Managed Care Program Annual Report (MCPAR) for Indiana: Hoosier HealthWise (HHW)

Due date	Last edited	Edited by	Status
06/29/2026	06/29/2026	Cinthia Gonzales Cruz	Submitted

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected
	Did you submit or do you plan on submitting a Network Adequacy and Access Assurances (NAAAR) Report for this program for this reporting period through the MDCT online tool? If “No”, please complete the following questions under each plan.	Yes, I plan on submitting it in MDCT

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Indiana
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Cinthia Gonzales
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	cinthia.gonzalescruz@fssa.in.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Cinthia Gonzales Cruz
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	cinthia.gonzalescruz@fssa.in.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	06/29/2026

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2025
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2025
A6	**Program name** Auto-populated from report dashboard.	Hoosier HealthWise (HHW)

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

	Indicator	Response
	Plan name	Managed Health Services CareSource MDwise Anthem

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Indicator	Response
BSS entity name	Maximus Health Services, Inc

Add In Lieu of Services and Settings (A.9)

This section must be completed if any in lieu of services or settings (ILOSs) *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** (See 42 CFR 438.3(e)(2) and 438.16).

Indicator	Response
ILOS name	None

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	1,848,453
BI.2	**Statewide Medicaid risk-based managed care enrollment** Enter the average number of individuals enrolled in risk-based Medicaid managed care per month during the reporting year (i.e., average member months). Include all MCOs and at-risk PIHPs and PAHPs only, and count each person only once, even if they are enrolled in multiple managed care programs or plans.	1,512,993

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	State Medicaid agency staff State actuaries EQRO

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter "No PI activities were performed during the reporting period" as your response. "N/A" is not an acceptable response.	Activities of focus in 2025 included an audit of Medicaid claims submitted to Medicaid between January 1, 2022 and March 31, 2025 from the five largest attendant care providers. Attendant care, however, is not applicable to the HHW program. Apart from the audit, the State and MCE SIU partners focused on ABA and UV coating audits.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	7.4 Program Integrity Overpayment Recovery
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard selected in indicator B.X.2.	In cases involving wasteful or abusive provider billing or service practices (including overpayments) identified by the OMPP PI Unit, FSSA may recover any identified overpayments directly from the provider or may require the MCO to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed. The OMPP PI Unit may also take disciplinary action against any provider identified by the MCO or FSSA that engages in inappropriate or abusive billing or service provision practices. If the fraud referral from the MCO generates an action that results

		in a monetary recovery, the reporting MCO does get a share of the final monetary amount (the contract does allow for the State and MFCU to retain the cost of pursuing the final action). If the State makes a recovery from a fraud investigation and/or corresponding legal action where the MCO has sustained a documented loss but the case did not result from a referral made by the MCO, the State shall not be obligated to repay any monies recovered to the MCO, but may do so at its discretion.
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	The MCOs submit monthly, quarterly, and yearly reports that detail the ongoing activities and status on overpayments. Additionally, members of the PI staff meet with each MCO monthly to discuss ongoing activities. MCOs also participate in a bi-monthly All MCO meeting.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	The Benefit Enrollment and Maintenance (834) file is sent to the health plans on a daily basis to account for changes in status. Additionally, the State sends the health plans a weekly reconciliation file to identify any discrepancies in enrollment. The MCOs are responsible for verifying member eligibility data and reconciling with capitation payments for each eligible member on a monthly basis. If an MCO discovers a discrepancy in eligibility or capitation information, the MCO must notify FSSA and the State fiscal agent within thirty (30) calendar days of discovering the discrepancy and no more than ninety (90) calendar days after FSSA delivers the eligibility records.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes

BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	Yes
BX.8b	**Federal database checks: Summarize instances of exclusion** Summarize the instances and whether the entity was notified as required in 438.602(d). Report actions taken, such as plan-level sanctions and corrective actions.	Throughout the reporting period, some providers were terminated for noncompliance with the federal conditions of participation, including failing background checks, felony convictions, and termination by Medicare.
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.	No
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit	FSSA recognizes the importance of monitoring MCO performance throughout the calendar year, and as a result the MCOs are required to submit quarterly encounter data quality reports. Each quarterly report includes year-to-date information and must be verified to a degree of at least ninety-eight percent (98%)

results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter "No such audits were conducted during the reporting year" as your response. "N/A" is not an acceptable response.	completeness for all claims. State actuaries, in collaboration with their MCO officer, review the report to reconcile whether results differ more than (+/-) 2%, which may result in financial penalties. These audits are not publicly posted. Additionally, as a result of Indiana Executive Order 25-24, an independent audit was completed by Health Management Associates to assure the prudent use of Medicaid funds. The results may be found here: https://www.in.gov/gov/files/EO-25-24-Waste-Fraud-and-Abuse-Report.pdf

Topic XIII. Prior Authorization

Beginning June 2026, Indicators B.XIII.1a-b–2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?**	Yes
BXIII.1a	**Timeframes for standard prior authorization decisions** Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and within state-established timeframes. For rating periods that start before January 1, 2026, a state's time frame may not exceed 14 calendar days after receiving the request. For rating periods that start on or after January 1, 2026, a state's time frame may not exceed 7 calendar days after receiving the request. Does the state set timeframes shorter than these maximum timeframes for standard prior authorization requests?	Yes
BXIII.1b	**State's timeframe for standard prior authorization decisions** Indicate the state's maximum timeframe, as number of days, for plans to provide notice of their decisions on standard prior authorization requests.	2
BXIII.2a	**Timeframes for expedited prior authorization decisions** Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and no later than 72 hours after receipt of the request for service. Does the state set timeframes shorter than the maximum timeframe for expedited prior authorization requests?	Yes
BXIII.2b	**State's timeframe for expedited prior authorization decisions** Indicate the state's maximum timeframe, as number of hours, for plans to provide notice of	48

	their decisions on expedited prior authorization requests.

