

Managed Care Program Annual Report (MCPAR) for Indiana: Healthy Indiana Plan (HIP)

Due date	Last edited	Edited by	Status
06/29/2026	06/23/2026	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.	06/23/2026

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.	Healthy Indiana Plan (HIP)

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	Anthem
	Managed Health Services
	MDwise
	CareSource

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 Independent 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	State Medicaid agency staff
	Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs.	State actuaries
	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.	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 HIP 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).	Section 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 overpayment directly from the provider or may require the MCE to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by the OMPP PI Unit. The OMPP PI Unit may also take disciplinary action against any provider identified by the MCE or the OMPP PI Unit as engaging in inappropriate or abusive billing or service provision practices. If the fraud referral from the MCE generates an

action that results in a monetary recovery, the reporting MCE 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 MCE has sustained a documented loss but the case did not result from a referral made by the MCE, the State shall not be obligated to repay any monies recovered to the MCE, 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 MCEs submit monthly, quarterly, and yearly reports that detail ongoing activities and status of overpayments. Additionally, PI officials meet with each MCE monthly to discuss ongoing activities.

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 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.	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%) 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

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C11.1	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 (#69649), MHS (#69655), MDwise (#69654), CareSource (#69651)
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2017
C11.2	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/
C11.3	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)
C11.4a	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
C11.4b	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.	For HIP members, only non-expansion population members receive state plan level benefits, including transportation. This includes pregnant members, medically frail, low income-parent caretakers (LIPC) and transitional medical assistance (TMA). These members also receive additional dental coverage over what the expansion population receives. Differences in dental coverage for non-expansion members include oral exams, x-rays, and restorative/corrective services. HIP plus

beneficiaries receive additional coverage, including dental, vision, chiropractic, over what the HIP basic population receives.

C11.5	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).	635,515
C11.6	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 HIP 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 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 2C Section 6. Encounter Data Quality Report, Exhibit 2C Section 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.	8.6. Encounter Data Submission and Exhibit 2C Section 6. Encounter Data Quality Report, Exhibit 2C Section 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 HIP 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 HIP 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 HIP 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)? 42 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?	03/23/2026
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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).

C1XII.10a	In the last analysis(es) conducted, were any deficiencies identified?	No
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C1XII.12a	Has the state posted the current parity analysis(es) covering this program on its website?	Yes
	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.	
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).	Anthem 289,256
		Managed Health Services 124,647
		MDwise 140,925
		CareSource 80,687
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)	Anthem 15.6%
		Managed Health Services 6.7%
		MDwise 7.6%
		CareSource 4.4%
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)	Anthem 19.1%
		Managed Health Services 8.2%
		MDwise 9.3%
		CareSource 5.3%
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	Anthem Elevance Health
		Managed Health Services Centene Corporation
		MDwise

controlled by a separate entity,
please report the managed
care plan name in this field.

McLaren Health Care

CareSource

CareSource Indiana, Inc.

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?	Anthem Yes
		Managed Health Services Yes
		MDwise Yes
		CareSource 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?	Anthem No
		Managed Health Services No
		MDwise No
		CareSource No

D1II.1b

**Projected Date for Validation
of MLR Data for This
Reporting Period**

When does the state anticipate
completing validation for this
plan?

Anthem

062027

Managed Health Services

062027

MDwise

06/2027

CareSource

062027

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.	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. 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. 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. 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.

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.	Anthem 99.84% Managed Health Services 98.98% MDwise 99.46% CareSource 99.69%
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.	Anthem 100% Managed Health Services 100% MDwise 100% CareSource 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.	Anthem
		2,213
		Managed Health Services
		2,050
		MDwise
		2,399
		CareSource
		1,116
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.	Anthem
		1,489
		Managed Health Services
		1,447
		MDwise
		1,317
		CareSource
		846
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.	Anthem
		28
		Managed Health Services
		22
		MDwise
		1
		CareSource
		3
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.	Anthem
		696
		Managed Health Services
		581

		MDwise 1,081
		CareSource 267
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.	Anthem 108 Managed Health Services 91 MDwise 28 CareSource 0
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).	Anthem N/A Managed Health Services N/A MDwise N/A CareSource 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	Anthem N/A Managed Health Services N/A MDwise N/A CareSource 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	Anthem
		2,171
	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
		2,000
		MDwise
		2,381
		CareSource
		1,055
D1IV.5b	Expedited appeals for which timely resolution was provided	Anthem
		40
	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
		45
		MDwise
		18
		CareSource
		61

