Additional Information Needed**: The caller/member needs to register with the practice/healthcare system before scheduling an appointment, the provider requires the caller's medical records to be reviewed before scheduling an appointment, and/or lab work is required before scheduling an appointment.

Survey Results

Table 44 summarizes the number of providers sampled, calls completed, appointments offered, and reasons for appointments not offered by program and scenario/provider.

Table 44. Survey Results

Call Status	HHW			HIP			HCC		
	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant
Anthem									
Number of providers sampled *(denominator)*	34	16	16	33	16	15	33	18	19
Invalid phone number	3	1	2	0	2	2	6	0	0
Non-responsive provider	5	2	1	8	5	5	6	2	3
Completed call	**26**	**13**	**13**	**25**	**9**	**8**	**21**	**16**	**16**
Percentage of completed calls	**76.47%**	**81.25%**	**81.25%**	**75.76%**	**56.25%**	**53.33%**	**63.64%**	**88.89%**	**84.21%**
Provider no longer with group, at indicated location, retired or location closed	7	5	5	11	2	2	2	4	4
Not accepting new patients or MCE/program insurance	13	2	2	5	3	1	6	2	2
No routine appointments, by referral only, walk-in clinic, or not a PMP/OBGYN	0	1	1	0	0	0	1	1	2
Additional information needed to schedule an appointment	1	0	0	0	0	0	1	1	0
Appointments offered	**5**	**5**	**5**	**9**	**4**	**5**	**11**	**8**	**8**
Percentage of appointments offered	**14.71%**	**31.25%**	**31.25%**	**27.27%**	**25.00%**	**33.3%**	**33.33%**	**44.44%**	**42.11%**

Table 44. Survey Results									
Call Status	**HHW**			**HIP**			**HCC**		
	PMP	**OB/GYN Not Pregnant**	**OB/GYN Pregnant**	**PMP**	**OB/GYN Not Pregnant**	**OB/GYN Pregnant**	**PMP**	**OB/GYN Not Pregnant**	**OB/GYN Pregnant**
CareSource									
Number of providers sampled *(denominator)*	50	25	26	50	25	24			
Invalid phone number	8	3	5	8	3	4			
Non-responsive provider	8	2	1	8	3	3			
Completed call	**34**	**20**	**20**	**34**	**19**	**17**			
Percentage of completed calls	**68.00%**	**80.00%**	**76.92%**	**68.00%**	**76.00%**	**70.83%**			
Provider no longer with group, at indicated location, retired or location closed	18	7	8	11	9	10			
Not accepting new patients or MCE/program insurance	6	4	4	12	5	0			
No routine appointments, by referral only, walk-in clinic, or not a PMP/OBGYN	1	2	3	3	0	2			
Appointments offered	**9**	**7**	**5**	**8**	**5**	**5**			
Percentage of appointments offered	**18.00%**	**28.00%**	**19.23%**	**16.00%**	**20.00%**	**20.83%**			
MDwise									
Number of providers sampled *(denominator)*	50	25	25	50	25	25			
Invalid phone number	8	9	8	4	6	7			
Non-responsive provider	4	0	3	1	2	3			
Completed call	**38**	**16**	**14**	**45**	**17**	**15**			

Table 44. Survey Results									
Call Status	**HHW**			**HIP**			**HCC**		
	PMP	**OB/GYN Not Pregnant**	**OB/GYN Pregnant**	**PMP**	**OB/GYN Not Pregnant**	**OB/GYN Pregnant**	**PMP**	**OB/GYN Not Pregnant**	**OB/GYN Pregnant**
Percentage of completed calls	**76.00%**	**64.00%**	**56.00%**	**90.00%**	**68.00%**	**60.00%**			
Provider no longer with group, at indicated location, retired or location closed	11	8	6	22	9	8			
Not accepting new patients or MCE/program insurance	21	1	3	14	3	3			
No routine appointments, by referral only, walk-in clinic, or not a PMP/OBGYN	1	1	1	0	1	2			
Additional information needed to schedule an appointment	0	1	2	1	0	1			
Appointments offered	**5**	**5**	**2**	**8**	**4**	**1**			
Percentage of appointments offered	**10.00%**	**20.00%**	**8.00%**	**16.00%**	**16.00%**	**4.00%**			
MHS									
Number of providers sampled *(denominator)*	50	17	18	24	23	22	26	10	10
Invalid phone number	3	1	1	2	3	4	1	0	0
Non-responsive provider	5	1	2	0	3	2	4	0	1
Completed call	**42**	**15**	**15**	**22**	**17**	**16**	**21**	**10**	**9**
Percentage of completed calls	**84.00%**	**88.24%**	**83.33%**	**91.67%**	**73.91%**	**72.73%**	**80.77%**	**100%**	**90.0%**
Provider no longer with group, at indicated location, retired or location closed	7	2	3	0	5	6	1	3	3

Table 44. Survey Results									
Call Status	**HHW**			**HIP**			**HCC**		
	PMP	**OB/GYN Not Pregnant**	**OB/GYN Pregnant**	**PMP**	**OB/GYN Not Pregnant**	**OB/GYN Pregnant**	**PMP**	**OB/GYN Not Pregnant**	**OB/GYN Pregnant**
Not accepting new patients or MCE/program insurance	17	4	5	13	7	6	8	2	1
No routine appointments, by referral only, walk-in clinic, or not a PMP/OBGYN	2	1	0	3	0	0	0	0	0
Additional information needed to schedule an appointment	0	0	0	1	0	0	0	1	1
Appointments offered	**16**	**8**	**7**	**5**	**5**	**4**	**12**	**4**	**4**
Percentage of appointments offered	**32.00%**	**47.06%**	**38.89%**	**20.83%**	**21.74%**	**18.18%**	**46.15%**	**40.00%**	**40.00%**
UHC									
Number of providers sampled *(denominator)*							100	50	50
Invalid phone number							6	8	5
Non-responsive provider							21	8	12
Completed call							**73**	**34**	**33**
Percentage of completed calls							**73.00%**	**68.00%**	**66.00%**
Provider no longer with group, at indicated location, retired or location closed							7	1	3
Not accepting new patients or MCE/program insurance							28	8	9
No routine appointments, by referral only, walk-in clinic, or not a PMP/OBGYN							1	0	3

Table 44. Survey Results									
Call Status	HHW			HIP			HCC		
	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant
Additional information needed to schedule an appointment							1	1	2
Appointments offered							36	24	16
Percentage of appointments offered							**36.00%**	**48.00%**	**32.00%**

For Anthem, the rate of reaching a provider's representative (i.e., completed calls) with the phone number from the online directory, overall, averaged 73.50% for the three scenarios evaluated. The frequency of scheduling an appointment ranged from an overall average of 34.72% for PMPs to an overall average of 46.67% for OB/GYNs. The most prevalent reason for not obtaining an appointment was due to the provider no longer practicing at the stated directory practice/location, followed by the provider not accepting new patients and/or the MCE/program insurance.

For CareSource, the rate of completed calls using phone numbers from the online directory averaged 72.00% for the three scenarios evaluated. The frequency of appointments offered was an average of 25.00% for PMPs and 28.95% for OB/GYNs. The most prevalent reason for not obtaining an appointment was due to the provider no longer practicing at the stated directory practice/location, followed by the provider not accepting new patients and/or the MCE/program insurance.

For MDwise, the rate of completed calls using phone numbers from the online directory averaged 72.50% for the three scenarios evaluated. The frequency of appointments offered was an average of 15.67% for PMPs and 19.35% for OB/GYNs. The most prevalent reason for not obtaining an appointment was due to the provider no longer practicing at the stated directory practice/location, followed by the provider not accepting new patients and/or the MCE/program insurance.

For MHS, the rate of completed calls using phone numbers from the online directory averaged 83.50% for the three scenarios evaluated. The frequency of appointments offered was an average of 38.82% for PMPs and 39.02% for OB/GYNs. The most prevalent reason for not obtaining an appointment was due to the provider not accepting new patients and/or the MCE/program insurance, followed by the provider no longer practicing at the stated directory practice/location.

For UHC, the rate of completed calls using phone numbers from the online directory averaged 70.00% for the three scenarios evaluated. The frequency of appointments offered was an average of 49.32% for PMPs and 59.70% for OB/GYNs. The most prevalent reason for not obtaining an appointment was due to the provider not accepting new patients and/or the MCE/program insurance, followed by the provider no longer practicing at the stated directory practice/location.

Appointment Wait Times

Appointment wait times are the time from the initial request for health care services to the earliest date offered for an appointment for services. The date the completed secret shopper call was made and the date the appointment was offered were used to calculate the number of (calendar) days between the call and the appointment date. These days were compared to appointment availability standards established by the MCE. **Table 45** shows the percentage of appointments offered that met the MCE's standards.

Table 45. Appointment Wait Time Compliance

Description	HHW				HIP				HCC			
	PMP	PMP Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant
Anthem												
MCE standards* *(calendar days)*	21 days		21 days	14 days	21 days		21 days	14 days	21 days		21 days	14 days
Average Wait Time from Secret Shopper Survey *(calendar days)*	41 days		70 days	40 days	38 days		90 days	34 days	36 days		76 days	28 days
Number of appointments offered *(denominator)*	**5**		**5**	**5**	**9**		**4**	**5**	**11**		**8**	**8**
Number of appointments not meeting the standard	3		4	4	5		3	2	7		6	7
Number of appointments	2		1	1	4		1	3	4		2	1

Table 45. Appointment Wait Time Compliance

Description	HHW				HIP				HCC			
	PMP	PMP Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant
meeting the standard												
Percentage of appointments meeting the standard	**40.00%**		**20.00%**	**20.00%**	**44.44%**		**25.00%**	**60.00%**	**36.36%**		**25.00%**	**12.50%**
CareSource												
MCE standards* *(calendar days)*	14 days		30 days	30 days	14 days		30 days	30 days				
Average Wait Time from Secret Shopper Survey *(calendar days)*	36 days		42 days	18 days	44 days		70 days	56 days				
Number of appointments offered *(denominator)*	**9**		**7**	**5**	**8**		**5**	**5**				
Number of appointments not meeting the standard	6		4	0	6		3	5				
Number of appointments meeting the standard	3		3	5	2		2	0				
Percentage of appointments meeting the standard	**33.33%**		**42.86%**	**100%**	**25.00%**		**40.00%**	**0.00%**				
MDwise												
MCE standards*	90 days	30 days	90 days	30 days	90 days	30 days	90 days	30 days				

Table 45. Appointment Wait Time Compliance

Description	HHW				HIP				HCC			
	PMP	PMP Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant
(calendar days)												
Average Wait Time from Secret Shopper Survey *(calendar days)*	40 days	9 days	119 days	141 days	61 days	61 days	38 days	28 days				
Number of appointments offered *(denominator)*	**4**	1	**5**	**2**	**6**	**2**	**4**	**1**				
Number of appointments not meeting the standard	0	0	3	2	1	1	0	0				
Number of appointments meeting the standard	4	1	2	0	5	1	4	1				
Percentage of appointments meeting the standard	**100%**	**100%**	**40.00%**	**0.00%**	**83.33%**	**50.00%**	**100%**	**100%**				
MHS												
MCE standards* *(calendar days)*	90 days	30 days	90 days	30 days	90 days	30 days	90 days	30 days	90 days	30 days	90 days	30 days
Average Wait Time from Secret Shopper Survey *(calendar days)*	63 days	2 days	62 days	22 days	100 days	-	90 days	28 days	50 days	33 days	74 days	38 days
Number of appointments offered	**15**	**1**	**8**	**7**	**5**	**0**	**5**	**4**	**10**	**2**	**4**	**4**

Table 45. Appointment Wait Time Compliance

Description	HHW				HIP				HCC			
	PMP	PMP Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant
(denominator)												
Number of appointments not meeting the standard	4	0	1	1	3	0	1	1	1	2	2	3
Number of appointments meeting the standard	11	1	7	6	2	-	4	3	9	0	2	1
Percentage of appointments meeting the standard	**73.33%**	**100%**	**87.50%**	**85.71%**	**40.00%**	**-**	**80.00%**	**75.00%**	**90.00%**	**0.00%**	**50.00%**	**25.00%**
UHC												
MCE standards* *(calendar days)*									90 days	30 days	90 days	30 days[2]
Average Wait Time from Secret Shopper Survey *(calendar days)*									64 days	29 days	59 days	23 days
Number of appointments offered *(denominator)*									**26**	**10**	**24**	**16**
Number of appointments not meeting the standard									6	4	5	2
Number of appointments									20	6	19	14

Table 45. Appointment Wait Time Compliance

Description	HHW				HIP				HCC			
	PMP	PMP Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant
meeting the standard												
Percentage of appointments meeting the standard									**76.92%**	**60.00%**	**79.17%**	**87.50%**

**MCE appointment standards are stated in terms of months. For evaluative purposes, 30 days equals one month.*

Overall, 31.67% of Anthem's appointments offered were within the MCE's wait time standards. The data reported reflects the status of the individual provider sampled and does not take into account earlier appointments that may have been offered with other providers within the group/practice contacted.

Overall, 38.46% of CareSource's appointments offered were within the MCE's wait time standards. The data reported reflects the status of the individual provider sampled and does not take into account earlier appointments that may have been offered with other providers within the group/practice contacted.

Overall, 72.00% of MDwise's appointments offered were within the MCE's wait time standards. The data reported reflects the status of the individual provider sampled and does not take into account earlier appointments that may have been offered with other providers within the group/practice contacted.

Overall, 70.77% of MHS's appointments offered were within the MCE's wait time standards. The data reported reflects the status of the individual provider sampled and does not take into account earlier appointments that may have been offered with other providers within the group/practice contacted.

Overall, 77.63% of UHC's appointments offered were within the MCE's wait time standards. The data reported reflects the status of the individual provider sampled and does not take into account earlier appointments that may have been offered with other providers within the group/practice contacted.

Provider Directory Inaccuracies

Certain online provider directory information for the providers sampled was verified with the provider representatives during the secret shopper survey. **Table 46** summarizes the inaccurate results of the provider's directory information verified, based on the provider

representative's response. Providers who were non-responsive were excluded, as the directory information may have been correct, but the calls were not answered to validate the information. Multiple inaccuracies may be noted for the individual providers contacted; however, each provider was assigned only one category, as the call may have ended if the phone number was incorrect, the provider was no longer affiliated with the group/practice, not accepting new patients, etc.

Table 46. Provider Directory Inaccuracies

Description	HHW		HIP		HCC	
	PMP	OB/GYN	PMP	OB/GYN	PMP	OB/GYN
Anthem						
Number of providers sampled	34	32	33	31	33	70
Non-responsive providers	5	3	8	10	6	11
Number of providers evaluated *(denominator)*	**29**	**29**	**25**	**21**	**27**	**59**
Phone Number (incorrect and/or Invalid)	4	6	0	4	9	3
Group Affiliation	7	9	11	4	1	8
Accepting/Not Accepting New Patients	5	8	6	5	5	11
Provider Type/Specialty	3	0	0	0	1	1
Service Location	0	1	0	1	4	2
Office Hours	0	0	0	0	0	0
Number of providers with at least one provider directory inaccuracy	**19**	**24**	**17**	**14**	**20**	**25**
Percentage of providers with at least one provider directory inaccuracy	**65.52%**	**82.76%**	**68.00%**	**66.67%**	**74.07%**	**78.13%**
CareSource						
Number of providers sampled	50	51	50	49		
Non-responsive providers	8	3	8	6		
Number of providers evaluated *(denominator)*	**42**	**48**	**42**	**43**		

Table 46. Provider Directory Inaccuracies						
Description	**HHW**		**HIP**		**HCC**	
	PMP	**OB/GYN**	**PMP**	**OB/GYN**	**PMP**	**OB/GYN**
Phone Number (incorrect and/or Invalid)	16	15	11	10		
Group Affiliation	11	14	5	16		
Accepting/Not Accepting New Patients	5	6	6	4		
Provider Type/Specialty	2	4	8	2		
Service Location	6	1	5	5		
Office Hours	0	0	0	1		
Number of providers with at least one provider directory inaccuracy	**40**	**40**	**35**	**38**		
Percentage of providers with at least one provider directory inaccuracy	**95.24%**	**83.33%**	**83.33%**	**88.37%**		
MDwise						
Number of providers sampled	50	50	50	50		
Non-responsive providers	4	3	1	5		
Number of providers evaluated *(denominator)*	**46**	**47**	**49**	**45**		
Phone Number (incorrect and/or Invalid)	9	19	8	18		
Group Affiliation	11	13	21	15		
Accepting/Not Accepting New Patients	14	9	7	5		
Provider Type/Specialty	8	2	8	4		
Service Location	1	1	3	0		
Office Hours	0	0	0	0		
Number of providers with at least one provider directory inaccuracy	**43**	**44**	**47**	**42**		

Table 46. Provider Directory Inaccuracies						
Description	**HHW**		**HIP**		**HCC**	
	PMP	**OB/GYN**	**PMP**	**OB/GYN**	**PMP**	**OB/GYN**
Percentage of providers with at least one provider directory inaccuracy	**93.48%**	**93.62%**	**95.92%**	**93.33%**		
MHS						
Number of providers sampled	50	35	24	45	26	20
Non-responsive providers	5	3	0	5	4	1
Number of providers evaluated *(denominator)*	**45**	**32**	**24**	**40**	**22**	**19**
Phone Number (incorrect and/or Invalid)	7	6	2	12	3	1
Group Affiliation	4	5	0	9	0	6
Accepting/Not Accepting New Patients	12	9	12	14	2	4
Provider Type/Specialty	4	0	2	0	3	0
Service Location	0	0	0	0	0	0
Office Hours	0	2	0	1	0	1
Number of providers with at least one provider directory inaccuracy	**27**	**22**	**16**	**36**	**8**	**12**
Percentage of providers with at least one provider directory inaccuracy	**60.00%**	**68.75%**	**66.67%**	**90.00%**	**36.36%**	**63.16%**
UHC						
Number of providers sampled					100	100
Non-responsive providers					21	20
Number of providers evaluated *(denominator)*					**79**	**80**
Phone Number (incorrect and/or Invalid)					10	14
Group Affiliation					5	4

Table 46. Provider Directory Inaccuracies

Description	HHW		HIP		HCC	
	PMP	OB/GYN	PMP	OB/GYN	PMP	OB/GYN
Accepting/Not Accepting New Patients					26	15
Provider Type/Specialty					7	6
Service Location					0	7
Office Hours					0	4
Number of providers with at least one provider directory inaccuracy					**48**	**50**
Percentage of providers with at least one provider directory inaccuracy					**60.76%**	**62.50%**

Anthem

Just over half of all providers sampled from Anthem's directories (51.07%) had at least one inaccurate data element reflected in the MCE's online provider directory. The information reported was incorrect for 69.14% of the PMPs contacted and 57.80% of the OB/GYNs contacted. Contacted providers accepting and/or not accepting new patients, Medicaid members/patients, and/or the MCE/program insurance was the largest inconsistency for OB/GYN (22.02%) providers. For the contacted PMPs, the greatest discrepancy was providers no longer affiliated with the group/practice (23.46%).