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Indiana has a separate contract with each MCO: Anthem (#69618), MHS (#69680), MDwise (#69716), CareSource (#69768)
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2017
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Dental Transportation
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	Since all members under 21 receive additional benefits due to EPSDT, there are few differences in dental coverage for HHW members depending on their age. HHW members will be provided with one of two benefit packages, A (full Medicaid) and Package C for Separate CHIP members. Nursing facility services and non-emergency transportation services are covered for members under benefit Package A and not under Package C. Package A covers up to 6 routine visits to

		podiatrists yearly, while Package C excludes this care but covers medically necessary surgical procedures, labs/X-rays, and hospital stays. Lastly, Package A covers 5 visits and 50 therapeutic physical treatments per year with chiropractors, while package C covers 5 visits and 14 treatments, with up to 36 more if medically necessary and pre-approved.
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	680,460
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter “There were no major changes to the population or benefits during the reporting year” as your response. “N/A” is not an acceptable response.	Towards the end of 2025, there was a significant shift in enrollment across the HHW MCOs, as MDwise is no longer a health plan with Indiana Medicaid effective January 1, 2026. Members enrolled with MDwise received notice to select another MCO during the open enrollment period. Members that had not chosen another MCO by December 24, 2025 were auto assigned to either MHS, CareSource, or Anthem. Additionally, enrollment began to decline in March 2025 which may be driven by a change in FSSA's policy, requiring members that do not qualify for ex parte renewals to respond to a mailer as part of the eligibility redetermination process.

Topic II: Medical Loss Ratio (MLR) Reporting

Number	Indicator	Response
C1II.1	**Submission Date of Most Recent MLR Report** When is the last date the state submitted the MLR Summary Report in the Medicaid Data Collection Tool (MDCT) MLR Portal for this program?	09/29/2025
C1II.2	**Most Recent MLR Reporting Period** Please report the beginning date of that MLR reporting period.	01/01/2023
N/A	Please report the end date of that MLR reporting period.	12/31/2023
C1II.3	**MLR Validation Completion** Has the state completed the validation of plan MLR data for the current MCPAR reporting period by the submission date of this report for all plans? (See detailed reporting in Section D1.II by plan.)	No
C1II.3a	**Anticipated Validation Date** When does the state anticipate doing so?	06/2027

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Overall data accuracy (as determined through data validation) Other, specify – Completeness of encounter claims data
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	8.6. Encounter Data Submission and Exhibit 2D Section 6 Encounter Data Quality Report, Exhibit 2D (7) Non-compliance with Shadow/Encounter Claims Submission Requirements.

C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	Exhibit 2D Section 6 Encounter Data Quality Report, Exhibit 2D (7) Non-compliance with Shadow/Encounter Claims Submission Requirements.
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with N/A if the program does not use incentives to reward encounter data quality.	FSSA may recognize MCOs that attain superior performance and/or improvement by publicizing their achievements. FSSA may include MCO's encounter and performance indicators on materials distributed to potential members to facilitate MCO selection. Additionally, the State may reward high performing MCOs through the auto-assignment logic.
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter “The state did not experience any barriers to collecting or validating encounter data during the reporting year” as your response. “N/A” is not an acceptable response.	The State did not experience any barriers to collecting or validating encounter data during the reporting year.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident", as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	The MCOs must make a decision on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal.
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	The MCOs must resolve expedited appeals within forty-eight (48) hours after receiving notice of the appeal.

C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	The MCOs must make a decision on non-expedited grievances as expeditiously as possible, but not more than thirty (30) calendar days following receipt of the grievance.

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://www.in.gov/medicaid/partners/medicaid-partners/maximus/
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	Member materials must be written at a fifth grade reading level. Alternative formats must be made available that considers the requirements of the Americans with Disabilities Act and the special needs of those who may be visually limited or have limited English proficiency. If a member calls with their own TTY services, Maximus will accept those calls and handle those calls as they would any other calls. Also, if a member requests TTY services for hearing impaired members, Maximus will refer them to TTY services that are offered.
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4). If the program does not offer LTSS, enter “N/A”.	N/A
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities’ performance?	Oversight of Maximus is completed by a state official that serves as their Contract Manager. The Contract Manager ensures that Maximus is completing all the deliverables outlined in the contract by reviewing reports submitted with performance metrics. For example, Maximus must submit monthly reports to the State, which captures call statistics, member enrollment, disenrollments, auto-assignment rates, grievances, staff turnover, etc.

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	**Does this program include MCOs?** If "Yes", please complete the following questions.	Yes
C1XII.5	**Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?** (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	Yes
C1XII.6	**Did the State or MCOs complete the most recent parity analysis(es)?**	State
C1XII.7a	**Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?** (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	Yes
C1XII.7b	**Describe the event(s) that necessitated an update to the parity analysis(es).** Select all that apply.	Changes in benefits Changes in quantitative treatment limits (QTLs), (limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits) Addition of a new managed care plan (MCP) providing services to MCO enrollees Other, specify – Definition of MH and SUD updated, additional context provided across various sections
C1XII.8	**When was the last parity analysis(es) for this program completed?**	12/31/2025

	States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	
C1XII.9	**When was the last parity analysis(es) for this program submitted to CMS?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	03/23/2026
C1XII.10a	**In the last analysis(es) conducted, were any deficiencies identified?**	No

C1XII.12a	**Has the state posted the current parity analysis(es) covering this program on its website?** The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report.States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.	Yes
C1XII.12b	**Provide the URL link(s).** Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.	https://www.in.gov/fssa/ompp/provider-information/mental-health-parity-compliance/

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Managed Health Services** 157,106 **CareSource** 72,864 **MDwise** 173,875 **Anthem** 276,616
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid enrollment (B.I.1)	**Managed Health Services** 8.5% **CareSource** 3.9% **MDwise** 9.4% **Anthem** 15%
D1I.3	**Plan share of risk-based Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in risk-based managed care?Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid risk-based managed care enrollment (B.I.2)	**Managed Health Services** 10.4% **CareSource** 4.8% **MDwise** 11.5% **Anthem** 18.3%
D1I.4: Parent	**Organization: The name of the parent entity that controls the Medicaid Managed Care Plan.** If the managed care plan is owned or controlled by a separate entity (parent), report the name of that entity. If the managed care plan is not	**Managed Health Services** Centene Corporation **CareSource** CareSource Indiana, Inc **MDwise**

controlled by a separate entity, please report the managed care plan name in this field.	McLaren Health Care **Anthem** Elevance Health