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).	Anthem 2,209 Managed Health Services 1,830 MDwise 2,393 CareSource 546
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.	Anthem 4 Managed Health Services 0 MDwise 0 CareSource 0
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.	Anthem 0 Managed Health Services 215 MDwise 3 CareSource 570
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).	Anthem 0 Managed Health Services 0 MDwise 0

		CareSource 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.	Anthem 0 Managed Health Services 5 MDwise 3 CareSource 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."	Anthem 0 Managed Health Services 0 MDwise 0 CareSource 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.	Anthem 0 Managed Health Services 0 MDwise 0 CareSource 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”.	Anthem
		26
		Managed Health Services
		174
		MDwise
		71
		CareSource
		199
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”.	Anthem
		385
		Managed Health Services
		650
		MDwise
		87
		CareSource
		349
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”.	Anthem
		104
		Managed Health Services
		211
		MDwise
		7
		CareSource
		20
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	Anthem
		156
		Managed Health Services

	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".	185 MDwise 4 CareSource 2
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".	Anthem 1,393 Managed Health Services 623 MDwise 2,080 CareSource 297
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".	Anthem 12 Managed Health Services 2 MDwise 27 CareSource 21
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).	Anthem N/A Managed Health Services N/A MDwise N/A CareSource 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".	Anthem 137 Managed Health Services 53 MDwise 73 CareSource 17
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".	Anthem 0 Managed Health Services 1 MDwise 1 CareSource 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".	Anthem 0 Managed Health Services 61 MDwise 38 CareSource 7
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".	Anthem 0 Managed Health Services 47 MDwise 11

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”.	Anthem 0 Managed Health Services 0 MDwise 0 CareSource 155
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”.	Anthem 0 Managed Health Services 7 MDwise 0 CareSource 6
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”.	Anthem 0 Managed Health Services 151 MDwise 0 CareSource 426

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.	Anthem
		16
		Managed Health Services
		9
		MDwise
		0
		CareSource
		1
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.	Anthem
		2
		Managed Health Services
		0
		MDwise
		0
		CareSource
		1
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.	Anthem
		14
		Managed Health Services
		9
		MDwise
		0
		CareSource
		0

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.	Anthem 0 Managed Health Services 9 MDwise 0 CareSource 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).	Anthem 18 Managed Health Services 18 MDwise 0 CareSource 2
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).	Anthem 164 Managed Health Services 43 MDwise 26 CareSource 26

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.	Anthem
		2,557
		Managed Health Services
		927
		MDwise
		635
		CareSource
		2,205
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.	Anthem
		67
		Managed Health Services
		26
		MDwise
		18
		CareSource
		0
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.	Anthem
		N/A
		Managed Health Services
		N/A
		MDwise
		N/A
		CareSource
		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	Anthem
		N/A
		Managed Health Services
		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

CareSource

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.

Anthem

2,503

Managed Health Services

927

MDwise

634

CareSource

2,205

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”.	Anthem
		149
		Managed Health Services
		8
		MDwise
		9
		CareSource
		1
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”.	Anthem
		1,248
		Managed Health Services
		29
		MDwise
		182
		CareSource
		29
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”.	Anthem
		11
		Managed Health Services
		0
		MDwise
		4
		CareSource
		0
D1IV.15d	Resolved grievances related to outpatient behavioral health services	Anthem 42

	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".	Managed Health Services 1 MDwise 18 CareSource 35
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".	Anthem 188 Managed Health Services 34 MDwise 34 CareSource 34
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".	Anthem 6 Managed Health Services 0 MDwise 4 CareSource 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".	Anthem N/A Managed Health Services N/A MDwise N/A CareSource 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".	Anthem 358 Managed Health Services 47 MDwise 232 CareSource 152
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".	Anthem 93 Managed Health Services 68 MDwise 84 CareSource 77
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".	Anthem 0 Managed Health Services 0 MDwise 0 CareSource 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".	Anthem 0 Managed Health Services 0 MDwise 0

		CareSource
		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".	Anthem 0 Managed Health Services 0 MDwise 0 CareSource 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".	Anthem 0 Managed Health Services 0 MDwise 0 CareSource 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".	Anthem 462 Managed Health Services 740 MDwise 68 CareSource 1,879

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.	Anthem
		143
		Managed Health Services
		9
		MDwise
		43
		CareSource
		18
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.	Anthem
		36
		Managed Health Services
		10
		MDwise
		1
		CareSource
		0
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.	Anthem
		714
		Managed Health Services
		25
		MDwise
		360
		CareSource
		195
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	Anthem
		296
		Managed Health Services
		74
		MDwise

acceptability of care provided by a provider or the plan.