The following observations were noted during the verification process:

- **Phone Number:** Of the providers with incorrect phone numbers, 10 of the calls were transferred by the provider representative, reached from the phone number listed in the directory and/or alternate phone numbers were offered.
- **Group Affiliation:** Of the providers no longer affiliated with the group/practice, four OB/GYN and two PMP provider representatives offered an appointment with another provider within the group/practice.
- **Accepting/Not Accepting New Patients:** Of the providers with inaccurate patient status information, seven OB/GYN and five PMP provider representatives offered an appointment with another provider within the group/practice.
- **Provider Type/Specialty:** The providers were identified as PMP or OB/GYN providers in Anthem's provider roster; however, the providers with provider type/specialty inconsistencies were identified as hospitalists, infectious disease, emergency medicine, or oncology (etc.) specialists in the online provider directory or by the provider representative.

- **Office Hours**: Of the providers sampled, 68 did not have office hours listed in the provider directory. For the providers with office hours listed, the hours noted in Anthem's online provider directory were correct.

CareSource

The majority of the providers sampled from CareSource's directories (76.50%) had at least one inaccurate data element reflected in the MCE's online provider directory. The information reported was incorrect for 89.29% of the PMPs contacted and 85.71% of the OB/GYNs contacted. Invalid or incorrect phone numbers were the largest discrepancy for the PMP providers (32.14%), and providers no longer affiliated with the group/practice was the greatest inconsistency for the OB/GYN providers (32.97%).

The following observations were noted during the verification process:

- **Phone Number**: Of the providers with incorrect phone numbers, 21 of the calls were transferred by the provider representative, reached from the phone number listed in the directory and/or alternate phone numbers were offered.
- **Group Affiliation**: Of the providers no longer affiliated with the group/practice, seven OB/GYN provider representatives offered an appointment with another provider within the group/practice. No other appointments were offered with the PMP providers.
- **Accepting/Not Accepting New Patients**: Of the providers with inaccurate patient status information, one OB/GYN provider representatives offered an appointment with another provider within the group/practice. No other appointments were offered with the PMP providers.
- **Provider Type/Specialty**: The providers were identified as PMP or OB/GYN providers in the MCE's provider roster; however, the providers with provider type/specialty inconsistencies were identified as hospitalists, cardiologists, or sports/orthopedic specialists/physicians (etc.) in the online provider directory or by the provider representative.
- **Office Hours**: Three of the providers sampled did not have office hours listed in the provider directory. Of the providers with office hours listed, one of the OB/GYN provider's office hours were incorrect.

MDwise

The majority of the providers sampled from MDwise's directories (94.12%) had at least one inaccurate data element reflected in the MCE's online provider directory. The information reported was incorrect for 94.74% of the PMPs surveyed and 93.48% of the OB/GYNs surveyed. Providers no longer affiliated with the group/practice was the greatest inconsistency for the PMP providers (33.68%) and invalid or incorrect phone numbers were the largest discrepancy for the OB/GYN providers (40.22%).

The following observations were noted during the verification process:

- **Phone Number**: Of the providers with incorrect phone numbers, 12 of the calls were transferred by the provider representative reached from the phone number listed in the directory and/or alternate phone numbers were offered.
- **Group Affiliation**: Of the providers no longer affiliated with the group/practice, three OB/GYN and one PMP provider representatives offered an appointment with another provider within the group/practice.

- **Accepting/Not Accepting New Patients**: Of the providers sampled, 133 had patient status information listed as unknown in the MCE's provider directory. Of the providers with unknown patient status, 7 PMP and 15 OB/GYN providers were accepting new patients and 32 PMP and 10 OB/GYN providers were not accepting new patients. The patient status remained unknown for the other 69 providers, as they had incorrect or invalid phone numbers, or were no longer with the group/practice.
- **Provider Type/Specialty**: The providers were identified as PMP or OB/GYN providers in the MCE's provider roster; however, the providers with provider type/specialty inconsistencies were identified as hospitalists, oncologists, or other specialty physicians in the online provider directory or by the provider representative.
- **Office Hours**: Five of the providers sampled did not have office hours listed in the provider directory.

MHS

Over half of all providers sampled from MHS's directories (67.22%) had at least one inaccurate data element reflected in the MCE's online provider directory. The information reported was incorrect for 56.04% of the PMPs contacted and 76.92% of the OB/GYNs contacted. Providers accepting and/or not accepting new patients, Medicaid members/patients, and/or the IHCP/program insurance was the largest inconsistency for both the PMP (28.57%) and OB/GYN (29.67%) providers.

The following observations were noted during the verification process:

- **Phone Number**: Of the providers with incorrect phone numbers, 17 of the calls were transferred by the provider representative reached from the phone number listed in the directory and/or alternate phone numbers were offered.
- **Group Affiliation**: Of the providers no longer affiliated with the group/practice, one OB/GYN provider representatives offered an appointment with another provider within the group/practice. No other appointments were offered with the PMP providers.
- **Accepting/Not Accepting New Patients**: Of the providers with inaccurate patient status information, 10 of the 53 providers were not accepting Medicaid, the program, or the MCE's insurance, and 8 of the 53 provider representatives offered an appointment with another provider within the group/practice.
- **Provider Type/Specialty**: The providers were identified as PMP or OB/GYN providers in the MCE's provider roster; however, the providers with provider type/specialty inconsistencies were identified as hospitalists, infectious disease, emergency medicine, pulmonology or chronic illness (etc.) specialists in the online provider directory or by the provider representative.
- **Office Hours**: All of the providers sampled had office hours listed in the provider directory; however, the hours listed were not correct for four of the providers sampled.

UHC

Just under half of all providers sampled from UHC's directories (49.00%) had at least one inaccurate data element reflected in the MCE's online provider directory. The information reported was incorrect for 60.76% of the PMPs contacted and 62.50% of the OB/GYNs contacted. Providers accepting and/or not accepting new patients, Medicaid members/patients, and/or the

MCE/program insurance was the largest inconsistency for both PMPs (54.17%) and OB/GYNs (18.75%).

The following observations were noted during the verification process:

- **Phone Number**: Of the providers with incorrect phone numbers, eight of the calls were transferred by the provider representative reached from the phone number listed in the directory and/or alternate phone numbers were offered.
- **Group Affiliation**: Of the providers no longer affiliated with the group/practice, provider representatives did not offer an appointment with another provider within the group/practice.
- **Accepting/Not Accepting New Patients**: Of the providers with inaccurate patient status information, seven of the PMP and seven of the OB/GYN provider representatives offered an appointment with another provider within the group/practice.
- **Provider Type/Specialty**: The providers were identified as PMP or OB/GYN providers in the MCE's provider roster; however, the providers with provider type/specialty inconsistencies were identified as hospitalists, ER physicians, travel physicians, or hematology specialists (etc.) in the online provider directory or by the provider representative.
- **Office Hours**: 20 of the providers sampled did not have office hours listed in the provider directory. Of the providers with office hours listed, four of the OB/GYN providers' office hours were incorrect.

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. 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 47**, all MCEs were compliant with the geographic accessibility standard.

Table 47. Strengths and AONs

Anthem	**Strengths**	
	HHW, HIP, and HCC	♦ Anthem met the requirements for provider-to-member ratios on 100% of the provider service types. ♦ Anthem met the provider accessibility standards for 98.09% of its members. ♦ Anthem had a 99.60% match rate on its provider directory service locations compared to its submitted provider data.
	AONs	

Table 47. Strengths and AONs

	HHW, HIP, and HCC	♦ Anthem did not meet the provider accessibility standards on the following provider service types: ▪ HHW Program • Acute Care Hospitals • Behavioral Health Providers • Diagnostic Testing • DME • Dentists • Home Health Providers • Inpatient Psychiatric Facilities • Orthodontists ▪ HIP Program • Acute Care Hospitals • Behavioral Health Providers • Diagnostic Testing • DME • Dentists • Home Health Providers • Inpatient Psychiatric Facilities • Orthodontists ▪ HCC Program • Acute Care Hospitals • Behavioral Health Providers • Diagnostic Testing • DME • Home Health Providers • Inpatient Psychiatric Facilities • Orthodontists
CareSource	**Strengths**	
	HHW and HIP	♦ CareSource met the requirements for provider to member ratios on 100% of the provider service

Table 47. Strengths and AONs

		types. ♦ CareSource met the provider accessibility standards for 96.37% of its members. ♦ CareSource had a 96.15% match rate on its provider directory service locations compared to its submitted provider data.
	AONs	
	HHW and HIP	♦ CareSource did not meet the provider accessibility standards on the following provider service types: ▪ HHW Program: • Oral Surgeons • Diagnostic Testing • DME • Endocrinologists • Dentists • Home Health Providers • Inpatient Psychiatric Facilities • Orthodontists • Pharmacy ▪ HIP Program: • Oral Surgeons • Diagnostic Testing • DME • Endocrinologists • Dentists • Home Health Providers • Inpatient Psychiatric Facilities • Orthodontists • Pharmacy
MDwise	**Strengths**	
	HHW and HIP	♦ MDwise met the requirements for provider to member ratios on 100% of the provider service

Table 47. Strengths and AONs

		types. ♦ MDwise met the provider accessibility standards for 93.54% of its members. ♦ MDwise had a 99.80% match rate on its provider directory service locations compared to its submitted provider data.
	AONs	
	HHW and HIP	♦ MDwise did not meet the provider accessibility standards on the following provider service types: ▪ HHW Program: • Oral Surgeons • Diagnostic Testing • DME • Gastroenterologists • Dentists • Home Health Providers • Inpatient Psychiatric Facilities • Orthodontists ▪ HIP Program: • Acute Care Hospitals • Oral Surgeons • Diagnostic Testing • DME • Gastroenterologists • Dentists • Home Health Providers • Inpatient Psychiatric Facilities • Orthodontists
MHS	**Strengths**	
	HHW, HIP, and HCC	♦ MHS met the requirements for provider-to-member ratios on 100% of the provider service types. ♦ MHS met the provider accessibility standards for 97.90% of its members. ♦ MHS had a 99.80% match rate on its provider directory service locations compared to its

Table 47. Strengths and AONs

		submitted provider data.
	AONs	
	HHW, HIP, and HCC	♦ MHS did not meet the provider accessibility standards on the following provider service types: ▪ HHW Program: • Acute Care Hospitals • Oral Surgeons • Diagnostic Testing • Durable Medical Equipment • Endocrinologists • Dentists • Home Health Providers • Inpatient Psychiatric Facilities • Orthodontists • Otolaryngologists ▪ HIP Program: • Acute Care Hospitals • Oral Surgeons • Diagnostic Testing • Durable Medical Equipment • Endocrinologists • Dentists • Home Health Providers • Inpatient Psychiatric Facilities • Orthodontists • Otolaryngologists ▪ HCC Program: • Oral Surgeons • Diagnostic Testing • Durable Medical Equipment

Table 47. Strengths and AONs		
		• Endocrinologists • Dentists • Home Health Providers • Orthodontists • Otolaryngologists
UHC	**Strengths**	
	HCC	♦ UHC met the requirements for provider to member ratios on 92.31% of the provider service types. ♦ UHC met the provider accessibility standards for 91.10% of its members. ♦ UHC had a 99.92% match rate on its provider directory service locations compared to its submitted provider data.
	AONs	
	HCC	♦ UHC did not meet the provider accessibility standards on the following provider service types: ▪ HCC Program: • Acute Care Hospitals • Oral Surgeons • Diagnostic Testing • DME • Dentists • Home Health Providers • Inpatient Psychiatric Facilities • Occupational Therapists • Orthodontists • Prosthetic Suppliers • Rheumatologists • Speech Therapists

Improvements

Table 48 displays the rating criteria for the degree to which the plan addressed the MY 2022 recommendations.

Table 48. Improvement Rating Criteria

Rating	Criteria
High	Recommendations were fully addressed.
Medium	Recommendations were partially addressed.
Low	Recommendations were not addressed.
Not Applicable	No comparison was available.

Table 49 displays the degree to which the plan addressed the previous year's AONs. Only plans that received AONs in the previous MY are included in the table.

Table 49. MY 2022 Recommendations Addressed in MY 2023

MY 2022 Recommendations	MY 2023 Results	Degree to Which Plan Addressed Recommendation(s)
Anthem		
Anthem did not meet the geographic accessibility standard of one OB/GYN provider within 30 miles for 100% of their HHW, HIP, and HCC female enrollees. Anthem should look at improving access for this standard in the following counties: Fountain, Perry, Pulaski, Spencer, Starke, Vermillion, and Warren.	♦ While Anthem met the geographic accessibility standard of one OBGYN provider within 60 miles, the results did not include providers of the same type within 30 miles for their HHW, HIP, and HCC female enrollees.	Not Applicable
CareSource		
None noted.	♦ NA	Not Applicable
MDwise		
None noted.	♦ NA	Not Applicable
MHS		

Table 49. MY 2022 Recommendations Addressed in MY 2023

MY 2022 Recommendations	MY 2023 Results	Degree to Which Plan Addressed Recommendation(s)
MHS did not meet the geographic accessibility standard of one OB/GYN provider within 30 miles for 100% of their HHW, HIP, and HCC female enrollees. MHS should look at improving access for this standard in the following counties: Benton, Fountain, Owen, Pulaski, Putnam, Switzerland, Vermillion, and Warren.	♦ While Anthem met the geographic accessibility standard of one OBGYN provider within 60 miles, the results did not include providers of the same type within 30 miles for their HHW, HIP, and HCC female enrollees.	Not Applicable
UHC		
UHC did not meet the geographic accessibility standard of one OB/GYN provider within 30 miles for 100% of its HCC female enrollees. UHC should look at improving access for this standard in the following counties: Fountain, Parke, Perry, Sullivan, and Switzerland.	♦ While UHC met the geographic accessibility standard of one OBGYN provider within 60 miles, the results did not include providers of the same type within 30 miles for their HCC female enrollees.	Not Applicable

Conclusions and Recommendations

The MCEs demonstrated a shared strength for maintaining greater than 90.00% on the provider accessibility standard.

Recommendations

1. The MCEs are encouraged to maintain accurate provider lists in all member materials and ensure service locations are correct, which will improve member accessibility.
2. 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.
3. Qsource suggests that each MCE use the total count of providers available against the total count of providers contracted within the IHCP for accurate benchmarking.
4. Qsource suggests that MCEs continue to monitor their provider network and implement corrective action for identified deficiencies.

Protocol 9: Conducting Focus Studies of Health Care Quality

Overview

OMPP engaged Qsource to perform the CMS mandatory and optional EQR activities. Qsource engaged Myers and Stauffer to assist in the EQR, which included designing and conducting Indiana's Protocol 9 activities, evaluating MCE clinical and non-clinical performance. For Protocol 9, OMPP selected two focus study topic areas for CY 2023:

- Extent and Impact of MCE Value-Based Purchasing (VBP) Arrangements with Providers; and
- MCE Relationship and Engagement Strategies with Hospitals.

For each study, Myers and Stauffer used a mixed method study design to collect quantitative and qualitative data to address each study's objectives. This report provides an introduction to the EQR, as well as national and state background information, detailed methodology, a comprehensive synthesis of all data collected and analyzed, and key findings and recommendations for each study.

Study 1 Background

OMPP has three strategic goals, as part of its Triple AIM structure, which strive to (1) reduce costs, (2) reduce utilization, and (3) improve member satisfaction. VBP program implementation could potentially support achievement of these overarching goals. Currently, however, the broad structure and extent of VBP program use and impact—from Indiana Medicaid through MCE to the Provider—is unknown. Therefore, the purpose of this focus study was to begin aggregating, synthesizing, and formulating an understanding of the IN Medicaid Managed Care VBP landscape by evaluating the outlined objectives.

Study 1 Purpose and Objectives

The purpose of Focus Study 1 was to evaluate and compare the extent and impact of MCEs VBP arrangements with providers, during CY 2023. Specifically, the objectives of the study were to address the following questions for CY 2023:

1. What is the current landscape of VBP models?
2. How do MCEs compare in moving from payment for volume to transitioning to payment for value?
3. What contracting mechanisms exist between MCEs and providers according to the Health Care Payment Learning & Action Network (HCP-LAN) framework?

Technical Methods of Data Collection and Analysis

The study evaluated the five MCEs approach to VBP arrangements with providers across the Indiana Medicaid program during CY 2023. This study was conducted in accordance with the 2023 CMS External Quality Review Protocols Guide. The data analysis and findings are organized into six major subsections: (1) Current VBP Landscape; (2) VBP

Program Contracts; (3) Incentive Payment Distributions; (4) Key Infrastructure for Supporting a Shift to VBP; (5) Enablers and Barriers to VBP Adoption; (6) OMPP and MCE Evaluation of Current VBP Programs. These subsections are structured to evaluate study objectives through a review of MCE submitted documents, self-reported survey data, and context gleaned from the key informant interview with OMPP staff.

Description of Data Obtained

A mixed method study design was used to collect quantitative and qualitative data to address the study objectives. MCEs were requested to (1) complete a 16 question self-report survey about MCE-level processes, perceptions, and finances related to the MCEs VBP initiatives; (2) submit report 0805 Physician Incentive Plans; and (3) submit 10 sample provider contracts with a VBP arrangement in place for each health program the MCE serves. A minimum submission review (MSR) was performed to ensure all requested information was received, accessible, and relevant. When issues occurred, the MCE was contacted to submit updated information through a Request for Information (RFI) process. Complete data were organized and analyzed by study objective and are presented in the findings section of the report. Additionally, an interview was conducted with OMPP staff to gather valuable insights on OMPP Quality Strategy goals and use of VBP arrangements, OMPP perceptions of current arrangements, and specific details related to current VBP arrangements. Following interview completion, the transcribed interview was reviewed and evaluated. Information collected during the interview was also compared to information submitted by MCEs and used to supplement those data, as appropriate.

