2022 Annual

EQR Technical Report

Indiana Family and Social Services (FSSA)

Office of Medicaid Policy and Planning (OMPP)

FINAL

Office of Medicaid Policy & Planning

Qsource®

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Acknowledgements, Acronyms, and Initialisms[1]

AAP ..... American Academy of Pediatrics
ACA ..... Affordable Care Act
ANA ..... Annual Network Adequacy
AMISYS Advance™ ..... a trademark of DST Systems, Inc.
Anthem……..Blue Cross Blue Shield Anthem, Managed Care Entity
AOD..... Alcohol and other drug abuse/dependence
AON..... Area of Noncompliance
ArcGIS™ .....a trademark of Environmental Systems Research Institute, Inc.
BH ..... Behavioral Health
CA ..... Compliance Assessment
CAP……Corrective Action Plan
CareSource……..CareSource Indiana, Managed Care Entity
CET ..... Care Engagement Team
CFR ..... Code of Federal Regulations
CHIP..... Children's Health Insurance Program
CHW..... Community Health Worker
CIS ..... Childhood Immunization Status
CM..... Care-Case Management / Manager
CMHC..... Community Mental Health Center
CMS ..... Centers for Medicare & Medicaid Services
CY ..... Calendar Year
DMHA..... Division of Mental Health and Addiction
ED ..... Emergency Department
EDI ..... Electronic Data Interchange
EDIS..... ED Index Score
EPSDT ..... Early and Periodic Screening, Diagnostic and Treatment
EQR..... External Quality Review
EQRO..... External Quality Review Organization
ER ..... Emergency Room
FFS..... Fee-For-Service
FORHP..... Federal Office of Rural Health Policy
FPL..... Federal Poverty Level
FQHC ..... Federally Qualified Health Center
FSSA ..... Indiana Family and Social Services Administration
FUA……Follow-up After Emergency Department Visit for Drug Abuse or Dependence
FUH ..... Follow-up After Hospitalization for Mental Illness
HCC.....Hoosier Care Connect
HCPCS..... Healthcare Common Procedure Coding System
HEDIS®.....Healthcare Effectiveness Data and Information Set, a registered trademark of the NCQA
HHS..... U.S. Department of Health and Human Services
HIP ..... Healthy Indiana Plan
HHW..... Hoosier Healthwise
HNS..... Health Needs Screening
IDOH ..... Indiana Department of Health
IHCP.....Indiana Health Coverage Programs
IHIE .....Indiana Health Information Exchange
IMD.....Institution for Mental Disease
IOP ..... Intensive Outpatient
IS ..... Information System(s)

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

ISCA ..... Information Systems Capability Assessment
ISCAT…….. Information Systems Capability Assessment Tool
IT ..... Information Technology
MCE ..... Managed Care Entity
MD ..... Medical Doctor / Physician
MDwise ..... Managed Care Entity
MHS ..... Managed Health Services, Managed Care Entity
MMIS ..... Medicaid Management Information System
MMR ..... Measles, Mumps, and Rubella
MOU ..... Memorandum of Understanding
MRO ..... Medication Rehabilitation Option
MY ..... Measurement Year
MSLC ..... Myers & Stauffer Limited Liability Company
N ..... No/Number
N/A ..... Not Applicable
NB ..... No Benefit (PMV)
NCQA ..... National Committee for Quality Assurance
NCQA HEDIS Compliance Audit™ ..... a trademark of NCQA
NQ ..... Not Required (PMV)
NQF ..... National Quality Forum
NR ..... Not Reported (PMV)
NP ..... Nurse Practitioner
NPI ..... National Provider Identifier
OMPP ..... Office of Medicaid Policy and Planning
OTP ..... Opiate Treatment Program
PA ..... Physician's Assistant
P&P ..... Policy and Procedure
PCP ..... Primary Care Provider/Physician
PDSA ..... Plan-Do-Study-Act
PHP ..... Partial Hospitalization
PIP ..... Performance Improvement Project
PMP ..... Primary Medical Provider
PMV ..... Performance Measure Validation
PPC ..... Postpartum Timeliness
PRS ..... Peer Recovery Specialist
QAPI ..... Quality Assessment and Performance Improvement
QDM ..... Quality Data Management
QIP ..... Quality Improvement Project
QSI-XL® ..... a registered trademark of Inovalon, Inc.
Qsource® ..... EQRO, a registered trademark
SOF ..... State Operated Facility
SMI ..... Severe Mental Illness
SQL ..... Structured Query Language
SUD ..... Substance Use Disorder
UB ..... Uniform Bill
UM ..... Utilization Management
W15 ..... Well-Child Visits During the First 15 Months
W30 ..... Well-Child Visits During the First 30 Months
WCV ..... Well-Child Visits