137

CareSource

56

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.

Anthem

26

Managed Health Services

2

MDwise

0

CareSource

0

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.

Anthem

737

Managed Health Services

157

MDwise

82

CareSource

778

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 perpetrated 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.

Anthem

20

Managed Health Services

0

MDwise

1

CareSource

0

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

Anthem

0

Managed Health Services

	exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	0
		MDwise
		0
		CareSource
		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).	Anthem 35 Managed Health Services 0 MDwise 0 CareSource 0
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.	Anthem 0 Managed Health Services 0 MDwise 0 CareSource 1
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.	Anthem 550 Managed Health Services 650 MDwise 11 CareSource 1,210

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.



Complete

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

1 / 52

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0033

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

Anthem

57.00%

Managed Health Services

59.74%

MDwise

46.91%

CareSource

57.80%



Complete

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

2 / 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-HEDIS

Measure results

Anthem
Follow up 30 day: 44.11%; Follow up 7 day: 32.71%

Managed Health Services
Follow up 30 day: 37.22%; Follow up 7 day: 26.95%

MDwise
Follow up 30 day: 34.46%; Follow up 7 day: 25.08%

CareSource
Follow up 30 day: 48.17%; Follow up 7 day: 37.17%



D2.VII.1 Measure Name: Rating of Personal (Primary Care) Doctor (9 + 10) 3 / 52

D2.VII.2 Measure Domain
Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number
0006

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 (Primary Care) Doctor (9 + 10)

Measure results

Anthem

64.46%

Managed Health Services

65.70%

MDwise

70.20%

CareSource

70.10%



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

Anthem

55.48%

Managed Health Services

54.48%

MDwise

47.77%

CareSource
47.23%



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

Anthem

46.22%

Managed Health Services

47.93%

MDwise

36.12%

CareSource

40.91%



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

6 / 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

Anthem

50.17%

Managed Health Services

49.28%

MDwise

46.42%

CareSource

48.41%



Complete

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

7 / 52

D2.VII.2 Measure Domain

Maternal and perinatal health

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

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

Anthem

Influenza: 23.56%, Tdap: 60.29%, Combination: 20.25%

Managed Health Services

Influenza: 21.38%, Tdap: 58.15%, Combination: 18.85%

MDwise

Influenza: 22.15%, Tdap: 61.51%, Combination: 19.21%

CareSource

Influenza: 24.59%, Tdap: 64.02%, Combination: 22.18%



Complete

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

8 / 52

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

Anthem

71.29%

Managed Health Services

69.34%

MDwise

63.50%

CareSource

65.94%



Complete

D2.VII.1 Measure Name: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) 9 / 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

Anthem

39.35%

Managed Health Services

38.98%

MDwise

42.52%

CareSource

43.77%



Complete

D2.VII.1 Measure Name: Initiation and Engagement of Substance Use Disorder Treatment (IET) 10 / 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

Anthem

Initiation: 43.08%, Engagement: 24.08%

Managed Health Services

Initiation: 38.17%, Engagement: 21.44%

MDwise

Initiation: 39.54%, Engagement: 20.50%

CareSource

Initiation: 36.24%, Engagement: 23.20%



Complete

D2.VII.1 Measure Name: Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) 11 / 52

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0071

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

Anthem

52.94%

Managed Health Services

51.11%

MDwise

55.36%

CareSource

38.46%



Complete

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

12 / 52

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

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

Anthem

73.72%

Managed Health Services

74.45%

MDwise

70.69%

CareSource

72.51%



Complete

D2.VII.1 Measure Name: Asthma Medication Ratio: Ages 19 to 64 (AMR)^{13 / 52}

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

Anthem

62.58%

Managed Health Services

62.02%

MDwise

47.09%

CareSource

67.47%



Complete

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

14 / 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**Anthem**

Follow up 30 day: 65.35%, Follow up 7 day: 44.06%

Managed Health Services

Follow up 30 day: 60.47%, Follow up 7 day: 37.85%

MDwise

Follow up 30 day: 49.02%, Follow up 7 day: 27.80%

CareSource

Follow up 30 day: 68.13%, Follow up 7 day: 48.98%



Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness (FUM) 15 / 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