Findings

Enhancing VBP program implementation could potentially support advancing OMPP overarching goals. As yet, the broad structure and extent of VBP program use and impact—from Indiana Medicaid through MCE to the Provider—was unknown. Therefore, data were used to begin aggregating, synthesizing, and formulating an understanding of the IN Medicaid Managed Care VBP landscape.

Overall, some movement is occurring in Indiana Medicaid Managed Care toward VBP adoption. While most MCEs have developed VBP-related strategic plans, and quality improvement and provider incentive programs exist, an OMPP-specific VBP goal is missing to guide programs and targets.

The majority of MCE VBP programs and reported provider contracts were pay-for-performance based. While the majority of incentive payments distributed to providers came from a shared risk arrangement as a result of a single contract. When assessing provider types engaged in VBP arrangements, primary care providers appear to be most engaged. Additionally, primary care providers were the only provider type in which all MCEs reported some engagement in a VBP arrangement.

Notably, the top barriers and enablers for VBP adoption were aligned. Enablers and barriers related to incentives/contract requirements and partnerships/collaboration reflected opposite ends of the spectrum, giving concrete issues to address to help facilitate VBP adoption.

Finally, while MCE evaluation of current VBP programs met their expected outcomes and seem to align with state goals, an internal OMPP evaluation indicated the Payment-for-Outcome (P4O) program may not be having the desired effect and reevaluation may be warranted. OMPP also noted clearer expectations and clarifications around VBP programs are needed.

Strengths, Weaknesses, and Conclusions

Overall, there is some movement occurring in Indiana Medicaid Managed Care toward VBP adoption. While most MCEs have developed VBP-related strategic plans and quality improvement and provider incentive programs exist, an OMPP-specific VBP goal to guide programs and targets is missing.

The majority of MCE VBP programs and reported provider contracts fall into HCP-LAN category of Pay-for-Performance. While the majority of incentive payments distributed to providers came from contracts in category 3B, this is attributed to a large 3B contract with MDwise. MDwise also distributed the most incentive payments to providers in CY23. Primary care providers appear to be most engaged when assessing provider types engaged in VBP arrangements (although this category also included urgent care providers and pediatricians). This was reflected in both the sample provider contracts submitted and the MCE survey responses. And primary care providers were the only provider type in which all MCEs reported some engagement in a VBP arrangement.

Key infrastructure components related to successfully shifting towards VBP at the MCE and MCE-to-Provider level were also assessed. Responses by MCEs on demographic data collection processes, data sharing capabilities and data lags, and stakeholder engagement varied. Responses indicated MCEs are in different places from an infrastructure perspective, as some have processes to identify demographic factors, most but not all have data sharing systems in place, all reported data lags, and all reported different means of communicating with providers on performance and VBP-related training.

Notably, top barriers and enablers for VBP adoption were aligned. With enablers and barriers related to incentives/contract requirements and partnerships/collaboration, reflecting opposite ends of the spectrum—giving concrete issues to address to help facilitate VBP adoption.

Finally, while MCE evaluation of current VBP programs met their expected outcomes and seem to align with state goals, an internal OMPP evaluation indicated the P4O program may not be having the desired effect and reevaluation may be warranted. OMPP also noted clearer expectations and clarifications around VBP programs are needed.

Recommendations

- Establish OMPP-specific VBP goals and targets, and establish an OMPP-specific VBP Adoption Strategic Plan;
- Develop policies that encourage or mandate the adoption of VBP models using clear and concise language for how they should be adopted/implemented;
- Update existing VBP program language, performance metrics, and targets to ensure alignment with newly established OMPP-specific VBP goals and targets, and to ensure clarity;
- Encourage MCEs to strengthen (or establish) VBP strategic plans to prepare for VBP expansion and movement across the HCP-LAN Framework Continuum, and to set clear and measurable goals;
- Establish mechanisms for regular evaluation of the use and impact of VBP arrangements;
- Strengthen stakeholder engagement between OMPP and MCEs as well as between MCEs and Providers—strong collaboration and partnership is key to successful adoption and implementation;
- Encourage and support enhancing MCE and Provider infrastructure to aid in the transition to value-based care.

Study 2 Background

The delivery of high-value, cost-effective health care requires the collaboration of multiple key stakeholders, notably hospitals and health plans. Both entities play a critical role in the patient care continuum, managing aspects such as care delivery, payment, and care management. Together, health plans and hospitals significantly shape the value, cost, and quality of care. However, the reality is health care often operates in silos, leading to fragmented care, increased costs, and redundant or unnecessary services. To mitigate these challenges and ensure the delivery of high-value care, hospitals and health plans must align on goals related to quality and clinical outcome through processes such as care coordination, utilization management, and quality improvement initiatives. This alignment is essential to streamlining patient care and harmonizing efforts across both sectors.

Achieving and maintaining alignment between hospitals and health plans is an ongoing process, as health care markets and patient needs are dynamic and continuously evolving. Consistent collaboration and engagement between the parties is necessary. Engagement can take on many forms of interaction such as data exchange, virtual or in-person meetings, site visits, and committee assemblies. While the format and frequency of engagement are important, equally critical is the substance of these interactions. Recommended areas of focus include utilization management, care management, quality improvement programs, value-based payment models, quality measures, and interoperability. Engagement in these key areas fosters alignment between hospitals and health plans.

Another factor influencing engagement between hospitals and health plans is ownership structure. Ownership here refers to the rights to control and benefit from a health plan or hospital, and it is possible for there to be multiple owners, resulting in complex ownership arrangements. These arrangements, whether

non-profit, for-profit, government-owned, or partnerships, can impact how hospitals and health plans engage with each other.

Study 2 Purpose and Objectives

The purpose of Focus Study 2 was to evaluate and compare the MCEs relationship and engagement strategies with hospitals in CY 2023.

Specifically, the objectives of the study were to address the following questions for CY 2023:

- For the CY 2023, how do MCEs compare in routine engagement strategies with hospitals?
- What format and frequency does engagement exist as reported by MCEs and as reported by hospitals?
- Is there a demonstrated difference based on ownership arrangements, financial incentive, or geography?

Technical Methods of Data Collection and Analysis

The study evaluated the five MCEs' approach to VBP arrangements with providers across the Indiana Medicaid program during CY 2023. This study was conducted in accordance with the 2023 CMS External Quality Review Protocols Guide. The data analysis and findings are organized into six major subsections: (1) Current VBP Landscape; (2) VBP Program Contracts; (3) Incentive Payment Distributions; (4) Key Infrastructure for Supporting a Shift to VBP; (5) Enablers and Barriers to VBP Adoption; (6) OMPP and MCE Evaluation of Current VBP Programs. These subsections are structured to evaluate study objectives through a review of MCE-submitted documents, self-reported survey data, and context gleaned from the key informant interview with OMPP staff.

Description of Data Obtained

A mixed method study design was used to collect quantitative and qualitative data to address the study objectives. MCEs were requested to complete a 16 question self-report survey about MCE-level processes, perceptions, and finances related to the MCEs VBP initiatives; submit report *0805 Physician Incentive Plans*; and submit 10 sample provider contracts with a VBP arrangement in place for each health program the MCE serves. A MSR was performed to ensure all requested information was received, accessible, and relevant. When issues occurred, the MCE was contacted to submit updated information through an RFI process. Complete data were organized and analyzed by study objective and are presented in the findings section of the report. Additionally, an interview was conducted with OMPP staff to gather valuable insights on OMPP Quality Strategy goals and use of VBP arrangements, OMPP perceptions of current arrangements, and specific details related to current VBP arrangements. Following interview completion, the transcribed interview was reviewed and evaluated. Information collected during the interview was also compared to information submitted by MCEs and used to supplement those data, as appropriate.

Findings

The delivery of high-value, cost-effective health care requires the collaboration of multiple stakeholders, notably hospitals and health plans. Both entities play a critical role in the patient care experience and together shape the value, cost and quality of care delivered. Achieving and maintaining engagement between hospitals and health plans is an ongoing process that can take on many forms (e.g., utilization management, quality improvement programs, community health engagement, care management, provider incentive programs, and participation in governance). The level of engagement and overall success is influenced by a variety of factors, including ownership arrangements, operational priorities, data infrastructure, geography, and financial incentives.

Engagement between MCEs and hospitals in Indiana is shaped by a complex relationship involving ownership arrangements, operational priorities, incentive programs, and data-sharing initiatives. There are areas of alignment and gaps that persist in these interactions. The healthcare market in Indiana has seen significant consolidation, directly influenced engagement strategies and shaped both financial dynamics and responsibilities. MCEs and hospitals both recognize the importance of engagement, but there is a misalignment regarding their perceptions of engagement levels and outcomes. This signals a need for MCEs to recalibrate their engagement strategies to better align with hospitals' operational challenges. Addressing these alignment gaps and refining engagement strategies is essential to foster collaboration, drive improved outcomes, and advance Indiana's healthcare goals.

Strengths, Weaknesses, and Conclusions

Of the five MCEs in Indiana, three are for-profit entities that hold some 67% of Medicaid enrollment. This distinction impacts engagement strategies. For-profit entities are apt to prioritize efficiency and financial outcomes, while non-profit organizations are apt to focus more on patient care and community health initiatives. Although MCEs in Indiana do not own hospital systems, several hospitals do hold ownership stakes in health plans, notably SIHO and Indiana University Health Plans. These ownership structures have the potential to influence engagement dynamics. Nonetheless, mutual ownership relationships could offer strategic opportunities for engagement in the future.

Self-reported engagement levels reveal a notable disconnect in perception between MCEs and hospitals. While Anthem, MDwise, and MHS rate their engagement as high and CareSource and UHC as medium, 43% of hospitals report low or very low engagement with MCEs. Common barriers to engagement included conflicting priorities, limited buy-in, and lack of interoperability. These overlapping concerns suggest that broader strategic changes in engagement are necessary to address these issues effectively.

Both MCEs and hospitals display an understanding of the importance of robust data-sharing mechanisms for engagement.

However, within this, MCEs prioritize electronic health system integration, while hospitals focus priorities on admission, discharge, and transfer (ADT) information. Systemic challenges exist within data-sharing such as incomplete hospital connections to Health Information Exchanges (HIEs) and the suboptimal quality of messages. These obstacles stand in the way of realizing the full potential of data-sharing.

Both MCEs and hospitals express interest in expanding value-based care; however, perceived outcomes from these initiatives are limited. For example, reducing hospital readmissions, a key goal of the OMPP's 2024 Quality Strategy, was among the least reported outcomes by both MCEs and hospitals. This signals a need for MCEs to recalibrate their engagement strategies to better align with hospitals' operational challenges. Addressing these alignment gaps and refining engagement strategies is essential to foster collaboration, drive improved outcomes, and advance Indiana's healthcare goals.

Recommendations

- Encourage MCEs to establish clear communication pathways and increase transparency with hospitals, with a particular emphasis on rural hospitals.
- Encourage MCEs to enhance data-sharing processes, including HIE connectivity, improving ADT message quality, and creating consistent messaging practices.
- Develop policies that account for ownership dynamics to encourage increased engagement.
- Encourage MCEs to recalibrate engagement strategies to better align with hospitals' operational realities, rather than rely on broad, one-size-fits-all initiatives.
- Establish mechanisms to monitor and assess MCE-hospital alignment and engagement with OMPP's established goals.
- Encourage MCEs to establish clear expectations with hospitals for roles, priorities, and performance metrics to foster better alignment and efficiency in engagements.
- Encourage MCEs to strengthen and expand VBP arrangements with hospitals, establishing clear shared goals and priority areas.

2024 EQR Conclusions and Recommendations

Qsource conducted mandatory EQR activities for the OMPP program for MY 2023. Each of CMS's EQR Protocols is a learning opportunity for the MCEs and OMPP. Qsource used a collaborative approach to assist the state and MCEs with developing best practices for future reviews and ensuring enrollee quality of care was paramount. Qsource is available to collaborate with OMPP and directly assist the MCEs in accomplishing the following recommendations for improvement.

To improve the quality of health for all enrollees, Qsource made the following recommendations.

QIP Validation

One of OMPP's goals is to continuously monitor quality improvement measures and strive to maintain high standards to improve the health of enrollees. OMPP contractually requires the MCEs to complete QIPs yearly. 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, which compromised Qsource's ability to evaluate and draw conclusions from the results and the validity of the study. MCEs used a Qsource developed QIP Summary Form (with accompanying QIP Summary Form Completion Instructions) and a QIP Validation Tool to standardize the process by which each MCE delivers QIP information to OMPP and Qsource quarterly and annually, respectively, and how the information was assessed. Although improvements are still needed in the submission of QIP data and progress measurement, the MCEs have shown moderate improvement. Qsource views the results as a learning opportunity for the MCEs and will assist in education to achieve better results next measurement year. OMPP should continue to monitor the MCEs' QIPs as part of its Quality Strategy to ensure quality, timeliness, and access to care for its enrollees.

PMV

PMV is designed to assess the accuracy of reported quality and performance measures and determine the extent to which the reported rates follow the measure specifications and reporting requirements. Qsource validated processes and systems to determine the MCEs' ability to produce accurate, complete, and timely performance measure reporting. As part of this activity, Qsource evaluated utilization of three ambulatory services: Physician-administered Drugs, Home Health/Home IV Therapy, and Hospice. Additionally, to assess MCE performance over time, Qsource validated two measures: Health Needs Survey and Comprehensive Health Needs Assessment Tool. 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's audit included a request to review each MCE's ISCA, to ensure that each MCE maintained a health information system that can accurately and completely collect, analyze, integrate, and report data on member and provider characteristics, and on services furnished to members.

Qsource determined that each of the MCEs aligned with the goals and objectives of CMS' Quality Strategy related to quality of care and access to care for enrollees. Each MCE had strategies in place to align with OMPP's goals and objectives relating to access to care for its enrollees and increasing enrollee satisfaction with those services.

In the ISCA, Qsource found that all MCEs were capable of reporting measures and had the capacity to produce accurate and complete encounter data. When reviewing selected encounter fields, the MCEs were mostly accurate and complete.

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

CA

Qsource conducted Compliance Assessment for the 2024 EQR to evaluate Indiana MCE adherence to compliance standards in accordance with CMS protocol and OMPP guidance performed every three years. This activity evaluated 16 standards, which included all compliance standards assessed during the 2021 Compliance Assessment and the addition of Emergency and Poststabilization, Disenrollment Requirements and Limitations, Enrollee Rights, Information Requirements, Early and Periodic Screening, Diagnostic, and Treatment, and Provider Selection. The CA also included five file reviews that assessed primary source compliance for the following types of files: UM Denials, Grievances, Appeals, Credentialing of Providers, and Recredentialing of Providers. Each MCE's ability to demonstrate how enrollee access, quality, and timeliness of care were standardized for implementation was determined by an assessment of regulatory and contractual obligations used to produce an overall compliance rating.

Four of the five MCEs participated in both the 2021 and 2024 EQR Compliance Assessments; the exception being UHC, who was not a contracted MCE during the 2021 EQR performance period. All MCEs achieved a High Confidence rating for overall Compliance Standards and File Review scores in the 2024 EQR indicating an average of 90.00% or greater number of elements were met. It was noted that 14 of the 16 Standards evaluated for 2024 CA achieved a 100% compliance score across all MCEs; Compliance Standard categories that exhibited less than 100% compliance in terms of performance include Grievance and Appeals system and Disenrollment Requirements and Limitations. Additionally, the Grievances and Appeals file review categories reflect the lowest compliance ratings received among the MCEs' File Review scores for the 2024 CA. The

MCEs included evidence of internal adjustments implemented to rectify all elements identified as noncompliant and portrayed active quality assurances to mitigate current and future maintained compliance. Qsource recommends the continued alignment of CFR Compliance Standards with OMPP quality metrics to assess MCE process updates applied as a result of EQR Compliance Assessment feedback.

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, OMPP 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 psychiatrists and OB/GYNs within the required travel time standard. Based on the analyses of the MCEs' geographical network adequacy, Qsource concluded there to be a high degree of confidence in the provider to member ratio and geographic access to providers for all five MCEs. This confidence is reflected in the MCEs reaching these two goals greater than 90.00% of the time, with some reaching 100% and most performing over 95.00%.

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.

Conducting Focus Studies for Health Care Quality

To address each goal within OMPP's Quality Strategy, OMPP makes use of the optional Protocol 9. These Focus Studies address critical aspects of reducing costs, utilization, and member satisfaction within the Medicaid managed care realm by conducting health care related focus studies that typically evaluate a specific service area (clinical or nonclinical) during a single year. For MY 2023, OMPP selected two focus study areas: Extent and Impact of MCE VBP Arrangements with Providers and MCE Relationship and Engagement Strategies with Hospitals.

Overall, the results of both focus studies demonstrated commitment from all five MCEs for delivery of high-value, cost-effective health care to Indiana's Medicaid population. However, to continue working towards the achievement of the Quality Strategy goals, Qsource recommends OMPP establish specific VBP goals and targets as well as an OMPP-specific

VBP Adoption Strategic Plan. Strengthening stakeholder engagement between OMPP and MCEs as well as between MCEs and Providers—strong collaboration and partnership is key to successful adoption and implementation of VBP. In addition, MCEs are encouraged to establish clear communication pathways and increase transparency with hospitals and expand VBP arrangements with hospitals, establishing clear shared goals and priority areas. Overall, the results of the 2024 (MY 2023) EQR activities demonstrated that the MCEs were well-qualified and committed to providing high-quality cost-effective healthcare for all enrollees.