Overview

In accordance with Title 42 *Code of Federal Regulations* (CFR) § 438.364, Qsource has produced this *2022 Annual EQRO Technical Report* to summarize the quality, timeliness, and accessibility of care furnished to enrollees in the Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) program by the managed care entities (MCEs). Indiana's MCEs include Anthem Blue Cross and Blue Shield (Anthem), CareSource Indiana (CareSource), MDwise, and Managed Health Services (MHS).

OMPP contracted with Qsource to conduct external quality review (EQR) activities and ensure that the results of those activities are reviewed to perform an external, independent assessment and produce an annual report. Qsource serves as OMPP's external quality review organization (EQRO) and prepared this *2022 Annual EQRO Technical Report* to document the Indiana Health Coverage Programs' MCE performance in providing services to enrollees and to identify areas for improvement and recommend interventions to improve the process and outcomes of care.

This section provides a brief history of OMPP, the population(s) served by each MCE, enrollee data for each Indiana Health Coverage Program (IHCP), OMPP's quality improvement initiative descriptions with 2021 results, the mandatory EQR activities conducted by Qsource in 2022 (including targeted quality objectives), guidelines provided by CMS for reporting EQR activities, and the intended utilization for this report.

OMPP Background

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

- **Healthy Indiana Plan** (HIP) was created in January 2008 under a separate Section 1115 waiver authority. The HIP 2.0 model is a health insurance program for uninsured adults under 138% of the Federal Poverty Level (FPL) between the ages of 19 and 64. The primary aim of the HIP program is to provide adults access to a health care plan that empowers them to take charge of their health and prepares them to move to private insurance as they improve their lives. HIP provides incentives for members to be health conscious by accessing preventive health care and encourages appropriate use of the emergency room (ER).
- **Hoosier Care Connect** (HCC) provides health coverage for the aged, blind, and disabled members

who are not dually eligible for Medicare. The program was implemented April 1, 2015, under a 1915(b)-waiver authority. The primary aim of HCC is to transition eligible members who are age 65 and over or who had blindness or a disability to a coordinated care program where their multiple health needs can be coordinated. This program also includes current and former wards and foster children. In 2021, health needs screens and comprehensive health assessments continued to be monitored as pay for outcome measures.

- **Hoosier Healthwise** (HHW) includes Indiana's Children's Health Insurance Program (CHIP) population and serves children and pregnant women. The program began in 1994 with members having the option to voluntarily enroll with an MCE in 1996. By 2005, enrollment with an MCE was mandatory for low-income families, pregnant women, and children. The HHW program aims to provide comprehensive health care coverage for uninsured Hoosiers to improve overall health, promote prevention, and encourage healthy lifestyles. A strong focus is on healthy mothers and babies with the intent to improve birth outcomes.

Five MCEs are contracted with the state of Indiana:

- Anthem Insurance Companies, Inc.;
- CareSource;
- MDwise, Inc.;
- MHS; and
- UnitedHealthcare.

Anthem and MHS service the HHW, HIP and HCC lines of business for risk-based managed care, while CareSource and MDwise service only the HHW and HIP lines of business. UnitedHealthcare began administering the HCC program on April 1, 2021. UnitedHealthcare did not participate in EQR activities in 2022 since it was not a full contract year.

Enrollees

As of September 2022, Indiana has enrolled 1,966,232 individuals in Medicaid and CHIP — a net increase of 75.45% since the first Marketplace Open Enrollment Period and related Medicaid program changes in October 2013.

Table 1 presents the IHCP enrollment for 2021 by month.