Topic II: Medical Loss Ratio (MLR) Reporting

Number	Indicator	Response
D1II.1	**MLR Data Received** Has the state received the MLR data specified at 42 CFR 438.8(k) from this plan for the current MCPAR reporting period as of the submission date of this MCPAR report?	**Managed Health Services** Yes **CareSource** Yes **MDwise** Yes **Anthem** Yes
D1II.1a	**MLR Data Validated** Has the state validated the final MLR data specified at 42 CFR 438.8(k) from this plan for the current MCPAR reporting period as of the submission date of this MCPAR report?	**Managed Health Services** No **CareSource** No **MDwise** No **Anthem** No

D1II.1b	**Projected Date for Validation of MLR Data for This Reporting Period** When does the state anticipate completing validation for this plan?	**Managed Health Services** 062027 **CareSource** 06/2027 **MDwise** 06/2027 **Anthem** 06/2027

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Managed Health Services** The MCOs must submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week. Additionally, the MCOs shall submit ninety-eight percent (98%) of adjudicated claims within twenty-one (21) calendar days of adjudication. **CareSource** The MCOs must submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week. Additionally, the MCOs shall submit ninety-eight percent (98%) of adjudicated claims within twenty-one (21) calendar days of adjudication. **MDwise** The MCOs must submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week. Additionally, the MCOs shall submit ninety-eight percent (98%) of adjudicated claims within twenty-one (21) calendar days of adjudication. **Anthem** The MCOs must submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week. Additionally, the MCOs shall submit ninety-eight percent (98%) of adjudicated claims within twenty-one (21) calendar days of adjudication.

D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	**Managed Health Services** 98.33% **CareSource** 99.65% **MDwise** 98.4% **Anthem** 99.89%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	**Managed Health Services** 100% **CareSource** 100% **MDwise** 100% **Anthem** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year.An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Managed Health Services** 1,049 **CareSource** 232 **MDwise** 388 **Anthem** 961
D1IV.1a	**Appeals denied** Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.	**Managed Health Services** 670 **CareSource** 177 **MDwise** 200 **Anthem** 660
D1IV.1b	**Appeals resolved in partial favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.	**Managed Health Services** 89 **CareSource** 1 **MDwise** 0 **Anthem** 26
D1IV.1c	**Appeals resolved in favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.	**Managed Health Services** 290 **CareSource** 54

MDwise

188

Anthem

275

D1IV.2

Active appeals

Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.

Managed Health Services

38

CareSource

0

MDwise

2

Anthem

95

D1IV.3

Appeals filed on behalf of LTSS users

Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable.An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).

Managed Health Services

N/A

CareSource

N/A

MDwise

N/A

Anthem

N/A

D1IV.4

Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”.Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the

Managed Health Services

N/A

CareSource

N/A

MDwise

N/A

Anthem

N/A

	reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”.The appeal and critical incident do not have to have been “related” to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year.See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Managed Health Services** 1,025 **CareSource** 214 **MDwise** 379 **Anthem** 954
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year.See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Managed Health Services** 17 **CareSource** 18 **MDwise** 9 **Anthem** 6

D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service.(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Managed Health Services** 991 **CareSource** 139 **MDwise** 388 **Anthem** 957
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem** 4
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Managed Health Services** 51 **CareSource** 93 **MDwise** 0 **Anthem** 0
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0

		Anthem 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Managed Health Services** 7 **CareSource** 0 **MDwise** 0 **Anthem** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO). If not applicable, enter "N/A."	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem** 0
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem** 0

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services.Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter “N/A”.	**Managed Health Services** 32 **CareSource** 27 **MDwise** 15 **Anthem** 4
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter “N/A”.	**Managed Health Services** 171 **CareSource** 72 **MDwise** 13 **Anthem** 322
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter “N/A”.	**Managed Health Services** 206 **CareSource** 7 **MDwise** 1 **Anthem** 49
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that	**Managed Health Services** 276 **CareSource**

	were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter “N/A”.	57 **MDwise** 1 **Anthem** 161
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter “N/A”.	**Managed Health Services** 92 **CareSource** 39 **MDwise** 302 **Anthem** 155
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter “N/A”.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem** 2
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter “N/A”.(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Managed Health Services** N/A **CareSource** N/A **MDwise** N/A **Anthem** N/A

D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter “N/A”.	**Managed Health Services** 104 **CareSource** 12 **MDwise** 45 **Anthem** 265
D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter “N/A”.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 2 **Anthem** 0
D1IV.7k:	**Resolved appeals related to durable medical equipment (DME) & supplies** Enter the total number of appeals resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter “N/A”.	**Managed Health Services** 123 **CareSource** 2 **MDwise** 9 **Anthem** 0
D1IV.7l:	**Resolved appeals related to home health / hospice** Enter the total number of appeals resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter “N/A”.	**Managed Health Services** 34 **CareSource** 0 **MDwise** 0

		Anthem 0
D1IV.7m:	**Resolved appeals related to emergency services / emergency department** Enter the total number of appeals resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include appeals related to emergency outpatient behavioral health – those should be included in indicator D1.IV.7d. If the managed care plan does not cover this type of service, enter “N/A”.	**Managed Health Services** 0 **CareSource** 23 **MDwise** 0 **Anthem** 0
D1IV.7n:	**Resolved appeals related to therapies** Enter the total number of appeals resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter “N/A”.	**Managed Health Services** 6 **CareSource** 1 **MDwise** 0 **Anthem** 0
D1IV.7o	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-n paid primarily by Medicaid, enter “N/A”.	**Managed Health Services** 168 **CareSource** 18 **MDwise** 0 **Anthem** 3

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.	**Managed Health Services** 5 **CareSource** 1 **MDwise** 0 **Anthem** 17
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem** 0
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Managed Health Services** 5 **CareSource** 1 **MDwise** 0 **Anthem** 17

D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Managed Health Services** 8 **CareSource** 1 **MDwise** 0 **Anthem** 0
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A".External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Managed Health Services** 34 **CareSource** 2 **MDwise** 0 **Anthem** 50
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A".External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Managed Health Services** 43 **CareSource** 8 **MDwise** 14 **Anthem** 52