Anthem

Follow up 30 day: 56.51%, Follow up 7 day: 39.61%

Managed Health Services

Follow up 30 day: 52.03%, Follow up 7 day: 34.37%

MDwise

Follow up 30 day: 44.86%, Follow up 7 day: 28.71%

CareSource

Follow up 30 day: 63.58%, Follow up 7 day: 50.10%



Complete

D2.VII.1 Measure Name: Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) 16 / 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

Anthem

51.31%

Managed Health Services

50.91%

MDwise

46.79%

CareSource

46.68%



Complete

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

17 / 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

Anthem

85.40%

Managed Health Services

86.49%

MDwise

82.18%

CareSource

87.14%



Complete

D2.VII.1 Measure Name: Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) 18 / 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

Anthem

77.21%

Managed Health Services

72.73%

MDwise

76.47%

CareSource

86.57%



Complete

D2.VII.1 Measure Name: Eye Exam for Patients With Diabetes (EED) 19 / 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

Anthem

48.85%

Managed Health Services

53.81%

MDwise

43.05%

CareSource

43.91%



Complete

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

20 / 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

Anthem

45.23%

Managed Health Services

47.35%

MDwise

39.09%

CareSource

49.42%



Complete

D2.VII.1 Measure Name: Statin Therapy for Patients With Diabetes (SPD)

21 / 52

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0545

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

Anthem

Received Therapy: 63.80%, Adherence: 71.11%

Managed Health Services

Received Therapy: 66.14%, Adherence: 71.52%

MDwise

Received Therapy: 64.85%, Adherence: 56.77%

CareSource

Received Therapy: 64.31%, Adherence: 72.38%



Complete

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

22 / 52

D2.VII.2 Measure Domain

Behavioral health 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

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

Anthem

26.84%

Managed Health Services

29.04%

MDwise

26.61%

CareSource

25.76%



Complete

D2.VII.1 Measure Name: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

23 / 52

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

1933

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

Anthem

68.97%

Managed Health Services

90.00%

MDwise

53.85%

CareSource

83.33%



Complete

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

24 / 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

Anthem

82.20%

Managed Health Services

81.40%

MDwise

80.95%

CareSource

79.85%



Complete

D2.VII.1 Measure Name: Use of Imaging Studies for Low Back Pain (LBP) 5 / 52

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

Anthem

62.50%

Managed Health Services

64.36%

MDwise

63.62%

CareSource

63.61%



Complete

D2.VII.1 Measure Name: Statin Therapy for Patients With Cardiovascular Disease (SPC)

26 / 52

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

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

Anthem

Received Therapy: 81.63%, Adherence: 74.18%

Managed Health Services

Received Therapy: 84.48%, Adherence: 75.66%

MDwise

Received Therapy: 83.84%, Adherence: 65.22%

CareSource

Received Therapy: 82.07%, Adherence: 73.26%



Complete

D2.VII.1 Measure Name: Pharmacotherapy Management of COPD Exacerbation (PCE)

27 / 52

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0549

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

Anthem

Systemic Corticosteroid: 75.57%, Bronchodilator: 82.62%

Managed Health Services

Systemic Corticosteroid: 75.22%, Bronchodilator: 83.19%

MDwise

Systemic Corticosteroid: 73.63%, Bronchodilator: 79.65%

CareSource

Systemic Corticosteroid: 69.85%, Bronchodilator: 75.37%



Complete

D2.VII.1 Measure Name: Adult Immunization Status (AIS-E)

28 / 52

D2.VII.2 Measure Domain

Primary care access and preventative care

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

3620

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

Anthem

Influenza: 12.75%, TdTdap: 48.42%, Zoster: 15.69%, Pneumococcal: 47.06%, Hepatitis B: 12.93%

Managed Health Services

Influenza: 9.30%, TdTdap: 43.16%, Zoster: 9.93%, Pneumococcal: 0.00%, Hepatitis B: 2.53%

MDwise

Influenza: 12.16%, TdTdap: 31.14%, Zoster: 12.42%, Pneumococcal: 33.33%, Hepatitis B: 1.61%

CareSource

Influenza: 12.08%, TdTdap: 49.85%, Zoster: 15.6%, Pneumococcal: 100%, Hepatitis B: 36.55%