Appendix A | ANA Excluded Source Data

Excluded Source Data Records: Anthem

Table A-1 summarizes Anthem's member and provider records that were excluded from analysis. From the member records submitted by Anthem, most of the records excluded from the analysis were members with out-of-state residence. The resulting count of members included in the analysis by program were as follows:

- HHW – 317,186 members
- HIP – 351,306 members
- HCC – 56,392 members

From the provider records submitted by Anthem, most of the records excluded from the analysis were providers which were not Medicaid eligible on October 1, 2023. The resulting count of providers included in the analysis by program were as follows:

- HHW – 316,772 provider service locations
- HIP – 317,149 provider service locations
- HCC – 316,373 provider service locations

Table A-1. Source Records Excluded from Analysis

Data Source	Health Programs			
Member Records	**HHW**	**HIP**	**HCC**	**All Programs**
Total Records Submitted	319,732	354,462	57,249	731,443
Total Records Excluded from Analysis	2,546	3,156	857	6,559
Invalid address	-	-	-	-
Not Medicaid eligible*	30	62	1	93
Duplicate record	-	-	-	-
Out-of-state residence	2,516	3,094	856	6,466
Provider Records	**HHW**	**HIP**	**HCC**	**All Programs**
Total Records Submitted	323,792	324,442	324,933	973,167

Table A-1. Source Records Excluded from Analysis				
Data Source	**Health Programs**			
Total Records Excluded from Analysis	7,020	7,293	8,560	22,873
Duplicate provider service location	496	466	464	1,426
Not Medicaid eligible*	5,460	5,788	6,317	17,565
Located more than 60 miles outside of Indiana	1,064	1,039	1,779	3,882
National Provider Identifier (NPI) deactivated by CMS	-	-	-	-

** Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against state records. The record was flagged as "Not Medicaid eligible" if the MMIS ID was not found, or if the member/provider was not actively enrolled on the snapshot date (October 1, 2023).*

Excluded Source Data Records: CareSource

Table A-2 summarizes CareSource's member and provider records that were excluded from analysis. From the member records submitted by CareSource, most of the records excluded from the analysis were members with out-of-state residence. The resulting count of members included in the analysis by program were as follows:

- HHW – 78,696 members
- HIP – 82,524 members

From the provider records submitted by CareSource, most of the records excluded from the analysis were due to duplicate provider service locations and providers located more than 60 miles outside of Indiana. The resulting count of providers included in the analysis by program were as follows:

- HHW – 284,638 provider service locations
- HIP – 281,224 provider service locations

Table A-2. Source Records Excluded from Analysis			
Data Source	**Health Programs**		
Member Records	**HHW**	**HIP**	**All Programs**
Total Records Submitted	79,500	83,445	162,945

Table A-2. Source Records Excluded from Analysis			
Data Source	**Health Programs**		
Total Records Excluded from Analysis	804	921	1,725
Invalid address	-	-	-
Not Medicaid eligible*	2	1	3
Duplicate record	-	-	-
Out-of-state residence	802	920	1,722
Provider Records			**All Programs**
Total Records Submitted	288,090	283,539	571,629
Total Records Excluded from Analysis	3,452	2,315	5,767
Invalid address	66	-	66
Duplicate provider service location	1,152	-	1,152
Not Medicaid eligible*	502	540	1,042
Located more than 60 miles outside of Indiana	1,732	1,775	3,507
National Provider Identifier (NPI) deactivated by CMS	-	-	-

** "Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against state records. The record was flagged as "Not Medicaid eligible" if the MMIS ID was not found, or if the member/provider was not actively enrolled on the snapshot date (October 1, 2023)*

Excluded Source Data Records: MDwise

Table A-3 summarizes MDwise's member and provider records that were excluded from analysis. From the member records submitted by MDwise, most of the records excluded from the analysis were members with out-of-state residence. The resulting count of members included in the analysis by program were as follows:

- HHW – 212,392 members
- HIP – 166,454 members

From the provider records submitted by MDwise, most of the records excluded from the analysis were duplicate provider service locations. The resulting count of providers included in the analysis by program were as follows:

- HHW – 117,597 provider service locations
- HIP – 117,434 provider service locations

Table A-3. Source Records Excluded from Analysis

Data Source	Health Programs		
Member Records	**HHW**	**HIP**	**All Programs**
Total Records Submitted	213,410	168,041	381,451
Total Records Excluded from Analysis	1,018	1,587	2,605
Invalid address	-	-	-
Not Medicaid eligible*	17	370	387
Duplicate record	6	2	8
Out-of-state residence	995	1,215	2,210
Provider Records	**HHW**	**HIP**	**All Programs**
Total Records Submitted	118,021	117,858	235,879
Total Records Excluded from Analysis	424	424	848
Duplicate provider service location	252	252	504
Not Medicaid eligible*	23	23	46
Located more than 60 miles outside of Indiana	149	149	298
National Provider Identifier (NPI) deactivated by CMS	-	-	-

** Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against state records. The record was flagged as "Not Medicaid eligible" if the MMIS ID was not found, or if the member/provider was not actively enrolled on the snapshot date (October 1, 2023).*

Excluded Source Data Records: MHS

Table A-4 summarizes MHS's member and provider records that were excluded from analysis. From the member records submitted by MHS, most of the records excluded from the analysis were members with out-of-state residence. The resulting count of members included in the analysis by program were as follows:

- HHW – 183,439 members

- HIP – 136,502 members
- HCC – 32,579 members

From the provider records submitted by MHS, most of the records excluded from the analysis were provider service locations greater than 60 miles outside of Indiana. The resulting count of providers included in the analysis by program were as follows:

- HHW – 67,081 provider service locations
- HIP – 66,844 provider service locations
- HCC – 67,940 provider service locations

Table A-4. Source Records Excluded from Analysis

Data Source	Health Programs			
Member Records	**HHW**	**HIP**	**HCC**	**All Programs**
Total Records Submitted	184,041	137,203	33,034	354,278
Total Records Excluded from Analysis	602	701	455	1,758
Invalid address	-	-	-	-
Not Medicaid eligible*	27	70	31	128
Duplicate record	2	-	4	6
Out-of-state residence	573	631	420	1,624
Provider Records	**HHW**	**HIP**	**HCC**	**All Programs**
Total Records Submitted	67,863	67,621	68,714	204,198
Total Records Excluded from Analysis	782	777	774	2,333
Duplicate provider service location	227	232	224	683
Not Medicaid eligible*	23	23	27	73
Located more than 60 miles outside of Indiana	532	522	523	1,577
National Provider Identifier (NPI) deactivated by CMS	-	-	-	-

**" Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against state records. The record was flagged as "Not Medicaid eligible" if the MMIS ID was not found, or if the member/provider was not actively enrolled on the snapshot date (October 1, 2023).*

Excluded Source Data Records: UHC

Table A-5 summarizes UHC's member and provider records that were excluded from analysis. From the member records submitted by UHC, most of the records excluded from the analysis were members with out-of-state residence. The resulting count of members included in the analysis by program were as follows:

- HCC – 5,667 members

From the provider records submitted by UHC, most of the records excluded from the analysis were due to not being Medicaid eligible on October 1, 2023. The resulting count of providers included in the analysis by program were as follows:

- HCC – 158,338 provider service locations

Table A-5. Source Records Excluded from Analysis

Data Source	Health Program
Member Records	**HCC**
Total Records Submitted	5,876
Total Records Excluded from Analysis	209
Invalid address	-
Not Medicaid eligible*	-
Duplicate record	-
Out-of-state residence	209
Provider Records	**HCC**
Total Records Submitted	160,212
Total Records Excluded from Analysis	1,874
Invalid address	1
Duplicate provider service location	265
Not Medicaid eligible*	1,357
Located more than 60 miles outside of Indiana	251

Table A-5. Source Records Excluded from Analysis	
Data Source	**Health Program**
National Provider Identifier (NPI) deactivated by CMS	-

** "Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against state records. The record was flagged as "Not Medicaid eligible" if the MMIS ID was not found, or if the member/provider was not actively enrolled on the snapshot date (October 1, 2023)*

Geographic Considerations Regarding the Calculation of Provider-to-Member Ratios

Provider to member ratios is a method for assessing the average patient load of healthcare providers within a network. Large patient loads may result in excessive wait periods for patients between the request for an appointment and the scheduled appointment date.

The method for assessing provider to member ratios counts each provider once, regardless of how many service locations the provider has. Hence, the assessment of provider-to-member ratio at a county level may yield different results than for the state overall.

In order to clarify expectations for counting providers, OMPP's instructions to MCEs regarding Report 0902 (Count of Providers) specify:

- "Each facility/provider shown on this report should appear in only one column and in only one county."
- "It is understood that providers often serve members in multiple counties. The total unique providers are summed at the top of each column. Therefore, these counts represent the total unique providers under contract with the MCE for the program."

The methodology for assigning individual providers to exactly one report column (provider service type, e.g., Anesthesiologist) and one county when assessing Report 0902 was as follows:

- Detailed data from the network adequacy assessment was used to count the number of members within an acceptable driving distance of each provider's service location.
- Each provider's service locations were ranked, favoring the service location with the highest member count. In the case of a tie, in-state locations were ranked higher than out-of-state locations. Each provider's county was assigned based on the service location with the highest ranking.

The following tables detail the provider to member ratios for all provider service types having ratio requirements by IHCP program.

Table A-6. Anthem – Provider to Member Ratios

Service Type	HHW	HIP	HCC	Provider Network Standard	Percent that Met Target
Anesthesiology	1:181	1:205	1:32	1:5,000	100%
Behavioral Health Providers	1:407	1:444	1:72	1:1,000	100%
Cardiology	1:344	1:404	1:61	1:5,000	100%
Dentists	1:236	1:262	1:42	1:2,000	100%
Dermatology	1:1,696	1:1,909	1:301	1:5,000	100%
DME	1:1,166	1:1,291	1:207	1:5,000	100%
Endocrinology	1:1,812	1:2,007	1:322	1:5,000	100%
Gastroenterology	1:663	1:794	1:117	1:5,000	100%
General Surgery	1:389	1:436	1:69	1:5,000	100%
Infectious Disease	1:1,475	1:1,657	1:262	1:5,000	100%
Nephrology	1:1,036	1:1,171	1:184	1:5,000	100%
OB/GYNs	1:282	1:314	1:50	1:2,000	100%
Occupational Therapists*	1:353	1:420	1:62	1:5,000	100%
Oncology	1:640	1:742	1:113	1:5,000	100%
Ophthalmology	1:952	1:973	1:167	1:5,000	100%
Orthopedic Surgery	1:432	1:489	1:76	1:5,000	100%
Otolaryngology	1:1,140	1:1,310	1:202	1:5,000	100%
Physiatrists*	1:501	1:564	1:89	1:5,000	100%

Table A-6. Anthem – Provider to Member Ratios

Service Type	HHW	HIP	HCC	Provider Network Standard	Percent that Met Target
Physical Therapists*	1:140	1:150	1:24	1:5,000	100%
PMPs	1:15	1:17	1:2	1:1,000	100%
Prosthetic Suppliers	1:1,166	1:1,291	1:207	1:5,000	100%
Psychiatry	1:501	1:564	1:89	1:5,000	100%
Pulmonology	1:694	1:811	1:123	1:5,000	100%
Rheumatology	1:2,665	1:2,927	1:473	1:5,000	100%
Speech Therapists*	1:474	1:618	1:84	1:5,000	100%
Urology	1:1,023	1:1,159	1:182	1:5,000	100%

** Occupational Therapists, Physiatrists, Physical Therapists, and Speech Therapists are considered under "Physiatrists/Rehabilitative" and have a total provider-to-member standard of 1 provider to every 5,000 members.*

Table A-7. CareSource – Provider to Member Ratios

Service Type	HHW	HIP	Provider Network Standard	Percent that Met Target
Anesthesiology	1:74	1:82	1:5,000	100%
Behavioral Health Providers	1:117	1:123	1:1,000	100%
Cardiology	1:127	1:142	1:5,000	100%
Dentists	1:91	1:97	1:2,000	100%
Dermatology	1:546	1:598	1:5,000	100%
DME	1:403	1:412	1:5,000	100%

Table A-7. CareSource – Provider to Member Ratios

Service Type	HHW	HIP	Provider Network Standard	Percent that Met Target
Endocrinology	1:501	1:522	1:5,000	100%
Gastroenterology	1:200	1:229	1:5,000	100%
General Surgery	1:117	1:123	1:5,000	100%
Infectious Disease	1:383	1:404	1:5,000	100%
Nephrology	1:383	1:406	1:5,000	100%
OB/GYNs	1:73	1:77	1:2,000	100%
Occupational Therapists*	1:171	1:179	1:5,000	100%
Oncology	1:200	1:232	1:5,000	100%
Ophthalmology	1:292	1:324	1:5,000	100%
Orthopedic Surgery	1:134	1:144	1:5,000	100%
Otolaryngology	1:319	1:357	1:5,000	100%
Physiatrists*	1:127	1:140	1:5,000	100%
Physical Therapists*	1:61	1:64	1:5,000	100%
PMPs	1:3	1:4	1:1,000	100%
Prosthetic Suppliers	1:374	1:385	1:5,000	100%
Psychiatry	1:127	1:140	1:5,000	100%
Pulmonology	1:236	1:262	1:5,000	100%
Rheumatology	1:715	1:757	1:5,000	100%

Table A-7. CareSource – Provider to Member Ratios

Service Type	HHW	HIP	Provider Network Standard	Percent that Met Target
Speech Therapists*	1:239	1:253	1:5,000	100%
Urology	1:293	1:310	1:5,000	100%

**Occupational Therapists, Physiatrists, Physical Therapists, and Speech Therapists are considered under "Physiatrists/Rehabilitative" and have a total provider-to-member standard of 1 provider to every 5,000 members.*

Table A-8. MDwise – Provider to Member Ratios

Service Type	HHW	HIP	Provider Network Standard	Percent that Met Target
Anesthesiology	1:209	1:165	1:5,000	100%
Behavioral Health Providers	1:463	1:363	1:1,000	100%
Cardiology	1:357	1:282	1:5,000	100%
Dentists	1:53,090	1:41,613	1:2,000	0%
Dermatology	1:2,166	1:1,733	1:5,000	100%
DME	1:1,199	1:940	1:5,000	100%
Endocrinology	1:1,830	1:1,434	1:5,000	100%
Gastroenterology	1:641	1:504	1:5,000	100%
General Surgery	1:399	1:314	1:5,000	100%
Infectious Disease	1:1,474	1:1,164	1:5,000	100%
Nephrology	1:935	1:736	1:5,000	100%

Table A-8. MDwise – Provider to Member Ratios

Service Type	HHW	HIP	Provider Network Standard	Percent that Met Target
OB/GYNs	1:254	1:200	1:2,000	100%
Occupational Therapists*	1:521	1:406	1:5,000	100%
Oncology	1:639	1:502	1:5,000	100%
Ophthalmology	1:1,129	1:880	1:5,000	100%
Orthopedic Surgery	1:483	1:378	1:5,000	100%
Otolaryngology	1:1,135	1:890	1:5,000	100%
Physiatrists*	1:488	1:381	1:5,000	100%
Physical Therapists*	1:218	1:169	1:5,000	100%
PMPs	1:15	1:12	1:1,000	100%
Prosthetic Suppliers	1:1,199	1:940	1:5,000	100%
Psychiatry	1:488	1:381	1:5,000	100%
Pulmonology	1:689	1:538	1:5,000	100%
Rheumatology	1:2,654	1:2,107	1:5,000	100%
Speech Therapists*	1:753	1:590	1:5,000	100%
Urology	1:1,083	1:849	1:5,000	100%

** Occupational Therapists, Physiatrists, Physical Therapists, and Speech Therapists are considered under "Physiatrists/Rehabilitative" and have a total provider-to-member standard of 1 provider to every 5,000 members.*

Table A-9. MHS – Provider to Member Ratios

Service Type	HHW	HIP	HCC	Provider Network Standard	Percent that Met Target
Anesthesiology	1:198	1:145	1:33	1:5,000	100%
Behavioral Health Providers	1:103	1:78	1:18	1:1,000	100%
Cardiology	1:336	1:253	1:60	1:5,000	100%
Dentists	1:154	1:115	1:27	1:2,000	100%
Dermatology	1:1,972	1:1,452	1:361	1:5,000	100%
Durable Medical Equipment (DME)	1:1,191	1:880	1:210	1:5,000	100%
Endocrinology	1:1,652	1:1,252	1:313	1:5,000	100%
Gastroenterology	1:643	1:478	1:123	1:5,000	100%
General Surgery	1:316	1:239	1:57	1:5,000	100%
Infectious Disease	1:1,595	1:1,197	1:288	1:5,000	100%
Nephrology	1:881	1:656	1:156	1:5,000	100%
OB/GYNs	1:243	1:180	1:44	1:2,000	100%
Occupational Therapists*	1:344	1:260	1:61	1:5,000	100%
Oncology	1:555	1:425	1:99	1:5,000	100%
Ophthalmology	1:975	1:737	1:179	1:5,000	100%
Orthopedic Surgery	1:383	1:287	1:69	1:5,000	100%
Otolaryngology	1:1,036	1:784	1:191	1:5,000	100%
Physiatrists*	1:566	1:431	1:101	1:5,000	100%

Table A-9. MHS – Provider to Member Ratios

Service Type	HHW	HIP	HCC	Provider Network Standard	Percent that Met Target
Physical Therapists*	1:169	1:127	1:30	1:5,000	100%
PMPs	1:25	1:19	1:4	1:1,000	100%
Prosthetic Suppliers	1:1,175	1:869	1:207	1:5,000	100%
Psychiatry	1:566	1:431	1:101	1:5,000	100%
Pulmonology	1:705	1:535	1:125	1:5,000	100%
Rheumatology	1:2,445	1:1,820	1:452	1:5,000	100%
Speech Therapists*	1:662	1:546	1:119	1:5,000	100%
Urology	1:1,030	1:780	1:185	1:5,000	100%

** Occupational Therapists, Physiatrists, Physical Therapists, and Speech Therapists are considered under "Physiatrists/Rehabilitative" and have a total provider-to-member standard of 1 provider to every 5,000 members.*

Table A-10. UHC – Provider to Member Ratios

Service Type	HCC	Provider Network Standard	Percent that Met Target
Anesthesiology	1:5	1:5,000	100%
Behavioral Health Providers	1:12	1:1,000	100%
Cardiology	1:14	1:5,000	100%
Dentists	1:7	1:2,000	100%
Dermatology	1:60	1:5,000	100%
DME	0:5,667	1:5,000	0.00%

Table A-10. UHC – Provider to Member Ratios

Service Type	HCC	Provider Network Standard	Percent that Met Target
Endocrinology	1:48	1:5,000	100%
Gastroenterology	1:22	1:5,000	100%
General Surgery	1:10	1:5,000	100%
Infectious Disease	1:41	1:5,000	100%
Nephrology	1:30	1:5,000	100%
OB/GYNs	1:7	1:2,000	100%
Occupational Therapists*	1:22	1:5,000	100%
Oncology	1:22	1:5,000	100%
Ophthalmology	1:21	1:5,000	100%
Orthopedic Surgery	1:12	1:5,000	100%
Otolaryngology	1:32	1:5,000	100%
Physiatrists*	1:10	1:5,000	100%
Physical Therapists*	1:8	1:5,000	100%
PMPs	2:1	1:1,000	100%
Prosthetic Suppliers	0:5,667	1:5,000	0.00%
Psychiatry	1:10	1:5,000	100%
Pulmonology	1:25	1:5,000	100%
Rheumatology	1:77	1:5,000	100%

Table A-10. UHC – Provider to Member Ratios

Service Type	HCC	Provider Network Standard	Percent that Met Target
Speech Therapists*	1:35	1:5,000	100%
Urology	1:24	1:5,000	100%

**Occupational Therapists, Physiatrists, Physical Therapists, and Speech Therapists are considered under "Physiatrists/Rehabilitative" and have a total provider-to-member standard of 1 provider to every 5,000 members.*

Appendix B | Detailed Analysis of Provider Network Access

Provider Network by County

The following tables are an assessment of each IHCP's reporting of its provider network. IHCPs are contractually required to annually submit to the state Report *0902 (Count of Enrolled Providers)* for each program it manages. The IHCPs' 0902 reports were compared to the detailed provider listings submitted for the network adequacy assessment. The assessment comprises each program the IHCP is contracted by (HHW, HIP, and HCC). Counts of providers are presented by county across all provider service types.