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.A grievance is “resolved” when it has reached completion and been closed by the plan.	**Managed Health Services** 221 **CareSource** 991 **MDwise** 204 **Anthem** 880
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Managed Health Services** 17 **CareSource** 0 **MDwise** 1 **Anthem** 19
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users.An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Managed Health Services** N/A **CareSource** N/A **MDwise** N/A **Anthem** N/A
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on	**Managed Health Services** N/A **CareSource** N/A **MDwise**

	behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user.If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field.To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	N/A **Anthem** N/A
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year.See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Managed Health Services** 221 **CareSource** 991 **MDwise** 203 **Anthem** 869

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Health Services** 1 **CareSource** 0 **MDwise** 1 **Anthem** 65
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Do not include grievances related to outpatient behavioral health services - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Health Services** 4 **CareSource** 1 **MDwise** 91 **Anthem** 424
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Health Services** 1 **CareSource** 0 **MDwise** 1 **Anthem** 2
D1IV.15d	**Resolved grievances related to outpatient behavioral health services**	**Managed Health Services** 1

	Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter “N/A”.	**CareSource** 17 **MDwise** 2 **Anthem** 5
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter “N/A”.	**Managed Health Services** 3 **CareSource** 4 **MDwise** 9 **Anthem** 15
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter “N/A”.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem** 0
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter “N/A”.	**Managed Health Services** N/A **CareSource** N/A **MDwise** N/A **Anthem** N/A

D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter “N/A”.	**Managed Health Services** 14 **CareSource** 67 **MDwise** 62 **Anthem** 39
D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter “N/A”.	**Managed Health Services** 9 **CareSource** 5 **MDwise** 19 **Anthem** 9
D1IV.15k	**Resolved grievances related to durable medical equipment (DME) & supplies** Enter the total number of grievances resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter “N/A”.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem** 0
D1IV.15l	**Resolved grievances related to home health / hospice** Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter “N/A”.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0

Anthem

0

D1IV.15m	**Resolved grievances related to emergency services / emergency department** Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter “N/A”.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem** 0
D1IV.15n	**Resolved grievances related to therapies** Enter the total number of grievances resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter “N/A”.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem** 0
D1IV.15o	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-n paid primarily by Medicaid, enter “N/A”.	**Managed Health Services** 188 **CareSource** 902 **MDwise** 19 **Anthem** 321

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service.Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Managed Health Services** 2 **CareSource** 40 **MDwise** 13 **Anthem** 16
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management.Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Managed Health Services** 3 **CareSource** 0 **MDwise** 0 **Anthem** 4
D1IV.16c	**Resolved grievances related to network adequacy or access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Managed Health Services** 7 **CareSource** 38 **MDwise** 144 **Anthem** 74
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care.Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or	**Managed Health Services** 16 **CareSource** 8 **MDwise**

	acceptability of care provided by a provider or the plan.	11 **Anthem** 38
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications.Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Managed Health Services** 2 **CareSource** 0 **MDwise** 0 **Anthem** 9
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**Managed Health Services** 61 **CareSource** 354 **MDwise** 33 **Anthem** 378
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud.Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Managed Health Services** 1 **CareSource** 0 **MDwise** 0 **Anthem** 1
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or	**Managed Health Services** 0 **CareSource**

	exploitation.Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	0 **MDwise** 0 **Anthem** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a prior authorization/service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem** 7
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal.Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Managed Health Services** 129 **CareSource** 551 **MDwise** 3 **Anthem** 353

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Quality & performance measure total count: 52

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care (PPC)

1 / 52

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

1517

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Timeliness Prenatal Care: 88.56%, Postpartum Care: 92.70%

CareSource

Timeliness Prenatal Care: 90.27%, Postpartum Care: 90.51%

MDwise

Timeliness Prenatal Care: 85.19%, Postpartum Care: 81.48%

Anthem

Timeliness Prenatal Care: 78.71%, Postpartum Care: 79.11%

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness (FUH)

2 / 52

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0576

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Follow up 30 day: 73.47%, Follow up 7 day: 48.79%

CareSource

Follow up 30 day: 89.35%, Follow up 7 day: 71.30%

MDwise

Follow up 30 day: 64.99%, Follow up 7 day: 42.56%

Anthem

Follow up 30 day: 81.64%, Follow up 7 day: 60.48%

Complete

D2.VII.1 Measure Name: Rating of child's personal doctor (9+10)

3 / 52

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

NA

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

CAHPS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Rating of personal doctor (9+10). Only this metric did not exclude SCHIP members. This data is a reflection of the entire HHW population by adults and children.

Measure results

Managed Health Services

Adult: 70.30%

CareSource

Adult: 85.40%, Child: 76.60%

MDwise

Adult: 67.20%, Child: 79.10%

Anthem

Child: 77.57%

Complete

D2.VII.1 Measure Name: Cervical Cancer Screening (CCS-E)

4 / 52

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0032

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

66.05%

CareSource

62.77%

MDwise

52.49%

Anthem

74.57%

Complete

D2.VII.1 Measure Name: Colorectal Cancer Screening (COL-E) 5 / 52

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0034

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

25.00%

CareSource

0.00%

MDwise

0.00%

Anthem

50.00%

Complete

D2.VII.1 Measure Name: Chlamydia Screening in Women (CHL) 6 / 52

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

0033

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

48.78%

CareSource

45.46%

MDwise

33.32%

Anthem

45.58%

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life (W30)

7 / 52

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Age 15 months: 66.52%, Age 15 to 30 months: 74.76%

CareSource

Age 15 months: 69.69%, Age 15 to 30 months: 76.68%

MDwise

Age 15 months: 56.39%, Age 15 to 30 months: 68.11%

Anthem

Age 15 months: 71.73%, Age 15 to 30 months: 74.47%

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits (WCV)

8 / 52

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1516

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

59.13%

CareSource

55.17%

MDwise

50.25%

Anthem

58.19%

Complete

D2.VII.1 Measure Name: Prenatal Immunization Status (PRS-E)

9 / 52

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Influenza: 20.48%, Tdap: 56.57%, Combination: 17.89%