Complete

D2.VII.1 Measure Name: Prenatal Depression Screening and Follow-Up (PND-E) 29 / 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

Anthem

Screening: 29.07%, Follow up: 57.46%

Managed Health Services

Screening: 44.36%, Follow up: 48.35%

MDwise

Screening: 10.99%, Follow up: 67.39%

CareSource

Screening: 61.82%, Follow up: 53.25%



Complete

D2.VII.1 Measure Name: Postpartum Depression Screening and Follow-Up (PDS-E) -30 / 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

Anthem

Screening: 13.91%, Follow up: 65.19%

Managed Health Services

Screening: 28.41%, Follow up: 62.77%

MDwise

Screening: 0.92%, Follow up: 81.25%

CareSource

Screening: 32.01%, Follow up: 63.64%



Complete

D2.VII.1 Measure Name: Cardiac Rehabilitation (CRE)

31 / 52

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0642

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

Anthem

Initiation: 17.22%, Engagement 1: 17.35%, Engagement 2: 9.80%,
Achievement: 3.97%

Managed Health Services

Initiation: 19.91%, Engagement 1: 19.03%, Engagement 2: 13.72%,
Achievement: 7.52%

MDwise

Initiation: 9.18%, Engagement 1: 0.66%, Engagement 2: 0.33%,
Achievement: 0.00%

CareSource

Initiation: 16.09%, Engagement 1: 16.09%, Engagement 2: 9.77%,
Achievement: 4.02%



Complete

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

32 / 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

Anthem

41.61%

Managed Health Services

39.89%

MDwise

36.27%

CareSource

37.91%



Complete

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

33 / 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

N/A-using HEDIS

Measure results

Anthem

Alcohol: 5.02%, Opioid: 6.80%, Other: 8.08%, Any: 13.89%

Managed Health Services

Alcohol: 4.21%, Opioid: 5.20%, Other: 6.88%, Any: 11.73%

MDwise

Alcohol: 3.97%, Opioid: 5.41%, Other: 6.37%, Any: 11.39%

CareSource

Alcohol: 5.45%, Opioid: 6.56%, Other: 8.93%, Any: 14.44%



Complete

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

34 / 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

Anthem

Follow up 30 day: 70.91,% Follow up 7 day: 47.49%

Managed Health Services

Follow up 30 day: 68.28%, Follow up 7 day: 45.86%

MDwise

Follow up 30 day: 65.71%, Follow up 7 day: 45.08%

CareSource

Follow up 30 day: 65.96%, Follow up 7 day: 44.47%



Complete

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

35 / 52

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

Anthem

2.27%

Managed Health Services

1.89%

MDwise

0.98%

CareSource

1.60%



Complete

D2.VII.1 Measure Name: Use of Opioids From Multiple Providers (UOP) 36 / 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**Anthem**

Multiple Prescribers: 22.74%, Multiple Pharmacies: 1.34%, Multiple Prescribers/Multiple Pharmacies: 1.02%

Managed Health Services

Multiple Prescribers: 21.94%, Multiple Pharmacies: 1.14%, Multiple Prescribers/Multiple Pharmacies: 0.92%

MDwise

Multiple Prescribers: 23.47%, Multiple Pharmacies: 1.12%, Multiple Prescribers/Multiple Pharmacies: 0.84%

CareSource

Multiple Prescribers: 25.27%, Multiple Pharmacies: 1.31%, Multiple Prescribers/Multiple Pharmacies: 0.85%



Complete

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

37 / 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**Anthem**

Covered 15 or more days: 5.06%, Covered 30 or more days: 3.24%

Managed Health Services

Covered 15 or more days: 2.18%, Covered 30 or more days: 1.09%

MDwise

Covered 15 or more days: 2.59%, Covered 30 or more days: 0.85%

CareSource

Covered 15 or more days: 5.11%, Covered 30 or more days: 3.51%



Complete

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

38 / 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**Anthem**

Screening: 17.78%, Follow up: 71.02%

Managed Health Services

Screening: 15.18%, Follow up: 70.49%

MDwise

Screening: 2.93%, Follow up: 79.97%

CareSource

Screening: 21.58%, Follow up: 68.28%



Complete

D2.VII.1 Measure Name: Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E) 39 / 52

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

Anthem

20.32%

Managed Health Services

20.03%

MDwise

5.91%

CareSource

11.87%



Complete

D2.VII.1 Measure Name: Appropriate Treatment for Upper Respiratory Infection (URI) 40 / 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