In accordance with the MCE Reporting Manual Instructions for Report 0902, each provider enumerated on this report is counted in exactly one provider service type and county. As stated in the manual, "It is understood that providers often serve members in multiple counties. The total unique providers are summed at the top of each column. Therefore, these counts represent the total unique providers under contract with the MCE for the program."

Table B-1. Count of Providers by County – Anthem

County	HCC			HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
All Counties	**29,554**	**42,033**	**(12,479)**	**29,016**	**41,862**	**(12,846)**	**28,201**	**40,805**	**(12,604)**	**86,771**	**124,700**	**(37,929)**
Adams	85	85	0	85	85	0	90	88	2	260	258	2
Allen	2,049	2,760	(711)	2,023	2,808	(785)	2,010	2,772	(762)	6,082	8,340	(2,258)
Bartholomew	507	461	46	499	453	46	505	453	52	1,511	1,367	144
Benton	2	4	(2)	2	2	0	2	3	(1)	6	9	(3)
Blackford	29	27	2	29	26	3	29	30	(1)	87	83	4
Boone	252	183	69	248	177	71	236	182	54	736	542	194
Brown	9	12	(3)	8	12	(4)	8	10	(2)	25	34	(9)
Carroll	44	30	14	44	10	34	44	13	31	132	53	79

Table B-1. Count of Providers by County – Anthem

County	HCC			HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Cass	122	87	35	121	115	6	127	87	40	370	289	81
Clark	574	656	(82)	574	678	(104)	575	669	(94)	1,723	2,003	(280)
Clay	39	27	12	38	25	13	37	23	14	114	75	39
Clinton	82	101	(19)	81	90	(9)	84	105	(21)	247	296	(49)
Crawford	18	5	13	18	3	15	18	4	14	54	12	42
Daviess	119	120	(1)	117	141	(24)	114	135	(21)	350	396	(46)
De Kalb	0	0	0	0	0	0	0	0	0	0	0	0
Dearborn	177	169	8	174	154	20	164	155	9	515	478	37
Decatur	85	75	10	82	81	1	83	81	2	250	237	13
Dekalb	56	0	56	56	0	56	59	0	59	171	0	171
Delaware	568	593	(25)	563	536	27	591	555	36	1,722	1,684	38
Dubois	147	164	(17)	140	164	(24)	147	167	(20)	434	495	(61)
Elkhart	503	613	(110)	492	592	(100)	544	655	(111)	1,539	1,860	(321)
Fayette	60	39	21	59	37	22	60	42	18	179	118	61
Floyd	286	533	(247)	269	526	(257)	255	536	(281)	810	1,595	(785)
Fountain	19	16	3	19	17	2	20	19	1	58	52	6
Franklin	73	46	27	73	43	30	74	48	26	220	137	83
Fulton	47	46	1	47	44	3	47	43	4	141	133	8
Gibson	72	64	8	69	67	2	67	61	6	208	192	16

Table B-1. Count of Providers by County – Anthem

County	HCC			HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Grant	199	235	(36)	194	230	(36)	194	241	(47)	587	706	(119)
Greene	67	71	(4)	66	66	0	69	65	4	202	202	0
Hamilton	1,751	1,750	1	1,712	1,646	66	1,666	1,625	41	5,129	5,021	108
Hancock	255	240	15	252	278	(26)	251	271	(20)	758	789	(31)
Harrison	80	89	(9)	78	87	(9)	82	84	(2)	240	260	(20)
Hendricks	736	817	(81)	736	859	(123)	700	811	(111)	2,172	2,487	(315)
Henry	160	199	(39)	159	179	(20)	149	152	(3)	468	530	(62)
Howard	393	439	(46)	389	422	(33)	383	406	(23)	1,165	1,267	(102)
Huntington	43	68	(25)	40	69	(29)	39	87	(48)	122	224	(102)
Jackson	133	152	(19)	129	181	(52)	143	172	(29)	405	505	(100)
Jasper	90	86	4	87	76	11	87	71	16	264	233	31
Jay	45	63	(18)	45	68	(23)	47	71	(24)	137	202	(65)
Jefferson	104	116	(12)	102	106	(4)	104	120	(16)	310	342	(32)
Jennings	48	41	7	48	42	6	48	44	4	144	127	17
Johnson	652	770	(118)	631	840	(209)	646	827	(181)	1,929	2,437	(508)
Knox	292	251	41	289	224	65	298	256	42	879	731	148
Kosciusko	145	188	(43)	143	210	(67)	138	187	(49)	426	585	(159)
La Porte	0	0	0	0	0	0	0	0	0	0	0	0
Lagrange	29	46	(17)	28	46	(18)	31	47	(16)	88	139	(51)

Table B-1. Count of Providers by County – Anthem

County	HCC			HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Lake	2,197	2,697	(500)	2,154	2,737	(583)	2,170	2,749	(579)	6,521	8,183	(1,662)
Laporte	383	0	383	378	0	378	389	0	389	1,150	0	1,150
Lawrence	152	108	44	149	113	36	134	113	21	435	334	101
Madison	339	681	(342)	334	620	(286)	331	698	(367)	1,004	1,999	(995)
Marion	4,486	8,218	(3,732)	4,395	8,279	(3,884)	4,258	8,352	(4,094)	13,139	24,849	(11,710)
Marshall	101	123	(22)	98	118	(20)	106	125	(19)	305	366	(61)
Martin	33	23	10	33	21	12	34	19	15	100	63	37
Miami	49	73	(24)	49	56	(7)	49	69	(20)	147	198	(51)
Monroe	565	867	(302)	560	886	(326)	559	876	(317)	1,684	2,629	(945)
Montgomery	142	97	45	142	107	35	139	106	33	423	310	113
Morgan	130	179	(49)	128	180	(52)	121	189	(68)	379	548	(169)
Newton	9	9	0	8	8	0	9	9	0	26	26	0
Noble	32	60	(28)	31	61	(30)	35	62	(27)	98	183	(85)
Ohio	4	3	1	4	3	1	4	3	1	12	9	3
Orange	37	43	(6)	37	38	(1)	32	39	(7)	106	120	(14)
Owen	9	12	(3)	9	8	1	10	9	1	28	29	(1)
Parke	24	10	14	24	8	16	25	12	13	73	30	43
Perry	65	59	6	63	60	3	66	56	10	194	175	19
Pike	12	8	4	12	8	4	12	8	4	36	24	12

Table B-1. Count of Providers by County – Anthem

County	HCC			HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Porter	435	592	(157)	425	557	(132)	394	546	(152)	1,254	1,695	(441)
Posey	19	17	2	19	18	1	20	17	3	58	52	6
Pulaski	29	21	8	28	18	10	27	21	6	84	60	24
Putnam	78	80	(2)	78	72	6	78	72	6	234	224	10
Randolph	33	59	(26)	33	49	(16)	33	44	(11)	99	152	(53)
Ripley	50	64	(14)	48	88	(40)	45	60	(15)	143	212	(69)
Rush	53	43	10	52	47	5	55	44	11	160	134	26
Scott	59	69	(10)	59	59	0	61	62	(1)	179	190	(11)
Shelby	120	159	(39)	117	165	(48)	127	170	(43)	364	494	(130)
Spencer	21	30	(9)	21	22	(1)	23	26	(3)	65	78	(13)
St. Joseph	955	2,345	(1,390)	937	2,404	(1,467)	992	2,374	(1,382)	2,884	7,123	(4,239)
Starke	28	51	(23)	28	47	(19)	27	50	(23)	83	148	(65)
Steuben	75	105	(30)	73	93	(20)	70	92	(22)	218	290	(72)
Sullivan	26	33	(7)	25	31	(6)	26	35	(9)	77	99	(22)
Switzerland	4	7	(3)	4	5	(1)	4	6	(2)	12	18	(6)
Tippecanoe	545	895	(350)	533	907	(374)	519	857	(338)	1,597	2,659	(1,062)
Tipton	40	30	10	40	33	7	37	31	6	117	94	23
Union	8	8	0	8	7	1	8	8	0	24	23	1
Vanderburgh	905	1,364	(459)	880	1,381	(501)	885	1,360	(475)	2,670	4,105	(1,435)

Table B-1. Count of Providers by County – Anthem

County	HCC			HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Vermillion	25	33	(8)	25	25	0	26	27	(1)	76	85	(9)
Vigo	511	842	(331)	503	783	(280)	493	801	(308)	1,507	2,426	(919)
Wabash	47	109	(62)	46	77	(31)	44	79	(35)	137	265	(128)
Warren	3	13	(10)	3	10	(7)	3	10	(7)	9	33	(24)
Warrick	246	422	(176)	241	396	(155)	243	415	(172)	730	1,233	(503)
Washington	36	40	(4)	36	38	(2)	36	43	(7)	108	121	(13)
Wayne	259	410	(151)	255	341	(86)	256	389	(133)	770	1,140	(370)
Wells	42	47	(5)	40	44	(4)	40	47	(7)	122	138	(16)
White	32	53	(21)	31	59	(28)	32	66	(34)	95	178	(83)
Whitley	45	52	(7)	45	52	(7)	49	54	(5)	139	158	(19)
Out of state	4,810	8,233	(3,423)	4,717	8,208	(3,491)	4,000	7,032	(3,032)	13,527	23,473	(9,946)

Table B-2. Count of Providers by County – CareSource

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
All Counties	60,831	34,953	25,878	58,752	33,365	25,387	119,583	68,318	51,265
Adams	212	102	110	182	75	107	394	177	217

Table B-2. Count of Providers by County – CareSource

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Allen	3,234	2,249	985	2,433	2,379	54	5,667	4,628	1,039
Bartholomew	828	385	443	836	376	460	1,664	761	903
Benton	28	1	27	27	1	26	55	2	53
Blackford	293	30	263	307	13	294	600	43	557
Boone	915	265	650	923	211	712	1,838	476	1,362
Brown	51	9	42	51	6	45	102	15	87
Carroll	107	11	96	108	4	104	215	15	200
Cass	225	80	145	230	80	150	455	160	295
Clark	1,175	466	709	1,184	643	541	2,359	1,109	1,250
Clay	54	23	31	60	21	39	114	44	70
Clinton	424	107	317	432	44	388	856	151	705
Crawford	40	9	31	39	6	33	79	15	64
Daviess	283	106	177	284	130	154	567	236	331
De Kalb	0	0	0	0	0	0	0	0	0
Dearborn	280	87	193	286	94	192	566	181	385
Decatur	427	83	344	429	66	363	856	149	707

Table B-2. Count of Providers by County – CareSource

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Dekalb	424	0	424	202	0	202	626	0	626
Delaware	1,299	542	757	1,317	516	801	2,616	1,058	1,558
Dubois	395	205	190	404	141	263	799	346	453
Elkhart	822	502	320	832	450	382	1,654	952	702
Fayette	137	30	107	141	25	116	278	55	223
Floyd	778	386	392	796	434	362	1,574	820	754
Fountain	75	14	61	77	8	69	152	22	130
Franklin	150	49	101	142	24	118	292	73	219
Fulton	130	53	77	132	37	95	262	90	172
Gibson	153	50	103	160	35	125	313	85	228
Grant	676	167	509	683	154	529	1,359	321	1,038
Greene	81	58	23	83	51	32	164	109	55
Hamilton	3,576	1,555	2,021	3,613	1,011	2,602	7,189	2,566	4,623
Hancock	630	288	342	639	240	399	1,269	528	741
Harrison	390	98	292	403	73	330	793	171	622
Hendricks	2,045	743	1,302	2,066	466	1,600	4,111	1,209	2,902

Table B-2. Count of Providers by County – CareSource

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Henry	464	107	357	478	90	388	942	197	745
Howard	1,014	382	632	1,026	328	698	2,040	710	1,330
Huntington	478	106	372	195	48	147	673	154	519
Jackson	382	134	248	396	131	265	778	265	513
Jasper	215	86	129	221	30	191	436	116	320
Jay	404	57	347	401	26	375	805	83	722
Jefferson	312	77	235	324	81	243	636	158	478
Jennings	151	46	105	158	30	128	309	76	233
Johnson	1,676	657	1,019	1,687	580	1,107	3,363	1,237	2,126
Knox	283	223	60	297	219	78	580	442	138
Kosciusko	642	166	476	444	103	341	1,086	269	817
La Porte	0	0	0	0	0	0	0	0	0
Lagrange	147	40	107	86	27	59	233	67	166
Lake	2,509	2,079	430	2,561	2,147	414	5,070	4,226	844
Laporte	593	0	593	617	0	617	1,210	0	1,210
Lawrence	610	77	533	636	61	575	1,246	138	1,108

Table B-2. Count of Providers by County – CareSource

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Madison	1,239	386	853	1,258	327	931	2,497	713	1,784
Marion	6,998	6,764	234	7,081	8,336	(1,255)	14,079	15,100	(1,021)
Marshall	261	99	162	270	46	224	531	145	386
Martin	47	11	36	46	8	38	93	19	74
Miami	206	49	157	204	37	167	410	86	324
Monroe	1,642	759	883	1,668	812	856	3,310	1,571	1,739
Montgomery	352	74	278	358	34	324	710	108	602
Morgan	996	164	832	1,005	66	939	2,001	230	1,771
Newton	25	6	19	25	6	19	50	12	38
Noble	370	42	328	140	32	108	510	74	436
Ohio	8	2	6	8	2	6	16	4	12
Orange	356	54	302	365	30	335	721	84	637
Owen	92	16	76	94	12	82	186	28	158
Parke	113	20	93	113	15	98	226	35	191
Perry	134	45	89	141	40	101	275	85	190
Pike	52	9	43	52	7	45	104	16	88

Table B-2. Count of Providers by County – CareSource

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Porter	877	398	479	891	231	660	1,768	629	1,139
Posey	99	24	75	99	11	88	198	35	163
Pulaski	43	26	17	46	14	32	89	40	49
Putnam	193	67	126	204	63	141	397	130	267
Randolph	144	45	99	150	37	113	294	82	212
Ripley	86	46	40	82	59	23	168	105	63
Rush	146	44	102	153	30	123	299	74	225
Scott	414	65	349	421	43	378	835	108	727
Shelby	577	139	438	584	124	460	1,161	263	898
Spencer	131	25	106	134	13	121	265	38	227
St. Joseph	1,556	1,597	(41)	1,601	1,919	(318)	3,157	3,516	(359)
Starke	108	45	63	108	33	75	216	78	138
Steuben	301	93	208	206	58	148	507	151	356
Sullivan	35	29	6	38	25	13	73	54	19
Switzerland	19	8	11	19	4	15	38	12	26
Tippecanoe	1,277	730	547	1,303	809	494	2,580	1,539	1,041

Table B-2. Count of Providers by County – CareSource

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Tipton	406	45	361	415	28	387	821	73	748
Union	19	2	17	20	2	18	39	4	35
Vanderburgh	1,468	1,116	352	1,508	1,341	167	2,976	2,457	519
Vermillion	110	12	98	116	7	109	226	19	207
Vigo	1,136	635	501	1,149	615	534	2,285	1,250	1,035
Wabash	423	103	320	271	26	245	694	129	565
Warren	76	13	63	80	7	73	156	20	136
Warrick	788	389	399	812	227	585	1,600	616	984
Washington	162	29	133	168	25	143	330	54	276
Wayne	985	419	566	999	436	563	1,984	855	1,129
Wells	181	43	138	147	26	121	328	69	259
White	275	58	217	278	28	250	553	86	467
Whitley	380	34	346	151	15	136	531	49	482
Out of state	5,308	7,184	(1,876)	4,743	5,584	(841)	10,051	12,768	(2,717)

Table B-3. Count of Providers by County – MDwise

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
All Counties	**33,768**	**26,175**	**7,593**	**33,926**	**26,180**	**7,746**	**67,694**	**52,355**	**15,339**
Adams	102	71	31	108	69	39	210	140	70
Allen	1,730	1,945	(215)	1,712	1,957	(245)	3,442	3,902	(460)
Bartholomew	411	330	81	392	326	66	803	656	147
Benton	10	4	6	9	4	5	19	8	11
Blackford	57	25	32	59	32	27	116	57	59
Boone	430	176	254	455	176	279	885	352	533
Brown	7	4	3	7	5	2	14	9	5
Carroll	20	9	11	20	6	14	40	15	25
Cass	144	97	47	144	100	44	288	197	91
Clark	468	430	38	470	432	38	938	862	76
Clay	50	22	28	50	22	28	100	44	56
Clinton	216	92	124	218	91	127	434	183	251
Crawford	15	5	10	14	5	9	29	10	19
Daviess	107	130	(23)	108	129	(21)	215	259	(44)
De Kalb	0	0	0	0	0	0	0	0	0
Dearborn	206	187	19	205	188	17	411	375	36
Decatur	215	101	114	205	96	109	420	197	223
Dekalb	165	0	165	166	0	166	331	0	331