CareSource

Influenza: 25.87%, Tdap: 67.01%, Combination: 23.22%

MDwise

Influenza: 24.83%,Tdap: 63.90%, Combination: 21.95%

Anthem

Influenza: 25.1%, Tdap: 64.45%, Combination: 22.23%

Complete

D2.VII.1 Measure Name: Prenatal Depression Screening and Follow-Up (PND-E)

10 / 52

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Screening: 46.12%, Follow up: 60.98%

CareSource

Screening: 69.45%, Follow up: 52.63%

MDwise

Screening: 8.73%, Follow up: 28.57%

Anthem

Screening: 26.13%, Follow up: 59.49%

Complete

D2.VII.1 Measure Name: Postpartum Depression Screening and Follow-Up (PDS-E)

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Screening: 28.22%, Follow up: 71.43%

CareSource

Screening: 37.70%, Follow up: 35.71%

MDwise

Screening: 0.15%, Follow up: 0.00%

Anthem

Screening: 13.18%, Follow up: 72.22%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Substance Use Disorder Treatment (IET)

12 / 52

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0004

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Initiation: 47.42%, Engagement: 16.25%

CareSource

Initiation: 46.36%, Engagement: 14.18%

MDwise

Initiation: 46.15%, Engagement: 10.52%

Anthem

Initiation: 46.27 %, Engagement: 16.53%

Complete

D2.VII.1 Measure Name: Asthma Medication Ratio (AMR)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

1800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

69.30%

CareSource

76.50%

MDwise

55.54%

Anthem

68.61%

Complete

D2.VII.1 Measure Name: Controlling High Blood Pressure (CBP)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0018

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

72.92%

CareSource

23.53%

MDwise

56.96%

Anthem

51.72%

Complete

D2.VII.1 Measure Name: Blood Pressure Control for Patients With Diabetes (BPD)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

84.62%

CareSource

68.89%

MDwise

76.98%

Anthem

66.53%

Complete

D2.VII.1 Measure Name: Eye Exam for Patients With Diabetes (EED)

16 / 52

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0055

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

47.46%

CareSource

33.33%

MDwise

45.00%

Anthem

47.03%

Complete

D2.VII.1 Measure Name: Kidney Health Evaluation for Patients With Diabetes (KED)

17 / 52

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

30.17%

CareSource

24.44%

MDwise

26.43%

Anthem

29.36%

Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed ADHD Medication (ADD-E) 18 / 52

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Initiation: 43.80%, Continuation: 50.54%

CareSource

Initiation: 50.98%, Continuation: 57.64%

MDwise

Initiation: 51.21%, Continuation: 60.18%

Anthem

Initiation: 44.38%, Continuation: 52.91%

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness (FUM) 19 / 52

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3489

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Follow up 30 day: 60.31%, Follow up 7 day: 41.08%

CareSource

Follow up 30 day: 72.51%, Follow up 7 day: 60.96%

MDwise

Follow up 30 day: 53.94%, Follow up 7 day: 38.07%

Anthem

Follow up 30 day: 67.95%, Follow up 7 day: 52.66%

Complete

D2.VII.1 Measure Name: Diagnosed Substance Use Disorders (DSU)

20 / 52

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Alcohol: 0.35%, Opioid: 0.12%, Other: 1.28%, Any: 1.49%

CareSource

Alcohol: 0.55%, Opioid: 0.16%, Other: 1.53%, Any: 1.86%

MDwise

Alcohol: 0.32%, Opioid: 0.07%, Other: 1.06%, Any: 1.25%

Anthem

Alcohol: 0.41%, Opioid: 0.10%, Other: 1.39%, Any: 1.62%

Complete

D2.VII.1 Measure Name: Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Follow up 30 day: 66.67%, Follow up 7 day: 57.14%

CareSource

Follow up 30 day: 58.62%, Follow up 7 day: 37.93%

MDwise

Follow up 30 day: 63.89%, Follow up 7 day: 47.22%

Anthem

Follow up 30 day: 65.63%, Follow up 7 day: 53.13%

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use (FUA)

22 / 52

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3488

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Follow up 30 day: 23.75%, Follow up 7 day: 20.00%

CareSource

Follow up 30 day: 27.78%, Follow up 7 day: 11.11%

MDwise

Follow up 30 day: 17.74%, Follow up 7 day: 8.87%

Anthem

Follow up 30 day: 34.43%, Follow up 7 day: 21.86%

Complete

D2.VII.1 Measure Name: Pharmacotherapy for Opioid Use Disorder (POD)

23 / 52

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

18.18%

CareSource

27.27%

MDwise

25.93%

Anthem

25.00%

Complete

D2.VII.1 Measure Name: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

24 / 52

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

1932

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

81.67%

CareSource

76.92%

MDwise

76.00%

Anthem

89.19%

Complete

D2.VII.1 Measure Name: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)

25 / 52

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Blood Glucose Testing: 55.31%, Cholesterol Testing: 38.77%, Blood Glucose and Cholesterol Testing: 36.83%

CareSource

Blood Glucose Testing: 57.07%, Cholesterol Testing: 38.56%, Blood Glucose and Cholesterol Testing: 37.02%

MDwise

Blood Glucose Testing: 49.75%, Cholesterol Testing: 31.86%, Blood Glucose and Cholesterol Testing: 30.93%

Anthem

Blood Glucose Testing: 53.69%, Cholesterol Testing: 36.07%, Blood Glucose and Cholesterol Testing: 34.12%

Complete

D2.VII.1 Measure Name: Risk of Continued Opioid Use (COU)

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Covered 15 or more days: 0.72%, Covered 31 or more days: 0.00%

CareSource

Covered 15 or more days: 0.49%, Covered 31 or more days: 0.49%

MDwise

Covered 15 or more days: 0.58%, Covered 31 or more days: 0.29%

Anthem

Covered 15 or more days: 0.60%, Covered 31 or more days: 0.17%

Complete

D2.VII.1 Measure Name: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2801

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

41.98%

CareSource

63.18%

MDwise

50.28%

Anthem

59.90%

Complete

D2.VII.1 Measure Name: Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Screening: 11.94%, Follow up: 77.52%

CareSource

Screening: 18.85%, Follow up: 77.95%

MDwise

Screening: 0.09%, Follow up: 0.00%

Anthem

Screening: 16.49%, Follow up: 77.61%

Complete

D2.VII.1 Measure Name: Oral Evaluation, Dental Services (OED)