Table 1. Total IHCP Enrollees by Month												
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Healthy Indiana Plan												
Anthem	286,927	290,894	296,078	301,270	305,455	309,843	314,530	319,534	323,456	326,998	331,650	336,001
CareSource	58,361	59,500	60,860	62,255	63,314	64,299	65,385	66,583	67,548	68,176	69,504	71,099
MDwise	144,913	146,669	149,221	151,627	153,447	155,069	157,083	159,236	160,893	162,382	164,438	166,581
MHS	109,372	111,050	113,229	115,276	116,918	118,473	120,141	121,932	123,345	124,560	126,388	128,229
Total	**599,573**	**608,113**	**619,388**	**630,428**	**639,134**	**647,684**	**657,139**	**667,285**	**675,242**	**682,116**	**691,980**	**701,910**
Hoosier Care Connect												
Anthem	58,874	59,357	59,806	59,886	60,085	60,155	60,237	60,267	60,591	60,793	61,272	61,318
MHS	35,333	35,534	35,819	35,828	35,823	35,664	35,559	35,466	35,517	35,521	35,680	35,538
Total	**94,207**	**94,891**	**95,625**	**95,714**	**95,908**	**95,819**	**95,796**	**95,733**	**96,108**	**96,314**	**96,952**	**96,856**
Hoosier Healthwise												
Anthem	275,697	278,861	282,567	285,664	288,781	292,084	295,352	299,266	302,649	306,250	309,405	312,579
CareSource	64,551	65,492	66,531	67,346	68,195	69,078	69,915	71,029	71,863	72,841	73,736	74,672
MDwise	214,803	216,495	218,011	219,499	221,219	222,741	224,362	226,351	228,008	229,663	231,023	232,663
MHS	166,344	168,180	169,908	171,501	172,982	174,614	176,190	178,045	179,625	181,341	183,046	184,743
Total	**721,395**	**729,028**	**737,017**	**744,010**	**751,177**	**758,517**	**765,819**	**774,691**	**782,145**	**790,095**	**797,210**	**804,657**

OMPP Quality Strategy Overview

Under regulations at 42 CFR 438.340(a) and 42 CFR 457.1240(e), CMS requires state Medicaid agencies that contract with MCEs develop and maintain a Medicaid quality strategy. The purpose of the strategy is to assess and improve the quality of health care and services provided by MCEs.

In 2021, Indiana outlined specific quality initiatives for the HHW, HIP and HCC programs. The initiatives outlined global aims that OMPP has identified that support the objectives for all its programs, shown below.

1. Quality – Monitor quality improvement measures and strive to maintain high standards.
    a. Improve health outcomes.
    b. Encourage quality, continuity, and appropriateness of medical care.
2. Prevention – Foster access to primary and preventive care services with a family focus.
    a. Promote primary and preventive care.
    b. Foster personal responsibility and healthy lifestyles.
3. Cost – Ensure medical coverage in a cost-effective manner.
    a. Deliver cost-effective coverage.
    b. Ensure the appropriate use of health care services.
    c. Ensure utilization management best practices.
4. Coordination/Integration – Encourage the organization of patient activities to ensure appropriate care.
    a. Integrate physical and behavioral health services.
    b. Emphasize communication and collaboration with network providers.

OMPP Strategic Objectives for Quality Improvement

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

The initiatives are at the forefront of planning and implementation of this Quality Strategy. Ongoing monitoring will provide OMPP with quality-related data for future monitoring and planning.

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

Table 2, Table 3, and Table 4 present the strategic initiatives for each IHCP with their 2021 achievement results.

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	2021 Baseline	2021 Results	Goal
Measure: Improvements in Children and Adolescents Well-Care Percentage of members with well-child visits during first 21 years of life. Healthcare Effectiveness Data and Information Set (HEDIS) measures, well-child visits in the first 30 months of life and child and adolescent well-care visits for ages 3-21, using hybrid data. **Domain: Quality and Timeliness of Care**	OMPP utilized HEDIS measures for tracking the percentages of well-child services in children and adolescents.	Anthem	At or above 50th percentile.	Above the 50th percentile for well-child visits in the first 30 months of life and above the 50th percentile of adolescent well-care visits for ages 3-21.	Achieve at or above the 90th percentile of the National Committee for Quality Assurance (NCQA) 2022 Quality Compass improvements in children and adolescent well-child W30 and WCV HEDIS measures.
		CareSource	At or above 50th percentile.	Above the 50th percentile for well-child visits in the first 30 months of life and above the 50th percentile for adolescent well-care visits for ages 3-21.	
		MDwise	At or above 50th percentile.	Above the 50th percentile for well-child visits in the first 30 months of life and above the 50th percentile for adolescent well-care visits for ages 3-21.	
		MHS	At or above 50th percentile.	Below the 50th percentile for well-child visits in the first 30 months of life and above the 50th percentile for adolescent well-care visits for ages 3-21.	
Measure: Lead Screening in Children **Domain: Quality and Timeliness of Care**	OMPP utilized HEDIS for tracking the percentage of children 2 years of age who had one or more capillary or venous blood lead tests for lead poisoning by their second birthday.	Anthem	At or above 25th percentile.	At or above the 25th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for lead screening in children.
		CareSource	At or above 25th percentile.	At or above the 25th percentile.	
		MDwise	At or above 25th percentile.	At or above the 25th percentile.	
		MHS	At or above 25th percentile.	At or above the 25th percentile.	
Measure: Asthma Medication Ratio	OMPP utilized HEDIS for tracking the percentage of	Anthem	At or above 50th percentile.	At or above the 50th percentile.	Achieve at or above the 90th percentile of the NCQA 2022 Quality
		CareSource	At or above 50th	At or above the 75th percentile.	