Table B-3. Count of Providers by County – MDwise

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Delaware	654	487	167	650	477	173	1,304	964	340
Dubois	204	173	31	210	166	44	414	339	75
Elkhart	418	366	52	414	371	43	832	737	95
Fayette	77	40	37	76	42	34	153	82	71
Floyd	335	296	39	328	293	35	663	589	74
Fountain	22	7	15	22	6	16	44	13	31
Franklin	72	50	22	68	49	19	140	99	41
Fulton	55	48	7	55	47	8	110	95	15
Gibson	94	53	41	94	44	50	188	97	91
Grant	414	177	237	413	186	227	827	363	464
Greene	49	44	5	48	46	2	97	90	7
Hamilton	2,584	1,222	1,362	2,562	1,199	1,363	5,146	2,421	2,725
Hancock	216	148	68	217	144	73	433	292	141
Harrison	119	86	33	119	84	35	238	170	68
Hendricks	1,367	573	794	1,409	541	868	2,776	1,114	1,662
Henry	169	103	66	169	100	69	338	203	135
Howard	493	257	236	493	257	236	986	514	472
Huntington	137	83	54	139	78	61	276	161	115
Jackson	164	104	60	163	96	67	327	200	127

Table B-3. Count of Providers by County – MDwise

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Jasper	169	79	90	170	68	102	339	147	192
Jay	91	52	39	91	48	43	182	100	82
Jefferson	166	43	123	168	40	128	334	83	251
Jennings	104	41	63	89	41	48	193	82	111
Johnson	646	488	158	637	484	153	1,283	972	311
Knox	190	205	(15)	196	201	(5)	386	406	(20)
Kosciusko	254	136	118	257	129	128	511	265	246
La Porte	0	0	0	0	0	0	0	0	0
Lagrange	109	39	70	112	35	77	221	74	147
Lake	1,577	1,563	14	1,577	1,568	9	3,154	3,131	23
Laporte	427	0	427	426	0	426	853	0	853
Lawrence	145	82	63	145	74	71	290	156	134
Madison	618	271	347	615	265	350	1,233	536	697
Marion	4,657	5,291	(634)	4,639	5,395	(756)	9,296	10,686	(1,390)
Marshall	132	77	55	134	85	49	266	162	104
Martin	24	12	12	24	15	9	48	27	21
Miami	142	61	81	142	50	92	284	111	173
Monroe	665	505	160	662	566	96	1,327	1,071	256
Montgomery	182	81	101	180	72	108	362	153	209

Table B-3. Count of Providers by County – MDwise

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Morgan	478	167	311	474	122	352	952	289	663
Newton	4	6	(2)	4	6	(2)	8	12	(4)
Noble	156	64	92	156	43	113	312	107	205
Ohio	3	3	0	3	3	0	6	6	0
Orange	87	45	42	88	48	40	175	93	82
Owen	35	14	21	35	17	18	70	31	39
Parke	23	9	14	23	10	13	46	19	27
Perry	68	47	21	67	47	20	135	94	41
Pike	12	10	2	12	10	2	24	20	4
Porter	569	436	133	568	429	139	1,137	865	272
Posey	33	12	21	33	11	22	66	23	43
Pulaski	35	11	24	35	12	23	70	23	47
Putnam	103	62	41	103	61	42	206	123	83
Randolph	70	29	41	70	33	37	140	62	78
Ripley	130	72	58	129	77	52	259	149	110
Rush	70	36	34	72	36	36	142	72	70
Scott	182	36	146	180	37	143	362	73	289
Shelby	114	109	5	112	105	7	226	214	12
Spencer	702	18	684	705	24	681	1,407	42	1,365

Table B-3. Count of Providers by County – MDwise

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
St. Joseph	209	1,190	(981)	209	1,190	(981)	418	2,380	(1,962)
Starke	40	43	(3)	39	43	(4)	79	86	(7)
Steuben	223	98	125	226	98	128	449	196	253
Sullivan	23	33	(10)	23	33	(10)	46	66	(20)
Switzerland	9	4	5	9	4	5	18	8	10
Tippecanoe	785	649	136	785	649	136	1,570	1,298	272
Tipton	226	21	205	231	25	206	457	46	411
Union	2	8	(6)	2	8	(6)	4	16	(12)
Vanderburgh	817	821	(4)	823	826	(3)	1,640	1,647	(7)
Vermillion	39	25	14	41	27	14	80	52	28
Vigo	579	554	25	575	557	18	1,154	1,111	43
Wabash	284	76	208	281	57	224	565	133	432
Warren	60	7	53	61	7	54	121	14	107
Warrick	471	358	113	474	368	106	945	726	219
Washington	50	26	24	47	32	15	97	58	39
Wayne	379	377	2	373	376	(3)	752	753	(1)
Wells	101	35	66	106	34	72	207	69	138
White	151	62	89	151	63	88	302	125	177
Whitley	150	40	110	148	30	118	298	70	228

Table B-3. Count of Providers by County – MDwise

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Out of state	4,002	3,591	411	4,198	3,622	576	8,200	7,213	987

Table B-4. Count of Providers by County – MHS

County	HCC			HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
All Counties	**18,523**	**20,971**	**(2,448)**	**18,310**	**21,345**	**(3,035)**	**18,063**	**21,098**	**(3,035)**	**54,896**	**63,414**	**(8,518)**
Adams	56	51	5	54	54	0	54	55	(1)	164	160	4
Allen	1,219	1,511	(292)	1,189	1,491	(302)	1,157	1,459	(302)	3,565	4,461	(896)
Bartholomew	298	259	39	287	265	22	290	273	17	875	797	78
Benton	15	3	12	14	3	11	14	3	11	43	9	34
Blackford	24	7	17	20	8	12	21	9	12	65	24	41
Boone	211	162	49	202	163	39	197	152	45	610	477	133
Brown	24	7	17	28	6	22	24	6	18	76	19	57
Carroll	36	12	24	37	11	26	37	10	27	110	33	77
Cass	84	75	9	85	76	9	84	73	11	253	224	29
Clark	348	385	(37)	358	397	(39)	346	401	(55)	1,052	1,183	(131)
Clay	34	20	14	33	20	13	33	22	11	100	62	38
Clinton	89	57	32	86	63	23	88	62	26	263	182	81

Table B-4. Count of Providers by County – MHS

County	HCC			HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Crawford	19	8	11	20	9	11	20	11	9	59	28	31
Daviess	89	63	26	97	66	31	97	69	28	283	198	85
De Kalb	0	0	0	0	0	0	0	0	0	0	0	0
Dearborn	121	115	6	118	116	2	119	112	7	358	343	15
Decatur	127	71	56	123	73	50	117	69	48	367	213	154
Dekalb	81	0	81	86	0	86	85	0	85	252	0	252
Delaware	419	423	(4)	389	393	(4)	383	385	(2)	1,191	1,201	(10)
Dubois	125	137	(12)	120	140	(20)	116	141	(25)	361	418	(57)
Elkhart	400	416	(16)	390	433	(43)	378	430	(52)	1,168	1,279	(111)
Fayette	65	42	23	66	43	23	67	44	23	198	129	69
Floyd	228	269	(41)	231	270	(39)	216	266	(50)	675	805	(130)
Fountain	28	17	11	20	17	3	20	20	0	68	54	14
Franklin	31	40	(9)	32	43	(11)	31	42	(11)	94	125	(31)
Fulton	50	40	10	50	41	9	53	40	13	153	121	32
Gibson	49	38	11	54	39	15	52	37	15	155	114	41
Grant	186	147	39	179	149	30	171	138	33	536	434	102
Greene	77	41	36	80	45	35	81	46	35	238	132	106
Hamilton	938	1,113	(175)	948	1,130	(182)	920	1,123	(203)	2,806	3,366	(560)
Hancock	213	186	27	211	183	28	211	187	24	635	556	79

Table B-4. Count of Providers by County – MHS

County	HCC			HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Harrison	101	78	23	94	83	11	92	77	15	287	238	49
Hendricks	536	477	59	532	499	33	509	477	32	1,577	1,453	124
Henry	136	87	49	127	103	24	131	93	38	394	283	111
Howard	337	312	25	328	306	22	329	307	22	994	925	69
Huntington	58	56	2	60	52	8	59	56	3	177	164	13
Jackson	108	90	18	101	89	12	102	90	12	311	269	42
Jasper	48	40	8	50	37	13	50	39	11	148	116	32
Jay	44	21	23	47	20	27	44	21	23	135	62	73
Jefferson	94	25	69	95	28	67	97	29	68	286	82	204
Jennings	67	45	22	67	43	24	67	40	27	201	128	73
Johnson	536	506	30	536	527	9	528	509	19	1,600	1,542	58
Knox	150	148	2	149	154	(5)	148	150	(2)	447	452	(5)
Kosciusko	132	135	(3)	125	136	(11)	122	131	(9)	379	402	(23)
La Porte	0	0	0	0	0	0	0	0	0	0	0	0
Lagrange	38	28	10	38	31	7	39	33	6	115	92	23
Lake	1,177	1,271	(94)	1,156	1,320	(164)	1,156	1,294	(138)	3,489	3,885	(396)
Laporte	249	0	249	244	0	244	239	0	239	732	0	732
Lawrence	103	82	21	101	80	21	105	79	26	309	241	68
Madison	328	337	(9)	325	341	(16)	312	348	(36)	965	1,026	(61)

Table B-4. Count of Providers by County – MHS

County	HCC			HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Marion	3,278	4,229	(951)	3,189	4,321	(1,132)	3,174	4,271	(1,097)	9,641	12,821	(3,180)
Marshall	116	98	18	115	108	7	116	110	6	347	316	31
Martin	37	20	17	37	19	18	37	16	21	111	55	56
Miami	54	42	12	54	41	13	56	46	10	164	129	35
Monroe	431	441	(10)	441	477	(36)	422	470	(48)	1,294	1,388	(94)
Montgomery	99	57	42	99	61	38	95	53	42	293	171	122
Morgan	163	114	49	156	111	45	154	111	43	473	336	137
Newton	20	8	12	21	7	14	21	7	14	62	22	40
Noble	48	37	11	50	37	13	54	40	14	152	114	38
Ohio	10	4	6	11	4	7	10	5	5	31	13	18
Orange	55	38	17	53	35	18	58	35	23	166	108	58
Owen	25	17	8	26	20	6	25	18	7	76	55	21
Parke	36	18	18	37	19	18	36	20	16	109	57	52
Perry	52	39	13	46	41	5	45	36	9	143	116	27
Pike	25	8	17	25	8	17	25	12	13	75	28	47
Porter	375	370	5	378	360	18	365	363	2	1,118	1,093	25
Posey	25	10	15	28	11	17	27	12	15	80	33	47
Pulaski	29	20	9	28	20	8	29	20	9	86	60	26
Putnam	68	54	14	68	53	15	67	51	16	203	158	45

Table B-4. Count of Providers by County – MHS

County	HCC			HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Randolph	54	36	18	52	39	13	53	36	17	159	111	48
Ripley	64	46	18	65	48	17	67	46	21	196	140	56
Rush	44	29	15	44	29	15	43	30	13	131	88	43
Scott	77	51	26	77	52	25	77	48	29	231	151	80
Shelby	115	88	27	116	86	30	111	85	26	342	259	83
Spencer	39	17	22	39	18	21	39	19	20	117	54	63
St. Joseph	719	854	(135)	718	852	(134)	711	840	(129)	2,148	2,546	(398)
Starke	57	31	26	57	31	26	57	29	28	171	91	80
Steuben	63	59	4	61	58	3	63	61	2	187	178	9
Sullivan	29	23	6	29	23	6	29	23	6	87	69	18
Switzerland	12	7	5	12	8	4	12	8	4	36	23	13
Tippecanoe	491	548	(57)	470	536	(66)	464	536	(72)	1,425	1,620	(195)
Tipton	37	20	17	55	20	35	58	19	39	150	59	91
Union	16	5	11	16	5	11	16	5	11	48	15	33
Vanderburgh	694	792	(98)	676	801	(125)	672	800	(128)	2,042	2,393	(351)
Vermillion	34	20	14	36	17	19	36	16	20	106	53	53
Vigo	428	395	33	419	397	22	405	392	13	1,252	1,184	68
Wabash	56	59	(3)	60	68	(8)	61	61	0	177	188	(11)
Warren	18	9	9	22	9	13	22	7	15	62	25	37

Table B-4. Count of Providers by County – MHS

County	HCC			HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Warrick	221	214	7	233	234	(1)	241	228	13	695	676	19
Washington	33	20	13	36	23	13	34	20	14	103	63	40
Wayne	216	339	(123)	231	335	(104)	222	337	(115)	669	1,011	(342)
Wells	59	41	18	61	47	14	62	45	17	182	133	49
White	34	30	4	35	31	4	35	34	1	104	95	9
Whitley	41	39	2	46	41	5	46	40	6	133	120	13
Out of state	0	2,122	(2,122)	0	2,188	(2,188)	0	2,179	(2,179)	0	6,489	(6,489)

Table B-5. Count of Providers by County – UHC

County	HCC		
	MCE Report 0902	Calculated	Over (Under) Reported
All Counties	25,047	24,756	291
Adams	47	56	(9)
Allen	2,124	1,761	363
Bartholomew	314	282	32
Benton	2	2	0
Blackford	7	17	(10)

Table B-5. Count of Providers by County – UHC			
County	HCC		
	MCE Report 0902	Calculated	Over (Under) Reported
Boone	109	158	(49)
Brown	2	4	(2)
Carroll	7	1	6
Cass	84	62	22
Clark	568	360	208
Clay	25	23	2
Clinton	42	108	(66)
Crawford	1	2	(1)
Daviess	117	105	12
De Kalb	0	0	0
Dearborn	216	116	100
Decatur	66	57	9
Dekalb	38	0	38
Delaware	470	397	73
Dubois	134	120	14
Elkhart	441	416	25
Fayette	35	27	8

Table B-5. Count of Providers by County – UHC			
County	HCC		
	MCE Report 0902	Calculated	Over (Under) Reported
Floyd	317	300	17
Fountain	10	9	1
Franklin	37	22	15
Fulton	24	25	(1)
Gibson	37	40	(3)
Grant	168	155	13
Greene	36	34	2
Hamilton	829	1,378	(549)
Hancock	131	163	(32)
Harrison	63	74	(11)
Hendricks	347	515	(168)
Henry	148	87	61
Howard	299	258	41
Huntington	55	46	9
Jackson	96	116	(20)
Jasper	30	62	(32)
Jay	27	36	(9)

Table B-5. Count of Providers by County – UHC			
County	HCC		
	MCE Report 0902	Calculated	Over (Under) Reported
Jefferson	89	32	57
Jennings	29	35	(6)
Johnson	460	494	(34)
Knox	198	178	20
Kosciusko	121	126	(5)
La Porte	0	0	0
Lagrange	36	37	(1)
Lake	1,957	1,562	395
Laporte	234	0	234
Lawrence	73	68	5
Madison	414	232	182
Marion	7,139	6,739	400
Marshall	54	68	(14)
Martin	5	8	(3)
Miami	43	62	(19)
Monroe	586	530	56
Montgomery	41	83	(42)

Table B-5. Count of Providers by County – UHC			
County	HCC		
	MCE Report 0902	Calculated	Over (Under) Reported
Morgan	79	107	(28)
Newton	4	3	1
Noble	49	43	6
Ohio	2	2	0
Orange	26	28	(2)
Owen	11	12	(1)
Parke	14	14	0
Perry	40	26	14
Pike	10	5	5
Porter	278	382	(104)
Posey	11	9	2
Pulaski	13	6	7
Putnam	72	52	20
Randolph	22	22	0
Ripley	32	50	(18)
Rush	19	19	0
Scott	67	49	18

Table B-5. Count of Providers by County – UHC

County	HCC		
	MCE Report 0902	Calculated	Over (Under) Reported
Shelby	124	119	5
Spencer	17	18	(1)
St. Joseph	1,050	1,509	(459)
Starke	42	51	(9)
Steuben	80	74	6
Sullivan	25	13	12
Switzerland	6	3	3
Tippecanoe	733	657	76
Tipton	13	13	0
Union	4	4	0
Vanderburgh	1,079	903	176
Vermillion	9	13	(4)
Vigo	497	483	14
Wabash	40	72	(32)
Warren	7	6	1
Warrick	284	325	(41)
Washington	26	25	1

Table B-5. Count of Providers by County – UHC			
County	HCC		
	MCE Report 0902	Calculated	Over (Under) Reported
Wayne	382	362	20
Wells	31	35	(4)
White	24	46	(22)
Whitley	32	21	11
Out of state	811	1,527	(716)

Provider Network Accessibility by Service Type

The following tables are an assessment of each IHCP's reporting of its provider network accessibility to its members across all provider types. IHCPs are contractually required to annually submit to the State a *Report 0903 Member Access to Providers* for each program it manages. Each IHCP's 0903 reports were compared to the provider network accessibility and calculated from the detailed provider and member listing the IHCP submitted for the network adequacy assessment. The assessment comprises sections for each MCE (HHW, HIP, and HCC). Counts of members are presented by provider service type.