29 / 52

D2.VII.2 Measure Domain

Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number

2517

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

50.51%

CareSource

43.13%

MDwise

44.20%

Anthem

48.32%

Complete

D2.VII.1 Measure Name: Topical Fluoride for Children (TFC)

30 / 52

D2.VII.2 Measure Domain

Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

12.75%

CareSource

11.09%

MDwise

9.36%

Anthem

12.06%

Complete

D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0024

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

BMI percentile: 85.40%, Counseling for Nutrition: 74.21%, Counseling for Physical Activity: 70.32%

CareSource

BMI percentile: 77.86%, Counseling for Nutrition: 61.56%, Counseling for Physical Activity: 59.61%

MDwise

BMI percentile: 70.07%, Counseling for Nutrition: 68.37%, Counseling for Physical Activity: 64.96%

Anthem

BMI percentile: 63.65%, Counseling for Nutrition: 23.52%, Counseling for Physical Activity: 19.57%

Complete

D2.VII.1 Measure Name: Lead Screening in Children (LSC)

32 / 52

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

70.25%

CareSource

76.89%

MDwise

74.04%

Anthem

69.74%

Complete

D2.VII.1 Measure Name: Appropriate Testing for Pharyngitis (CWP)

33 / 52

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0002

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

89.51%

CareSource

89.93%

MDwise

87.98%

Anthem

89.71%

Complete

D2.VII.1 Measure Name: Use of Imaging Studies for Low Back Pain (LBP)

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0052

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

70.05%

CareSource

73.51%

MDwise

62.94%

Anthem

62.94%

Complete

D2.VII.1 Measure Name: Appropriate Treatment for Upper Respiratory Infection (URI)

35 / 52

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0069

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

90.95%

CareSource

91.92%

MDwise

89.30%

Anthem

89.85%

Complete

D2.VII.1 Measure Name: Antibiotic Utilization for Respiratory Conditions (AXR)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

32.48%

CareSource

30.26%

MDwise

30.34%

Anthem

32.90%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS-E)

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

DTaP: 68.14%, IPV: 84.00%, MMR: 82.47%, HiB: 81.64%, Hepatitis B: 86.43%, VZV: 82.05%, Pneumococcal Conjugate: 67.34% , Hepatitis A: 81.05%, Rotavirus: 69.91%, Influenza: 28.16%, Combo 3: 61.97%, Combo 7: 55.91%, Combo 10: 22.59%

CareSource

DTaP: 69.42%, IPV: 84.71%, MMR: 82.98%, HiB: 82.79%, Hepatitis B: 86.73%, VZV: 82.35%, Pneumococcal Conjugate: 68.49%, Hepatitis A: 82.04%, Rotavirus: 70.45%, Influenza: 34.23%, Combo 3: 62.69%, Combo 7: 56.04%, Combo 10: 27.14%

MDwise

DTaP: 67.22%, IPV: 83.95%, MMR: 82.94%, HiB: 81.99%, Hepatitis B: 84.57%, VZV: 82.34%, Pneumococcal Conjugate: 67.63%, Hepatitis A: 81.66%, Rotavirus: 68.71%, Influenza: 28.46%, Combo 3: 59.74%, Combo 7: 53.31%, Combo 10: 22.27%

Anthem

DTaP: 68.31%, IPV: 83.37% , MMR: 81.7%, HiB: 81.67%, Hepatitis B: 85.27%, VZV: 80.74%, Pneumococcal Conjugate: 67.90%, Hepatitis A: 80.09%, Rotavirus: 68.26%, Influenza: 26.03%, Combo 3: 62.11%, Combo 7: 55.11%, Combo 10: 20.74%

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents (IMA-E)

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Meningococcal: 86.14%, Tdap: 86.57%, HPV: 33.27%, Combo1: 85.71%, Combo2: 33.15%

CareSource

Meningococcal: 82.78%, Tdap: 83.17%, HPV: 31.99%, Combo1: 82.43%, Combo2: 31.81%

MDwise

Meningococcal: 86.32%, Tdap: 86.88%, HPV: 34.56%, Combo1: 85.96%, Combo2: 34.39%

Anthem

Meningococcal: 85.01%, Tdap: 85.55%, HPV: 32.68%, Combo1: 84.65%, Combo2: 32.59%

Complete

D2.VII.1 Measure Name: Adults' Access to Preventive/Ambulatory Health Services (AAP)

39 / 52

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

90.58%

CareSource

91.67%

MDwise

82.94%

Anthem

90.95%

Complete

D2.VII.1 Measure Name: Breast Cancer Screening (BCS-E)

40 / 52

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

2372

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Managed Health Services

33.33%

CareSource

50.00%

MDwise

33.33%

Anthem

39.02%

Complete

D2.VII.1 Measure Name: Glycemic Status Assessment for Patients With Diabetes (GSD)

41 / 52

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0059

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Managed Health Services

Less than 8: 50.00%, Greater than 9: 45.76%

CareSource

Less than 8: 64.44%, Greater than 9: 28.89%

MDwise

Less than 8: 49.64%, Greater than 9: 46.76%

Anthem

Less than 8: 45.76%, Greater than 9: 46.19%

Complete

D2.VII.1 Measure Name: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

42 / 52

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0058

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Managed Health Services

67.60%

CareSource

72.74%

MDwise

65.36%

Anthem

66.04%

Complete

D2.VII.1 Measure Name: Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

43 / 52

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

1934

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Managed Health Services

85.71%

CareSource

0.00%

MDwise

0.00%

Anthem

50.00%

Complete

D2.VII.1 Measure Name: Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) 44 / 52

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

1879

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Managed Health Services

40.00%

CareSource

25.00%

MDwise

33.33%

Anthem

25.00%

Complete

D2.VII.1 Measure Name: Use of Opioids From Multiple Providers (UOP) 45 / 52

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2950

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Managed Health Services

Multiple Prescribers: 45.45%, Multiple Pharmacies: 0.00%, Multiple Prescribers Multiple Pharmacies: 0.00%

CareSource

Multiple Prescribers: 25.00%, Multiple Pharmacies: 0.00%, Multiple Prescribers Multiple Pharmacies: 0.00%