Anthem

75.62%

Managed Health Services

78.12%

MDwise

77.09%

CareSource

80.23%



Complete

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

41 / 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

Anthem

27.77%

Managed Health Services

27.88%

MDwise

25.98%

CareSource

24.24%



Complete

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

42 / 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

Anthem

77.80%

Managed Health Services

76.71%

MDwise

73.33%

CareSource

74.75%



Complete

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

43 / 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

Anthem

Timeliness Prenatal Care: 91.48%, Postpartum Care: 85.89%

Managed Health Services

Timeliness Prenatal Care: 87.10%, Postpartum Care: 83.94%

MDwise

Timeliness Prenatal Care: 83.85%, Postpartum Care: 75.77%

CareSource

Timeliness Prenatal Care: 87.83%, Postpartum Care: 87.59%



Complete

D2.VII.1 Measure Name: Glycemic Status Assessment for Patients With Diabetes (GSD) 44 / 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

Anthem

Less than 8: 63.50%, Greater than 9: 26.76%

Managed Health Services

Less than 8: 66.67%, Greater than 9: 24.33%

MDwise

Less than 8: 55.72%, Greater than 9: 40.15%

CareSource

Less than 8: 62.29%, Greater than 9: 30.41%



Complete

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

45 / 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

Anthem

Follow-Up PHQ-9: 39.26%, Depression Remission: 8.66%, Depression Response: 13.79%

Managed Health Services

Follow-Up PHQ-9: 40.23%, Depression Remission: 6.90%, Depression Response: 14.05%

MDwise

Follow-Up PHQ-9: 44.17%, Depression Remission: 6.07%, Depression Response: 13.59%

CareSource

Follow-Up PHQ-9: 40.00%, Depression Remission: 7.50%, Depression Response: 13.44%



Complete

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

46 / 52

D2.VII.2 Measure Domain

Dental and oral health services

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

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

Program-specific rate

2517

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

Anthem

28.34%

Managed Health Services

29.56%

MDwise

23.64%

CareSource

24.20%



Complete

D2.VII.1 Measure Name: Unhealthy Alcohol Use Screening and Follow-Up (ASF-E) 47 / 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

Anthem

Screening: 0.97%, Follow up: 1.38%

Managed Health Services

Screening: 2.66%, Follow up: 0.00%

MDwise

Screening: 0.00%, Follow up: 0.00%

CareSource

Screening: 0.00%, Follow up: 0.00%



Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits (WCV) 48 / 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

Anthem

26.74%

Managed Health Services

27.97%

MDwise

20.69%

CareSource



Complete

D2.VII.1 Measure Name: Documented Assessment After Mammogram (DBM-E) 49 / 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**Anthem**

0.01%

Managed Health Services

0.00%

MDwise

0.00%

CareSource

0.00%



Complete

D2.VII.1 Measure Name: Follow-Up After Abnormal Mammogram Assessment (FMA-E)

50 / 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

Anthem

0.00%

Managed Health Services

0.00%

MDwise

0.00%

CareSource

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

Anthem

54.53%

Managed Health Services

49.79%

MDwise

40.84%

CareSource

43.82%



Complete

D2.VII.1 Measure Name: Social Need Screening and Intervention (SNS- 52 / 52 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**Anthem**

Food Screening: 1.67%, Food Intervention: 1.30%, Housing Screening: 2.44%, Housing Intervention: 0.00%, Transportation Screening: 1.46%, Transportation Intervention: 0.22%

Managed Health Services

Food Screening: 0.77%, Food Intervention: 1.98%, Housing Screening: 0.81%, Housing Intervention: 0.00%, Transportation Screening: 0.02%, Transportation Intervention: 100%

MDwise

Food Screening: 0.00%, Food Intervention: 0.00%, Housing Screening: 0.00%, Housing Intervention: 0.00%, Transportation Screening: 0.00%, Transportation Intervention: 0.00%

CareSource

Food Screening: 3.87%, Food Intervention: 53.20%, Housing Screening: 4.00%, Housing Intervention: 35.79%, Transportation Screening: 3.91%, Transportation Intervention: 44.39%

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.