Table B-6. Member Access to Providers – Verification of Report 0903: Anthem						
Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
HHW						
ABA Providers	314,049	*	*	0	*	*
Acute Care Hospitals	314,049	317,186	(3,137)	0	25	(25)

Table B-6. Member Access to Providers – Verification of Report 0903: Anthem

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Addiction Services	314,049	*	*	0	*	*
Anesthesiologists	314,049	317,186	(3,137)	0	0	0
Behavioral Health Providers	314,049	317,186	(3,137)	0	2	(2)
Cardiologists	314,049	317,186	(3,137)	0	0	0
Cardiothoracic Surgeons	314,049	317,186	(3,137)	0	0	0
Cardiovascular Surgeons	314,049	317,186	(3,137)	0	0	0
Clinic	314,049	*	*	0	*	*
Oral Surgeons	314,049	317,186	(3,137)	3	0	3
Dermatologists	314,049	317,186	(3,137)	0	0	0
Diagnostic Testing	314,049	317,186	(3,137)	0	19,673	(19,673)
DME	314,049	317,186	(3,137)	3,067	82,713	(79,646)
Endocrinologists	314,049	317,186	(3,137)	0	0	0
ESRD Clinic	314,049	317,186	(3,137)	0	0	0
Gastroenterologists	314,049	317,186	(3,137)	0	0	0
Dentists	314,049	317,186	(3,137)	0	3	(3)
General Surgeons	314,049	317,186	(3,137)	0	0	0
Hematologists	314,049	317,186	(3,137)	0	0	0
Home Health Providers	314,049	317,186	(3,137)	5,906	73,747	(67,841)
Infectious Disease Specialists	314,049	317,186	(3,137)	0	0	0
Inpatient Psychiatric Facilities	314,049	317,186	(3,137)	0	7,437	(7,437)

Table B-6. Member Access to Providers – Verification of Report 0903: Anthem

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Interventional Radiologists	314,049	317,186	(3,137)	0	0	0
Nephrologists	314,049	317,186	(3,137)	0	0	0
Neurological Surgeons	314,049	317,186	(3,137)	0	0	0
Neurologists	314,049	317,186	(3,137)	0	0	0
Nonhospital-based Anesthesiologists	314,049	317,186	(3,137)	0	0	0
OB/GYN	314,049	160,453	153,596	0	0	0
Occupational Therapists	314,049	317,186	(3,137)	0	0	0
Oncologists	314,049	317,186	(3,137)	0	0	0
Ophthalmologists	314,049	317,186	(3,137)	0	0	0
Optometrists	314,049	317,186	(3,137)	0	0	0
Orthodontists	314,049	317,186	(3,137)	87,619	96,473	(8,854)
Orthopedic Surgeons	314,049	317,186	(3,137)	0	0	0
Otolaryngologists	314,049	317,186	(3,137)	0	0	0
Pathologists	314,049	317,186	(3,137)	0	0	0
Pharmacy	314,049	317,186	(3,137)	0	0	0
Physiatrists**	*	317,186	*	*	0	*
Physical Therapists	314,049	317,186	(3,137)	0	0	0
PMPs	314,049	317,186	(3,137)	0	0	0
Podiatrists**	*	317,186	*	*	0	*
Prosthetic Suppliers	314,049	317,186	(3,137)	0	0	0

Table B-6. Member Access to Providers – Verification of Report 0903: Anthem

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Psychiatrists	314,049	317,186	(3,137)	0	0	0
Pulmonologists	314,049	317,186	(3,137)	0	0	0
Radiation Oncologists	314,049	317,186	(3,137)	0	0	0
Radiologists	314,049	317,186	(3,137)	19,918	0	19,918
Rheumatologists	314,049	317,186	(3,137)	0	0	0
Speech Therapists	314,049	317,186	(3,137)	0	0	0
Urologists	314,049	317,186	(3,137)	0	0	0
HIP						
ABA Providers	338,035	*	*	0	*	*
Acute Care Hospitals	338,035	351,306	(13,271)	0	8	(8)
Addiction Services	338,035	*	*	0	*	*
Anesthesiologists	338,035	351,306	(13,271)	0	0	0
Behavioral Health Providers	338,035	351,306	(13,271)	0	3	(3)
Cardiologists	338,035	351,306	(13,271)	0	0	0
Cardiothoracic Surgeons	338,035	351,306	(13,271)	0	0	0
Cardiovascular Surgeons	338,035	351,306	(13,271)	0	0	0
Clinic	338,035	*	*	0	*	*
Oral Surgeons	338,035	351,306	(13,271)	251	0	251
Dermatologists	338,035	351,306	(13,271)	0	0	0
Diagnostic Testing	338,035	351,306	(13,271)	0	23,175	(23,175)

Table B-6. Member Access to Providers – Verification of Report 0903: Anthem

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
DME	338,035	351,306	(13,271)	4,471	91,768	(87,297)
Endocrinologists	338,035	351,306	(13,271)	0	0	0
ESRD Clinic	338,035	351,306	(13,271)	0	0	0
Gastroenterologists	338,035	351,306	(13,271)	0	0	0
Dentists	338,035	351,306	(13,271)	0	1	(1)
General Surgeons	338,035	351,306	(13,271)	0	0	0
Hematologists	338,035	351,306	(13,271)	0	0	0
Home Health Providers	338,035	351,306	(13,271)	5,950	81,416	(75,466)
Infectious Disease Specialists	338,035	351,306	(13,271)	0	0	0
Inpatient Psychiatric Facilities	338,035	351,306	(13,271)	0	246	(246)
Interventional Radiologists	338,035	351,306	(13,271)	0	0	0
Nephrologists	338,035	351,306	(13,271)	0	0	0
Neurological Surgeons	338,035	351,306	(13,271)	0	0	0
Neurologists	338,035	351,306	(13,271)	0	0	0
Nonhospital-based Anesthesiologists	338,035	351,306	(13,271)	0	0	0
OB/GYN	338,035	207,653	130,382	0	0	0
Occupational Therapists	338,035	351,306	(13,271)	0	0	0
Oncologists	338,035	351,306	(13,271)	0	0	0
Ophthalmologists	338,035	351,306	(13,271)	0	0	0
Optometrists	338,035	351,306	(13,271)	0	0	0

Table B-6. Member Access to Providers – Verification of Report 0903: Anthem

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Orthodontists	338,035	351,306	(13,271)	92,012	105,689	(13,677)
Orthopedic Surgeons	338,035	351,306	(13,271)	0	0	0
Otolaryngologists	338,035	351,306	(13,271)	0	0	0
Pathologists	338,035	351,306	(13,271)	0	0	0
Pharmacy	338,035	351,306	(13,271)	0	0	0
Physiatrists**	*	351,306	*	*	0	*
Physical Therapists	338,035	351,306	(13,271)	0	0	0
PMPs	338,035	351,306	(13,271)	0	0	0
Podiatrists**	*	351,306	*	*	3	*
Prosthetic Suppliers	338,035	351,306	(13,271)	0	0	0
Psychiatrists	338,035	351,306	(13,271)	0	0	0
Pulmonologists	338,035	351,306	(13,271)	0	0	0
Radiation Oncologists	338,035	351,306	(13,271)	0	0	0
Radiologists	338,035	351,306	(13,271)	22,406	0	22,406
Rheumatologists	338,035	351,306	(13,271)	0	0	0
Speech Therapists	338,035	351,306	(13,271)	0	0	0
Urologists	338,035	351,306	(13,271)	0	0	0
HCC						
ABA Providers	56,174	*	*	0	*	*
Acute Care Hospitals	56,174	56,392	(218)	0	4	(4)

Table B-6. Member Access to Providers – Verification of Report 0903: Anthem

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Addiction Services	56,174	*	*	0	*	*
Anesthesiologists	56,174	56,392	(218)	0	0	0
Behavioral Health Providers	56,174	56,392	(218)	0	1	(1)
Cardiologists	56,174	56,392	(218)	0	0	0
Cardiothoracic Surgeons	56,174	56,392	(218)	0	0	0
Cardiovascular Surgeons	56,174	56,392	(218)	0	0	0
Clinic	56,174	*	*	0	*	*
Oral Surgeons	56,174	56,392	(218)	0	0	0
Dermatologists	56,174	56,392	(218)	0	0	0
Diagnostic Testing	56,174	56,392	(218)	0	4,041	(4,041)
DME	56,174	56,392	(218)	784	14,799	(14,015)
Endocrinologists	56,174	56,392	(218)	0	0	0
ESRD Clinic	56,174	56,392	(218)	0	0	0
Gastroenterologists	56,174	56,392	(218)	0	0	0
Dentists	56,174	56,392	(218)	0	0	0
General Surgeons	56,174	56,392	(218)	0	0	0
Hematologists	56,174	56,392	(218)	0	0	0
Home Health Providers	56,174	56,392	(218)	1,003	12,880	(11,877)
Infectious Disease Specialists	56,174	56,392	(218)	0	0	0
Inpatient Psychiatric Facilities	56,174	56,392	(218)	0	368	(368)

Table B-6. Member Access to Providers – Verification of Report 0903: Anthem

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Interventional Radiologists	56,174	56,392	(218)	0	0	0
Nephrologists	56,174	56,392	(218)	0	0	0
Neurological Surgeons	56,174	56,392	(218)	0	0	0
Neurologists	56,174	56,392	(218)	0	0	0
Nonhospital-based Anesthesiologists	56,174	56,392	(218)	0	0	0
OB/GYN	56,174	26,919	29,255	0	0	0
Occupational Therapists	56,174	56,392	(218)	0	0	0
Oncologists	56,174	56,392	(218)	0	0	0
Ophthalmologists	56,174	56,392	(218)	0	0	0
Optometrists	56,174	56,392	(218)	0	0	0
Orthodontists	56,174	56,392	(218)	16,284	17,644	(1,360)
Orthopedic Surgeons	56,174	56,392	(218)	0	0	0
Otolaryngologists	56,174	56,392	(218)	0	0	0
Pathologists	56,174	56,392	(218)	0	0	0
Pharmacy	56,174	56,392	(218)	0	0	0
Physiatrists	56,174	56,392	(218)	0	0	0
Physical Therapists	56,174	56,392	(218)	0	0	0
PMPs	56,174	56,392	(218)	0	0	0
Podiatrists	56,174	56,392	(218)	0	0	0
Prosthetic Suppliers	56,174	56,392	(218)	0	0	0

Table B-6. Member Access to Providers – Verification of Report 0903: Anthem

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Psychiatrists	56,174	56,392	(218)	0	0	0
Pulmonologists	56,174	56,392	(218)	0	0	0
Radiation Oncologists	56,174	56,392	(218)	0	0	0
Radiologists	56,174	56,392	(218)	3,332	0	3,332
Rheumatologists	56,174	56,392	(218)	0	0	0
Speech Therapists	56,174	56,392	(218)	0	0	0
Urologists	56,174	56,392	(218)	0	0	0

** Note – Fields populated with an asterisk (*) were not calculated since there was no accessibility requirement.*
*** Note – Podiatrists and Physiatrists are only covered for members enrolled in the HCC program.*

Table B-7. Member Access to Providers – Verification of Report 0903: CareSource

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
HHW						
ABA Providers	82,030	*	*	0	*	*
Acute Care Hospitals	82,030	78,696	3,334	0	0	0
Addiction Services	82,030	*	*	0	*	*
Anesthesiologists	82,030	78,696	3,334	0	0	0
Behavioral Health Providers	82,030	78,696	3,334	0	0	0
Cardiologists	82,030	78,696	3,334	0	0	0

Table B-7. Member Access to Providers – Verification of Report 0903: CareSource

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Cardiothoracic Surgeons	82,030	78,696	3,334	0	0	0
Cardiovascular Surgeons	82,030	78,696	3,334	0	0	0
Clinic	82,030	*	*	0	*	*
Oral Surgeons	82,030	78,696	3,334	98	10	88
Dermatologists	82,030	78,696	3,334	0	0	0
Diagnostic Testing	82,030	78,696	3,334	0	33,988	(33,988)
DME	82,030	78,696	3,334	0	23,566	(23,566)
Endocrinologists	82,030	78,696	3,334	0	97	(97)
ESRD Clinic	82,030	78,696	3,334	0	0	0
Gastroenterologists	82,030	78,696	3,334	0	0	0
Dentists	82,030	78,696	3,334	111	272	(161)
General Surgeons	82,030	78,696	3,334	0	0	0
Hematologists	82,030	78,696	3,334	0	0	0
Home Health Providers	82,030	78,696	3,334	0	37,538	(37,538)
Infectious Disease Specialists	82,030	78,696	3,334	0	0	0
Inpatient Psychiatric Facilities	82,030	78,696	3,334	0	21	(21)
Interventional Radiologists	82,030	78,696	3,334	0	0	0
Nephrologists	82,030	78,696	3,334	0	0	0
Neurological Surgeons	82,030	78,696	3,334	0	0	0
Neurologists	82,030	78,696	3,334	0	0	0

Table B-7. Member Access to Providers – Verification of Report 0903: CareSource

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Nonhospital-based Anesthesiologists	82,030	78,696	3,334	0	0	0
OB/GYN	82,030	40,236	41,794	0	0	0
Occupational Therapists	82,030	78,696	3,334	0	0	0
Oncologists	82,030	78,696	3,334	0	0	0
Ophthalmologists	82,030	78,696	3,334	0	0	0
Optometrists	82,030	78,696	3,334	0	0	0
Orthodontists	82,030	78,696	3,334	16,587	23,994	(7,407)
Orthopedic Surgeons	82,030	78,696	3,334	0	0	0
Otolaryngologists	82,030	78,696	3,334	0	0	0
Pathologists	82,030	78,696	3,334	0	0	0
Pharmacy	82,030	78,696	3,334	0	5,276	(5,276)
Physical Therapists	82,030	78,696	3,334	0	0	0
PMPs	82,030	78,696	3,334	0	0	0
Prosthetic Suppliers	82,030	78,696	3,334	0	0	0
Psychiatrists	82,030	78,696	3,334	0	0	0
Pulmonologists	82,030	78,696	3,334	0	0	0
Radiation Oncologists	82,030	78,696	3,334	0	0	0
Radiologists	82,030	78,696	3,334	0	0	0
Rheumatologists	82,030	78,696	3,334	0	0	0
Speech Therapists	82,030	78,696	3,334	0	0	0

Table B-7. Member Access to Providers – Verification of Report 0903: CareSource

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Urologists	82,030	78,696	3,334	0	0	0
HIP						
ABA Providers	81,381	*	*	0	*	*
Acute Care Hospitals	81,381	82,524	(1,143)	0	0	0
Addiction Services	81,381	*	*	0	*	*
Anesthesiologists	81,381	82,524	(1,143)	0	0	0
Behavioral Health Providers	81,381	82,524	(1,143)	0	0	0
Cardiologists	81,381	82,524	(1,143)	0	0	0
Cardiothoracic Surgeons	81,381	82,524	(1,143)	0	0	0
Cardiovascular Surgeons	81,381	82,524	(1,143)	0	0	0
Clinic	81,381	*	*	0	*	*
Oral Surgeons	81,381	82,524	(1,143)	602	665	(63)
Dermatologists	81,381	82,525	(1,144)	0	0	0
Diagnostic Testing	81,381	82,524	(1,143)	0	35,885	(35,885)
DME	81,381	82,524	(1,143)	0	23,613	(23,613)
Endocrinologists	81,381	82,524	(1,143)	0	73	(73)
ESRD Clinic	81,381	82,524	(1,143)	0	0	0
Gastroenterologists	81,381	82,524	(1,143)	0	0	0
Dentists	81,381	82,524	(1,143)	178	348	(170)
General Surgeons	81,381	82,524	(1,143)	0	0	0

Table B-7. Member Access to Providers – Verification of Report 0903: CareSource

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Hematologists	81,381	82,524	(1,143)	0	0	0
Home Health Providers	81,381	82,524	(1,143)	0	39,308	(39,308)
Infectious Disease Specialists	81,381	82,524	(1,143)	0	0	0
Inpatient Psychiatric Facilities	81,381	82,524	(1,143)	0	39	(39)
Interventional Radiologists	81,381	82,524	(1,143)	0	0	0
Nephrologists	81,381	82,524	(1,143)	0	0	0
Neurological Surgeons	81,381	82,525	(1,144)	0	0	0
Neurologists	81,381	82,524	(1,143)	0	0	0
Nonhospital-based Anesthesiologists	81,381	82,524	(1,143)	0	0	0
OB/GYN	81,381	43,672	37,709	0	0	0
Occupational Therapists	81,381	82,524	(1,143)	0	0	0
Oncologists	81,381	82,524	(1,143)	0	0	0
Ophthalmologists	81,381	82,524	(1,143)	0	0	0
Optometrists	81,381	82,524	(1,143)	0	0	0
Orthodontists	81,381	82,524	(1,143)	17,611	24,418	(6,807)
Orthopedic Surgeons	81,381	82,524	(1,143)	0	0	0
Otolaryngologists	81,381	82,525	(1,144)	0	0	0
Pathologists	81,381	82,524	(1,143)	0	0	0
Pharmacy	81,381	82,524	(1,143)	0	5,618	(5,618)
Physical Therapists	81,381	82,524	(1,143)	0	0	0

Table B-7. Member Access to Providers – Verification of Report 0903: CareSource

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
PMPs	81,381	82,525	(1,144)	0	0	0
Prosthetic Suppliers	81,381	82,525	(1,144)	0	0	0
Psychiatrists	81,381	82,525	(1,144)	0	0	0
Pulmonologists	81,381	82,524	(1,143)	0	0	0
Radiation Oncologists	81,381	82,524	(1,143)	0	0	0
Radiologists	81,381	82,524	(1,143)	0	0	0
Rheumatologists	81,381	82,524	(1,143)	0	0	0
Speech Therapists	81,381	82,524	(1,143)	0	0	0
Urologists	81,381	82,524	(1,143)	0	0	0

** Note – Fields populated with an asterisk (*) were not calculated since there was no accessibility requirement.*

Table B-8. Member Access to Providers – Verification of Report 0903: MDwise

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
HHW						
ABA Providers	217,393	*	*	0	*	*
Acute Care Hospitals	217,393	212,362	5,031	12	0	12
Addiction Services	217,393	*	*	0	*	*
Anesthesiologists	217,393	212,362	5,031	0	0	0
Behavioral Health Providers	217,393	212,362	5,031	19	0	19

Table B-8. Member Access to Providers – Verification of Report 0903: MDwise

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Cardiologists	217,393	212,362	5,031	0	0	0
Cardiothoracic Surgeons	217,393	212,362	5,031	0	0	0
Cardiovascular Surgeons	217,393	212,362	5,031	0	0	0
Clinic	217,393	*	*	0	*	*
Oral Surgeons	217,393	212,362	5,031	0	94,061	(94,061)
Dermatologists	217,393	212,362	5,031	0	0	0
Diagnostic Testing	217,393	212,362	5,031	36,743	32,712	4,031
DME	217,393	212,362	5,031	0	69,954	(69,954)
Endocrinologists	217,393	212,362	5,031	6,828	0	6,828
ESRD Clinic	217,393	212,362	5,031	71	0	71
Gastroenterologists	217,393	212,362	5,031	0	5	(5)
Dentists	217,393	212,362	5,031	0	97,457	(97,457)
General Surgeons	217,393	212,362	5,031	0	0	0
Hematologists	217,393	212,362	5,031	0	0	0
Home Health Providers	217,393	212,362	5,031	3,666	103,865	(100,199)
Infectious Disease Specialists	217,393	212,362	5,031	0	0	0
Inpatient Psychiatric Facilities	217,393	212,362	5,031	7,567	4,821	2,746
Interventional Radiologists	217,393	212,362	5,031	2,177	0	2,177
Nephrologists	217,393	212,362	5,031	0	0	0
Neurological Surgeons	217,393	212,362	5,031	0	0	0