MDwise

Multiple Prescribers: 33.33%, Multiple Pharmacies: 0.00%, Multiple Prescribers Multiple Pharmacies: 0.00%

Anthem

Multiple Prescribers: 32.14%, Multiple Pharmacies: 0.00%, Multiple Prescribers Multiple Pharmacies: 0.00%

Complete

D2.VII.1 Measure Name: Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0712

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Managed Health Services

19.09%

CareSource

13.27%

MDwise

0.00%

Anthem

17.11%

Complete

D2.VII.1 Measure Name: Use of Opioids at High Dosage (HDO)

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2940

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Managed Health Services

0.00%

CareSource

0.00%

MDwise

0.00%

Anthem

0.00%

Complete

D2.VII.1 Measure Name: Depression Remission or Response for Adolescents and Adults (DRR-E)

48 / 52

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Managed Health Services

Follow-Up PHQ-9: 39.72%, Depression Remission: 8.36%, Depression Response: 14.29%

CareSource

Follow-Up PHQ-9: 47.67%, Depression Remission: 11.63%, Depression Response: 23.26%

MDwise

N/A

Anthem

Follow-Up PHQ-9: 31.12%, Depression Remission: 5.81%, Depression Response: 11.00%

Complete

D2.VII.1 Measure Name: Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Managed Health Services

Screening: 3.03%, Follow up: 0.00%

CareSource

Screening: 0.00% Follow up: 0.00%

MDwise

Screening: 0.00% Follow up: 0.00%

Anthem

Screening: 0.33%, Follow up: 0.00%

Complete

D2.VII.1 Measure Name: Documented Assessment After Mammogram (DBM-E)

50 / 52

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Managed Health Services

0.00%

CareSource

0.00%

MDwise

0.00%

Anthem

0.00%

Complete

D2.VII.1 Measure Name: Blood Pressure Control for Patients With Hypertension (BPC-E)

51 / 52

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Managed Health Services

46.77%

CareSource

29.63%

MDwise

20.21%

Anthem

51.85%

Complete

D2.VII.1 Measure Name: Diagnosed Mental Health Disorders (DMH)

52 / 52

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Managed Health Services

25.06%

CareSource

22.73%

MDwise

24.14%

Anthem

26.16%

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. The state should include all sanctions the state issued regardless of what entity identified the non-compliance (e.g. the state, an auditing body, the plan, a contracted entity like an external quality review organization).

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Sanction total count: 37

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 1 / 37

D3.VIII.2 Plan performance issue
Contract Noncompliance

D3.VIII.3 Plan name
MDwise

D3.VIII.4 Reason for intervention

As contractually required, MDwise did not notify the State of a key staff change within the timeframes required.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$0

D3.VIII.7 Date assessed
01/24/2025

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 01/27/2025

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 2 / 37

D3.VIII.2 Plan performance issue
Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name
MDwise

D3.VIII.4 Reason for intervention

As contractually required, MDwise did not submit their annual Health Equity Plan by the due date.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$0

D3.VIII.7 Date assessed

02/24/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 02/24/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

3 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

CareSource

D3.VIII.4 Reason for intervention

Liquidated damages were imposed on CareSource for responding late to an internet quorum (IQ) inquiry.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$400

D3.VIII.7 Date assessed

02/24/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 03/14/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

4 / 37

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

MDwise did not meet the contract standards for appeals and grievances in the Q4 2024 priority reports.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,460

D3.VIII.7 Date assessed

03/11/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 04/02/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

5 / 37

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

CareSource

D3.VIII.4 Reason for intervention

CareSource did not meet the contract standards in the Q4 2024 priority reports.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,460

D3.VIII.7 Date assessed

03/17/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 05/02/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

6 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Liquidated damages were imposed on Anthem for responding late to internet quorum (IQ) inquiries in March 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$800

D3.VIII.7 Date assessed

04/22/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 05/06/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

7 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Liquidated damages were imposed on Anthem for responding late to internet quorum (IQ) inquiries in April 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$1,600

D3.VIII.7 Date assessed

05/28/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 06/13/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

8 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

MHS did not update the provider manual on their website and posted a YouTube video without the State's review and approval.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

05/30/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 08/26/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

9 / 37

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

MHS did not meet the contract standards in the Q1 2025 priority reports.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$10,080

D3.VIII.7 Date assessed

06/03/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 06/24/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

10 / 37

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

CareSource

D3.VIII.4 Reason for intervention

CareSource did not meet the contract standards in the Q1 2025 priority reports tied to the return of member calls within 1 business day.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$1,470

D3.VIII.7 Date assessed

06/06/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 07/15/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

11 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

MDwise did not notify the State of a HIPAA violation within 1 business day as contractually required.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

06/09/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 06/10/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

12 / 37

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Anthem did not meet the contract standards for appeals and grievances in the Q1 2025 priority reports.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$11,760

D3.VIII.7 Date assessed

06/10/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 06/27/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

13 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

MDwise had late and unsatisfactory responses to three IQ's in May 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$1,200

D3.VIII.7 Date assessed

D3.VIII.8 Remediation date non-compliance was corrected

06/13/2025

Yes, remediated 06/26/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

14 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Anthem released provider facing material without the State's review and approval.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

06/18/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 06/26/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

15 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Anthem failed to respond timely to provider inquiries and concerns.