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	2021 Baseline	2021 Results	Goal
Domain: Quality and Timeliness of Care	children aged 5-11 years who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater.		percentile.		Compass for asthma medication ratio.
		MDwise	At or above 50th percentile.	At or above the 50th percentile.	
		MHS	At or above 50th percentile.	At or above the 75th percentile.	
Measure: Prenatal Depression Screening in Pregnant Women **Domain: Quality and Access to Care**	OMPP utilized HEDIS for tracking the percentage of women receiving prenatal depression screening in pregnant women	Anthem	NCQA in process of baselining.	Successful submission of results.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for prenatal depression screening.
		CareSource	NCQA in process of baselining.	Successful submission of results.	
		MDwise	NCQA in process of baselining.	Successful submission of results.	
		MHS	NCQA in process of baselining.	Successful submission of results.	

Table 3. Healthy Indiana Plan Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	2021 Baseline	2021 Results	Goal
Measure: POWER Account Roll-Over (HEDIS AAP) HIP members who obtain a preventive exam during the measurement year receive power account roll-over. Only codes and code combinations listed in the categories	OMPP utilized HEDIS for tracking the percentage of HIP members who receive a qualifying preventive exam.	Anthem	At or above the 25th percentile.	At or above the 25th percentile.	Achieve rate at or above the 75th percentile of the NCQA 2022 Quality Compass of members who received a preventative exam.
		CareSource	At or above the 25th percentile.	Below the 25th percentile.	
		MDwise	At or above the 25th percentile.	At or above the 25th percentile.	
		MHS	At or above the 25th percentile.	At or above the 25th percentile.	

Table 3. Healthy Indiana Plan Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	2021 Baseline	2021 Results	Goal
'Preventive Care Counseling Office Visit' and 'Alternative Preventive Care Counseling Visit' apply to this measure. **Domain: Quality and Access to Care**					
Measure: Prenatal Depression Screening in Pregnant Women **Domain: Quality and Access to Care**	OMPP utilized HEDIS for tracking the percentage of women receiving prenatal depression screening in pregnant women.	Anthem	NCQA in process of baselining.	Successful submission of results.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for prenatal depression screening.
		CareSource	NCQA in process of baselining.	Successful submission of results.	
		MDwise	NCQA in process of baselining.	Successful submission of results.	
		MHS	NCQA in process of baselining.	Successful submission of results.	
Measure: Timeliness of Ongoing Prenatal Care **Domain: Quality and Timeliness of Care**	OMPP utilized HEDIS for tracking the percentage of women receiving timeliness of ongoing prenatal care.	Anthem	At or above the 10th percentile.	At or above the 50th percentile.	Achieve at or above the 50th percentile of the NCQA 2022 Quality Compass for the timeliness of prenatal.
		CareSource	At or above the 10th percentile.	At or above the 25th percentile.	
		MDwise	At or above the 10th percentile.	At or above the 50th percentile.	
		MHS	At or above the 10th percentile.	At or above the 50th percentile.	
Measure: Frequency of Post-partum Care **Domain: Quality and Timeliness of Care**	OMPP utilized HEDIS for tracking the percentage of women who receive required post-partum visits.	Anthem	At or above the 25th percentile.	At or above the 75th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for required post-partum visits.
		CareSource	At or above the 25th percentile.	Below the 25th percentile.	
		MDwise	At or above the 25th percentile.	At or above the 50th percentile.	