Table B-8. Member Access to Providers – Verification of Report 0903: MDwise

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Neurologists	217,393	212,362	5,031	0	0	0
Nonhospital-based Anesthesiologists	217,393	212,362	5,031	0	0	0
OB/GYN	217,393	106,710	110,683	0	0	0
Occupational Therapists	217,393	212,362	5,031	0	0	0
Oncologists	217,393	212,362	5,031	0	0	0
Ophthalmologists	217,393	212,362	5,031	0	0	0
Optometrists	217,393	212,362	5,031	0	0	0
Orthodontists	217,393	212,362	5,031	56,806	212,362	(155,556)
Orthopedic Surgeons	217,393	212,362	5,031	0	0	0
Otolaryngologists	217,393	212,362	5,031	0	0	0
Pathologists	217,393	212,362	5,031	0	0	0
Pharmacy	217,393	212,362	5,031	6	0	6
Physical Therapists	217,393	212,362	5,031	0	0	0
PMPs	217,393	212,362	5,031	0	0	0
Prosthetic Suppliers	217,393	212,362	5,031	14	0	14
Psychiatrists	217,393	212,362	5,031	0	0	0
Pulmonologists	217,393	212,362	5,031	0	0	0
Radiation Oncologists	217,393	212,362	5,031	0	0	0
Radiologists	217,393	212,362	5,031	0	0	0
Rheumatologists	217,393	212,362	5,031	0	0	0

Table B-8. Member Access to Providers – Verification of Report 0903: MDwise						
Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Speech Therapists	217,393	212,362	5,031	0	0	0
Urologists	217,393	212,362	5,031	0	0	0
HIP						
ABA Providers	164,835	*	*	0	*	*
Acute Care Hospitals	164,835	166,454	(1,619)	16	1	15
Addiction Services	164,835	*	*	0	*	*
Anesthesiologists	164,835	166,454	(1,619)	0	0	0
Behavioral Health Providers	164,835	166,454	(1,619)	19	0	19
Cardiologists	164,835	166,454	(1,619)	0	0	0
Cardiothoracic Surgeons	164,835	166,454	(1,619)	0	0	0
Cardiovascular Surgeons	164,835	166,454	(1,619)	0	0	0
Clinic	164,835	*	*	0	*	*
Oral Surgeons	164,835	166,454	(1,619)	0	74,977	(74,977)
Dermatologists	164,835	166,454	(1,619)	0	0	0
Diagnostic Testing	164,835	166,454	(1,619)	30,099	29,216	883
DME	164,835	166,454	(1,619)	0	58,143	(58,143)
Endocrinologists	164,835	166,454	(1,619)	5,516	0	5,516
ESRD Clinic	164,835	166,454	(1,619)	56	0	56
Gastroenterologists	164,835	166,454	(1,619)	0	6	(6)
Dentists	164,835	166,454	(1,619)	0	79,948	(79,948)

Table B-8. Member Access to Providers – Verification of Report 0903: MDwise

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
General Surgeons	164,835	166,454	(1,619)	0	0	0
Hematologists	164,835	166,454	(1,619)	0	0	0
Home Health Providers	164,835	166,454	(1,619)	3,304	87,085	(83,781)
Infectious Disease Specialists	164,835	166,454	(1,619)	0	0	0
Inpatient Psychiatric Facilities	164,835	166,454	(1,619)	6,461	4,252	2,209
Interventional Radiologists	164,835	166,454	(1,619)	2,308	0	2,308
Nephrologists	164,835	166,454	(1,619)	0	0	0
Neurological Surgeons	164,835	166,454	(1,619)	0	0	0
Neurologists	164,835	166,454	(1,619)	0	0	0
Nonhospital-based Anesthesiologists	164,835	166,454	(1,619)	0	0	0
OB/GYN	164,835	104,174	60,661	0	0	0
Occupational Therapists	164,835	166,454	(1,619)	0	0	0
Oncologists	164,835	166,454	(1,619)	0	0	0
Ophthalmologists	164,835	166,454	(1,619)	0	0	0
Optometrists	164,835	166,454	(1,619)	0	0	0
Orthodontists	164,835	166,454	(1,619)	44,760	166,454	(121,694)
Orthopedic Surgeons	164,835	166,454	(1,619)	0	0	0
Otolaryngologists	164,835	166,454	(1,619)	0	0	0
Pathologists	164,835	166,454	(1,619)	0	0	0
Pharmacy	164,835	166,454	(1,619)	6	0	6

Table B-8. Member Access to Providers – Verification of Report 0903: MDwise

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Physical Therapists	164,835	166,454	(1,619)	0	0	0
PMPs	164,835	166,454	(1,619)	0	0	0
Prosthetic Suppliers	164,835	166,454	(1,619)	18	0	18
Psychiatrists	164,835	166,454	(1,619)	0	0	0
Pulmonologists	164,835	166,454	(1,619)	0	0	0
Radiation Oncologists	164,835	166,454	(1,619)	0	0	0
Radiologists	164,835	166,454	(1,619)	0	0	0
Rheumatologists	164,835	166,454	(1,619)	0	0	0
Speech Therapists	164,835	*	*	0	*	*
Urologists	164,835	166,454	(1,619)	0	0	0

** Note – Fields populated with an asterisk (*) were not calculated since there was no accessibility requirement.*

Table B-9. Member Access to Providers - Verification of Report 0903: MHS

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
HHW						
ABA Providers	187,083	*	*	0	*	*
Acute Care Hospitals	187,083	183,439	3,644	0	7	(7)
Addiction Services	187,083	*	*	0	*	*
Anesthesiologists	187,083	183,439	3,644	0	0	0

Table B-9. Member Access to Providers - Verification of Report 0903: MHS

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Behavioral Health Providers	187,083	183,439	3,644	0	0	0
Cardiologists	187,083	183,439	3,644	0	0	0
Cardiothoracic Surgeons	187,083	183,439	3,644	0	0	0
Cardiovascular Surgeons	187,083	183,439	3,644	0	0	0
Clinic	187,083	*	*	0	*	*
Dentists/Oral Surgeons	187,083	183,439	3,644	139	198	(59)
Dermatologists	187,083	183,439	3,644	0	0	0
Diagnostic Testing	187,083	183,439	3,644	106,137	29,866	76,271
DME	187,083	183,439	3,644	0	22,356	(22,356)
Endocrinologists	187,083	183,439	3,644	0	89	(89)
ESRD Clinic	187,083	183,439	3,644	0	0	0
Gastroenterologists	187,083	183,439	3,644	0	0	0
General Dentistry	187,083	183,439	3,644	0	136	(136)
General Surgeons	187,083	183,439	3,644	0	0	0
Hematologists	187,083	183,439	3,644	0	0	0
Home Health Providers	187,083	183,439	3,644	0	45,146	(45,146)
Infectious Disease Specialists	187,083	183,439	3,644	0	0	0
Inpatient Psychiatric Facilities	187,083	183,439	3,644	0	3	(3)
Interventional Radiologists	187,083	183,439	3,644	0	0	0
Nephrologists	187,083	183,439	3,644	0	0	0

Table B-9. Member Access to Providers - Verification of Report 0903: MHS

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Neurological Surgeons	187,083	183,439	3,644	0	0	0
Neurologists	187,083	183,439	3,644	0	0	0
Nonhospital-based Anesthesiologists	187,083	183,439	3,644	0	0	0
OB/GYN	187,083	92,444	94,639	0	0	0
Occupational Therapists	187,083	183,439	3,644	0	0	0
Oncologists	187,083	183,439	3,644	0	0	0
Ophthalmologists	187,083	183,439	3,644	0	0	0
Optometrists	187,083	183,439	3,644	0	0	0
Orthodontists	187,083	183,439	3,644	52,034	76,805	(24,771)
Orthopedic Surgeons	187,083	183,439	3,644	0	0	0
Otolaryngologists	187,083	183,439	3,644	0	232	(232)
Pathologists	187,083	183,439	3,644	0	0	0
Pharmacy	187,083	183,439	3,644	0	0	0
Physiatrists**	**	183,439	*	*	0	*
Physical Therapists	187,083	183,439	3,644	0	0	0
PMPs	187,083	183,439	*	0	0	0
Podiatrists**	**	183,439	(83,440)	*	0	*
Prosthetic Suppliers	187,083	183,439	3,644	0	0	0
Psychiatrists	187,083	183,439	3,644	0	0	0
Pulmonologists	187,083	183,439	3,644	0	0	0

Table B-9. Member Access to Providers - Verification of Report 0903: MHS						
Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Radiation Oncologists	187,083	183,439	3,644	0	0	0
Radiologists	187,083	183,439	3,644	0	0	0
Rheumatologists	187,083	183,439	3,644	0	0	0
Speech Therapists	187,083	183,439	3,644	0	0	0
Urologists	187,083	183,439	3,644	0	0	0
HIP						
ABA Providers	140,108	*	*	0	*	*
Acute Care Hospitals	140,108	136,502	3,606	0	3	(3)
Addiction Services	140,108	*	*	0	*	*
Anesthesiologists	140,108	136,502	3,606	0	0	0
Behavioral Health Providers	140,108	136,502	3,606	0	0	0
Cardiologists	140,108	136,502	3,606	0	0	0
Cardiothoracic Surgeons	140,108	136,502	3,606	0	0	0
Cardiovascular Surgeons	140,108	136,502	3,606	0	0	0
Clinic	140,108	*	*	0	*	*
Dentists/Oral Surgeons	140,108	136,502	3,606	155	78	77
Dermatologists	140,108	136,502	3,606	0	0	0
Diagnostic Testing	140,108	136,502	3,606	76,343	24,623	51,720
DME	140,108	136,502	3,606	0	17,429	(17,429)
Endocrinologists	140,108	136,502	3,606	0	43	(43)

Table B-9. Member Access to Providers - Verification of Report 0903: MHS

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
ESRD Clinic	140,108	136,502	3,606	0	0	0
Gastroenterologists	140,108	136,502	3,606	0	0	0
General Dentistry	140,108	136,502	3,606	0	114	(114)
General Surgeons	140,108	136,502	3,606	0	0	0
Hematologists	140,108	136,502	3,606	0	0	0
Home Health Providers	140,108	136,502	3,606	0	35,779	(35,779)
Infectious Disease Specialists	140,108	136,502	3,606	0	0	0
Inpatient Psychiatric Facilities	140,108	136,502	3,606	0	4	(4)
Interventional Radiologists	140,108	136,502	3,606	0	0	0
Nephrologists	140,108	136,502	3,606	0	0	0
Neurological Surgeons	140,108	136,502	3,606	0	0	0
Neurologists	140,108	136,502	3,606	0	0	0
Nonhospital-based Anesthesiologists	140,108	136,502	3,606	0	0	0
OB/GYN	140,108	82,669	57,439	0	0	0
Occupational Therapists	140,108	136,502	3,606	0	0	0
Oncologists	140,108	136,502	3,606	0	0	0
Ophthalmologists	140,108	136,502	3,606	0	0	0
Optometrists	140,108	136,502	3,606	0	0	0
Orthodontists	140,108	136,502	3,606	34,819	51,247	(16,428)
Orthopedic Surgeons	140,108	136,502	3,606	0	0	0

Table B-9. Member Access to Providers - Verification of Report 0903: MHS						
Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Otolaryngologists	140,108	136,502	3,606	0	8	(8)
Pathologists	140,108	136,502	3,606	0	0	0
Pharmacy	140,108	136,502	3,606	0	0	0
Physiatrists**	**	136,502	*	*	0	*
Physical Therapists	140,108	136,502	3,606	0	0	0
PMPs	140,108	136,502	3,606	0	0	0
Podiatrists**	**	136,502	*	*	0	*
Prosthetic Suppliers	140,108	136,502	3,606	0	0	0
Psychiatrists	140,108	136,502	3,606	0	0	0
Pulmonologists	140,108	136,502	3,606	0	0	0
Radiation Oncologists	140,108	136,502	3,606	0	0	0
Radiologists	140,108	136,502	3,606	0	0	0
Rheumatologists	140,108	136,502	3,606	0	0	0
Speech Therapists	140,108	136,502	3,606	0	0	0
Urologists	140,108	136,502	3,606	0	0	0
HCC						
ABA Providers	33,051	*	*	0	*	*
Acute Care Hospitals	33,051	32,579	472	0	0	0
Addiction Services	33,051	*	*	0	*	*
Anesthesiologists	33,051	32,579	472	0	0	0

Table B-9. Member Access to Providers - Verification of Report 0903: MHS

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Behavioral Health Providers	33,051	32,579	472	0	0	0
Cardiologists	33,051	32,579	472	0	0	0
Cardiothoracic Surgeons	33,051	32,579	472	0	0	0
Cardiovascular Surgeons	33,051	32,579	472	0	0	0
Clinic	33,051	*	*	0	*	*
Dentists/Oral Surgeons	33,051	32,579	472	59	32	27
Dermatologists	33,051	32,579	472	0	0	0
Diagnostic Testing	33,051	32,579	472	17,252	5,799	11,453
DME	33,051	32,579	472	0	4,831	(4,831)
Endocrinologists	33,051	32,579	472	0	15	(15)
ESRD Clinic	33,051	32,579	472	0	0	0
Gastroenterologists	33,051	32,579	472	0	0	0
General Dentistry	33,051	32,579	472	0	19	(19)
General Surgeons	33,051	32,579	472	0	0	0
Hematologists	33,051	32,579	472	0	0	0
Home Health Providers	33,051	32,579	472	0	6,241	(6,241)
Infectious Disease Specialists	33,051	32,579	472	0	0	0
Inpatient Psychiatric Facilities	33,051	32,579	472	0	0	0
Interventional Radiologists	33,051	32,579	472	0	0	0
Nephrologists	33,051	32,579	472	0	0	0

Table B-9. Member Access to Providers - Verification of Report 0903: MHS

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Neurological Surgeons	33,051	32,579	472	0	0	0
Neurologists	33,051	32,579	472	0	0	0
Nonhospital-based Anesthesiologists	33,051	32,579	472	0	0	0
OB/GYN	33,051	15,041	18,010	0	0	0
Occupational Therapists	33,051	32,579	472	0	0	0
Oncologists	33,051	32,579	472	0	0	0
Ophthalmologists	33,051	32,579	472	0	0	0
Optometrists	33,051	32,579	472	0	0	0
Orthodontists	33,051	32,579	472	7,436	11,740	(4,304)
Orthopedic Surgeons	33,051	32,579	472	0	0	0
Otolaryngologists	33,051	32,579	472	0	2	(2)
Pathologists	33,051	32,579	472	0	0	0
Pharmacy	33,051	32,579	472	0	0	0
Physiatrists	33,051	32,579	472	0	0	0
Physical Therapists	33,051	32,579	472	0	0	0
PMPs	33,051	32,579	472	0	0	0
Podiatrists	33,051	32,579	472	0	0	0
Prosthetic Suppliers	33,051	32,579	472	0	0	0
Psychiatrists	33,051	32,579	472	0	0	0
Pulmonologists	33,051	32,579	472	0	0	0

Table B-9. Member Access to Providers - Verification of Report 0903: MHS

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Radiation Oncologists	33,051	32,579	472	0	0	0
Radiologists	33,051	32,579	472	0	0	0
Rheumatologists	33,051	32,579	472	0	0	0
Speech Therapists	33,051	32,579	472	0	0	0
Urologists	33,051	32,579	472	0	0	0

** Note – Fields populated with an asterisk (*) were not calculated since there was no accessibility requirement.*
*** Note – Podiatrists and Physiatrists are only covered for members enrolled in the HCC program.*

Table B-10. Member Access to Providers – Verification of Report 0903: UHC

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
HCC						
ABA Providers	5,812	*	*	0	*	*
Acute Care Hospitals	5,812	5,667	145	0	822	(822)
Addiction Services	5,812	*	*	0	*	*
Anesthesiologists	5,812	5,667	145	0	0	0
Behavioral Health Providers	5,812	5,667	145	0	0	0
Cardiologists	5,812	5,667	145	0	0	0
Cardiothoracic Surgeons	5,812	5,667	145	0	0	0
Cardiovascular Surgeons	5,812	5,667	145	0	0	0
Clinic	5,812	*	*	0	*	*

Table B-10. Member Access to Providers – Verification of Report 0903: UHC

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Oral Surgeons	5,812	5,667	145	846	635	211
Dermatologists	5,812	5,667	145	0	0	0
Diagnostic Testing	5,812	5,667	145	0	2,681	(2,681)
DME	5,812	5,667	145	0	5,667	(5,667)
Endocrinologists	5,812	5,667	145	0	0	0
ESRD Clinic	5,812	5,667	145	0	0	0
Gastroenterologists	5,812	5,667	145	0	0	0
Dentists	5,812	5,667	145	7	21	(14)
General Surgeons	5,812	5,667	145	0	0	0
Hematologists	5,812	5,667	145	0	0	0
Home Health Providers	5,812	5,667	145	0	5,667	(5,667)
Infectious Disease Specialists	5,812	5,667	145	0	0	0
Inpatient Psychiatric Facilities	5,812	5,667	145	4	143	(139)
Interventional Radiologists	5,812	5,667	145	0	0	0
Nephrologists	5,812	5,667	145	0	0	0
Neurological Surgeons	5,812	5,667	145	0	0	0
Neurologists	5,812	5,667	145	0	0	0
Nonhospital-based Anesthesiologists	5,812	5,667	145	0	0	0
OB/GYN	5,812	2,603	3,209	0	0	0
Occupational Therapists	5,812	5,667	145	7	2	5

Table B-10. Member Access to Providers – Verification of Report 0903: UHC

Service Type	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Oncologists	5,812	5,667	145	0	0	0
Ophthalmologists	5,812	5,667	145	0	0	0
Optometrists	5,812	5,667	145	0	0	0
Orthodontists	5,812	5,667	145	1,851	1,610	241
Orthopedic Surgeons	5,812	5,667	145	0	0	0
Otolaryngologists	5,812	5,667	145	0	0	0
Pathologists	5,812	5,667	145	0	0	0
Pharmacy	5,812	5,667	145	0	0	0
Physiatrists	5,812	5,667	145	0	0	0
Physical Therapists	5,812	5,667	145	0	0	0
PMPs-Physicians	5,812	5,667	145	0	0	0
Podiatrists	5,812	5,667	145	0	0	0
Prosthetic Suppliers	5,812	5,667	145	0	5,667	(5,667)
Psychiatrists	5,812	5,667	145	0	0	0
Pulmonologists	5,812	5,667	145	0	0	0
Radiation Oncologists	5,812	5,667	145	0	0	0
Radiologists	5,812	5,667	145	0	0	0
Rheumatologists	5,812	5,667	145	0	15	(15)
Speech Therapists	5,812	5,667	145	0	2	(2)
Urologists	5,812	5,667	145	0	0	0

** Note – Fields populated with an asterisk (*) were not calculated since there was no accessibility requirement.*