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

$0

1

D3.VIII.7 Date assessed

07/15/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 10/14/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

16 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Liquidated damages were imposed on Anthem for responding late to internet quorum (IQ) inquiries in July 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$400

D3.VIII.7 Date assessed

08/14/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 09/02/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

17 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

During a review of MHS' key staff, it was found that MHS had staff listed across multiple plans for key staff positions.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

08/26/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 11/06/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

18 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

MDwise failed to update their hospital observation policy.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

08/27/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 12/31/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

19 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

Liquidated damages were imposed on MDwise for responding late to an internet quorum (IQ) inquiry in August 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$400

D3.VIII.7 Date assessed

09/04/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 09/11/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

20 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

MDwise's vendor sent unapproved letters to providers during recoupment efforts.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$75,000

D3.VIII.7 Date assessed

09/19/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 12/31/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

21 / 37

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name

CareSource

Reporting (timeliness, completeness, accuracy)

D3.VIII.4 Reason for intervention

CareSource did not follow the State's CAHPS reporting requirements.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$124,800

D3.VIII.7 Date assessed

09/19/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 01/13/2026

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

CareSource

D3.VIII.4 Reason for intervention

CareSource distributed unapproved materials to providers.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

09/26/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 10/16/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

MDwise failed to timely notify OMPP of 2 separate system outages in May of 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

10/10/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 12/31/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

CareSource

D3.VIII.4 Reason for intervention

CareSource submitted noncompliant priority reports in Q2 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$10,400

D3.VIII.7 Date assessed

10/16/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 11/06/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

25 / 37

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

MHS submitted inaccurate priority reports in Q2 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$31,200

D3.VIII.7 Date assessed

10/16/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 10/23/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

26 / 37

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

MDwise submitted inaccurate priority reports in Q2 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,250

D3.VIII.7 Date assessed

D3.VIII.8 Remediation date non-compliance was corrected

10/16/2025

Yes, remediated 12/31/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

27 / 37

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Anthem missed reporting metrics in the priority reports in Q2 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$18,375

D3.VIII.7 Date assessed

10/17/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 11/06/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

28 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Liquidated damages were imposed on Anthem for responding late to an internet quorum (IQ) inquiry and insufficiently completing another in October 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$1,200

D3.VIII.7 Date assessed

11/07/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 11/19/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

29 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

MHS did not timely send members their member materials.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

11/12/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 12/15/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

30 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

CareSource

D3.VIII.4 Reason for intervention

Calls were not routed appropriately during a system outage.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

11/17/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 11/17/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

31 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Liquidated damages were imposed on Anthem for insufficiently responding to an internet quorum (IQ) inquiry.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$400

D3.VIII.7 Date assessed

12/04/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 12/16/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

32 / 37

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

CareSource

D3.VIII.4 Reason for intervention

CareSource included unapproved language for members in their app.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

12/18/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 01/07/2026

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

33 / 37

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Anthem did not meet the contract standards in the Q4 2024 priority reports.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$6,930

D3.VIII.7 Date assessed

03/10/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 03/25/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

34 / 37

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

MHS did not follow the State's CAHPS reporting requirements.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$62,400

D3.VIII.7 Date assessed

09/19/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 01/13/2026

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

35 / 37

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

MDwise did not follow the State's CAHPS reporting requirements.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$124,800

D3.VIII.7 Date assessed

09/19/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 01/28/2026

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Anthem did not follow the State's CAHPS reporting requirements.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$62,400

D3.VIII.7 Date assessed

09/26/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 11/26/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

Liquidated damages were imposed on MHS for responding late to internet quorum (IQ) inquiries in Feb. 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$400

D3.VIII.7 Date assessed

03/13/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 04/07/2025

D3.VIII.9 Corrective action plan

Yes

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Managed Health Services** 4 **CareSource** 7 **MDwise** 7 **Anthem** 11
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Managed Health Services** 106 **CareSource** 68 **MDwise** 77 **Anthem** 197
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Managed Health Services** 89 **CareSource** 58 **MDwise** 18 **Anthem** 156
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Managed Health Services** Makes referrals to the SMA and MFCU concurrently **CareSource**

		Makes referrals to the SMA and MFCU concurrently **MDwise** Makes referrals to the SMA and MFCU concurrently **Anthem** Makes referrals to the SMA and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals.	**Managed Health Services** 4 **CareSource** 0 **MDwise** 1 **Anthem** 5
D1X.9a:	**Plan overpayment reporting to the state: Start Date** What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Managed Health Services** 01/01/2025 **CareSource** 01/01/2025 **MDwise** 01/01/2025 **Anthem** 01/01/2025
D1X.9b:	**Plan overpayment reporting to the state: End Date** What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Managed Health Services** 12/31/2025 **CareSource** 12/31/2025 **MDwise** 12/31/2025 **Anthem**

		12/31/2025
D1X.9c:	**Plan overpayment reporting to the state: Dollar amount** From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	**Managed Health Services** $468,077.05 **CareSource** $750,743 **MDwise** $25,512,436.20 **Anthem** $111,237,403.22
D1X.9d:	**Plan overpayment reporting to the state: Corresponding premium revenue** What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	**Managed Health Services** $0 **CareSource** $0 **MDwise** $0 **Anthem** $0
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Managed Health Services** Daily **CareSource** Daily **MDwise** Daily **Anthem** Daily

Topic XI: ILOS

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if "Yes", which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter "0" for utilization.

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**Managed Health Services** No ILOSs were offered by this plan **CareSource** No ILOSs were offered by this plan **MDwise** No ILOSs were offered by this plan **Anthem** No ILOSs were offered by this plan

Topic XIII. Prior Authorization

Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If "Yes", please complete the following questions under each plan.	Yes

Topic XIV. Patient Access API Usage

> ⚠ **Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".**

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If "Yes", please complete the following questions under each plan.	Yes

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus Health Services, Inc** Enrollment Broker
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus Health Services, Inc** Enrollment Broker/Choice Counseling

Section F: Notes

Notes

Use this section to optionally add more context about your submission. If you choose not to respond, proceed to “Review & submit.”

Number	Indicator	Response
F1	**Notes (optional)**	URLs for the MDwise plan that address requirements in XIII. Prior Authorization and XIV. Patient Access cannot be provided because MDwise no longer participates in Indiana Medicaid's programs, including HHW, effective January 1, 2026. As a result, they have paused efforts tied to the final rule and their main webpage is provided. Metrics D1.XIII.6 &D1.XIII.7 and D1.XIII.11 & D1.XIII.12 do not sum to 100% because MDwise did not include prior authorization requests that were modified. Further, NR is provided for metric D1.XIII.15 for MDwise because they do not extend prior authorization reviews. The data provided in section X. Program Integrity is not unique to HHW. These are not differentiated by program as providers who commit fraud, waste, or abuse will typically do so across all plans they're contracted with. Further, the State is providing the CY 2025 overpayment amounts retained by the MCE due to their capitation. This can include overpayments from incorrectly billed claims, provider refunds, etc. All quality measures exclude SCHIP beneficiaries except CAHPS.