Complete

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

1 / 35

D3.VIII.2 Plan performance issue**D3.VIII.3 Plan name**
MDwise

Contract compliance

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 / 35

D3.VIII.2 Plan performance issue**D3.VIII.3 Plan name**
MDwise

Reporting (timeliness, completeness, accuracy)

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 / 35

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 / 35

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 / 35

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 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

03/13/2025

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

Yes, remediated 04/07/2025

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: Liquidated damages

6 / 35

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 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

03/17/2025

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

7 / 35

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

8 / 35

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name

Anthem

Contract Noncompliance

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)

9 / 35

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

10 / 35

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

11 / 35

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



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 12 / 35**D3.VIII.2 Plan performance issue** **D3.VIII.3 Plan name**
Contract Noncompliance 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 13 / 35**D3.VIII.2 Plan performance issue** **D3.VIII.3 Plan name**
Reporting (timeliness, completeness, accuracy) 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

14 / 35

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

MDwise had 3 late IQ responses 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

06/13/2025

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: Liquidated damages

15 / 35

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) 16 / 35

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Anthem received a letter for failing to respond timely to provider inquiries and concerns.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$0

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

17 / 35

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	D3.VIII.6 Sanction amount
1	\$400
D3.VIII.7 Date assessed	D3.VIII.8 Remediation date non-compliance was corrected
08/14/2025	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) 18 / 35

D3.VIII.2 Plan performance issue	D3.VIII.3 Plan name
Contract Noncompliance	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	D3.VIII.6 Sanction amount
1	\$0
D3.VIII.7 Date assessed	D3.VIII.8 Remediation date non-compliance was corrected
08/26/2025	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) 19 / 35

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
MDwise

Contract Noncompliance

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

20 / 35

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
MDwise

Contract Noncompliance

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

21 / 35

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
Contract Noncompliance 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

22 / 35

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
Reporting (timeliness, completeness, accuracy) CareSource

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

23 / 35

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

CareSource

D3.VIII.4 Reason for intervention

CareSource distributed unapproved provider materials.

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: Liquidated damages

24 / 35

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 in September 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$400

D3.VIII.7 Date assessed

10/06/2025

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

Yes, remediated 10/15/2025

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 25 / 35

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**

Contract Noncompliance

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 26 / 35

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**

Reporting (timeliness, completeness, accuracy)

Anthem

D3.VIII.4 Reason for intervention

Anthem submitted inaccurate priority reports in Q2 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

1

\$25,680

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

27 / 35

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

28 / 35

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

29 / 35

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

10/16/2025

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

30 / 35

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

31 / 35

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)

32 / 35

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
Contract Noncompliance 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



D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 33 / 35

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
Contract Noncompliance 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

34 / 35

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
Contract Noncompliance Anthem

D3.VIII.4 Reason for intervention

Liquidated damages were imposed on Anthem for insufficiently responding to an internet quorum (IQ) inquiry in November 2025.

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

35 / 35

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
Contract Noncompliance 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

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).	Anthem
		11
		Managed Health Services
		4
		MDwise
D1X.2	Count of opened program integrity investigations How many program integrity investigations were opened by the plan during the reporting year?	7
		CareSource
		7
		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
		106
		MDwise
		77
		CareSource
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.	68
		Anthem
		156
		Managed Health Services
		89
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.	MDwise
		18
		CareSource
		58
		Anthem
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.	Makes referrals to the SMA and MFCU concurrently
		Managed Health Services

Makes referrals to the SMA and MFCU concurrently

MDwise

Makes referrals to the SMA and MFCU concurrently

CareSource

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.

Anthem

5

Managed Health Services

4

MDwise

1

CareSource

0

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?

Anthem

01/01/2025

Managed Health Services

01/01/2025

MDwise

01/01/2025

CareSource

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?

Anthem

12/31/2025

Managed Health Services

12/31/2025

MDwise

12/31/2025

CareSource

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?	Anthem \$111,237,403.22 Managed Health Services \$468,077.05 MDwise \$25,512,436.20 CareSource \$750,743
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))	Anthem \$0 Managed Health Services \$0 MDwise \$0 CareSource \$0
D1X.10	Changes in beneficiary circumstances Select the frequency the plan reports changes in beneficiary circumstances to the state.	Anthem Daily Managed Health Services Daily MDwise Daily CareSource Daily

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.	Anthem No ILOSs were offered by this plan
		Managed Health Services No ILOSs were offered by this plan
		MDwise No ILOSs were offered by this plan
		CareSource 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 HIP, 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 HIP. 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 2024 overpayment amounts retained by the MCE due to their capitation. This can include overpayments from incorrectly billed claims, provider refunds, etc.