Table 3. Healthy Indiana Plan Quality Strategy Initiatives					
Measure and Domain	**Methodology**	**MCE**	**2021 Baseline**	**2021 Results**	**Goal**
		MHS	At or above the 25th percentile.	At or above the 50th percentile.	
Measure: Completion of Health Needs Screen **Domain: Quality**	Administrative reporting	Anthem	At or above 60%	45.60%	Achieve at or above 60% of all new members completing the health needs screening within 90 days of enrollment.
		CareSource	At or above 60%	35.01%	
		MDwise	At or above 60%	60.83%	
		MHS	At or above 60%	70.36%	
Measure: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 7 day **Domain: Quality and Access to Care**	HEDIS measure using administrative data	Anthem	At or above the 25th percentile.	At or above the 50th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
		CareSource	At or above the 25th percentile.	At or above the 50th percentile.	
		MDwise	At or above the 25th percentile.	At or above the 50th percentile.	
		MHS	At or above the 25th percentile.	At or above the 50th percentile.	
Measure: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 30 day **Domain: Quality and Access to Care**	HEDIS measure using administrative data	Anthem	At or above the 25th percentile.	At or above the 75th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
		CareSource	At or above the 25th percentile.	At or above the 50th percentile.	
		MDwise	At or above the 25th percentile.	At or above the 50th percentile.	
		MHS	At or above the 25th percentile.	At or above the 25th percentile.	

Table 4. Hoosier Care Connect Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	2021 Baseline	2021 Results	Goal
Measure: Adult Preventive Care (HEDIS) **Domain: Quality and Access to Care**	OMPP used the adult preventive care HEDIS measure for tracking preventive care.	Anthem	At or above the 25th percentile.	At or above the 75th percentile.	Achieve at or above the 75th percentile for NCQA 2022 Quality Compass for members 20 years and older who had a preventive care visit.
		MHS	At or above the 25th percentile.	At or above the 50th percentile.	
Measure: Completion of Health Needs Screen (≥60%) **Domain: Quality and Timely Access to Care**	Administrative reporting	Anthem	At or above 60%.	44.45%	Achieve completion of a Health Needs Screen for > 60%of all members during the first 90 days of enrollment.
		MHS	At or above 60%.	78.08%	
Measure: Completion of Comprehensive Health Assessment Tool **Domain: Quality and Timely Access to Care**	Administrative reporting	Anthem	At or above 73%.	77.60%	Achieve completion of a comprehensive health assessment for >79% for all members who are stratified into complex case management or the Right Choice Program following the initial screening, during the first 150 days of enrollment.
		MHS	At or above 73%.	87.53%	
Measure: Follow-up after emergency department visit for alcohol and other drug abuse dependence 7 day **Domain: Quality and Access to Care**	HEDIS measure using administrative data	Anthem	At or above the 25th percentile	At or above the 50th percentile	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
		MHS	At or above the 25th percentile	At or above the 25th percentile	
Measure: Follow-up after emergency department visit for	HEDIS measure using	Anthem	At or above the 25th percentile	At or above the 25th percentile	Achieve at or above the 75th percentile of the NCQA

Table 4. Hoosier Care Connect Quality Strategy Initiatives					
Measure and Domain	**Methodology**	**MCE**	**2021 Baseline**	**2021 Results**	**Goal**
alcohol and other drug abuse dependence 30 day **Domain: Quality and Access to Care**	administrative data	MHS	At or above the 25th percentile	At or above the 25th percentile	2022 Quality Compass

Qsource noted four performance metrics which had successful increases and/or met HEDIS rate goals for 2021:

- Timeliness of Ongoing Prenatal Care - HIP
  - OMPP utilized HEDIS for tracking the percentage of women receiving timeliness of ongoing prenatal care.
  - Achieve at or above the 50th percentile of the NCQA 2022 Quality Compass for the timeliness of prenatal care.
  - Three of the four plans achieved the HEDIS 50th percentile goal: Anthem, MDwise and MHS.
- Frequency of Post-partum Care – HIP
  - OMPP utilized HEDIS for tracking the percentage of women who receive required post-partum visits.
  - Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for required post-partum visits.
  - Anthem achieved the 75th percentile with MHS and MDwise making progress from the 25th to above the 50th percentile.
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 30 day - HIP
  - Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
  - Anthem reached the 75th percentile with MHS and MDwise improving from the 25th to above the 50th percentile.
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 7 day - HIP
  - Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
  - None of the plans reached the 75th percentile; however, all 4 plans improved from the 25th to the 50th percentile.

- Adult Preventive Care (HEDIS) - HCC
  - OMPP used the adult preventive care HEDIS measure for tracking preventive care.
  - Achieve at or above the 75th percentile for NCQA 2022 Quality Compass for members 20 years and older who had a preventive care visit.
  - Anthem reached the 75th percentile with MDwise improving from the 25th to above the 50th percentile.

Qsource noted seven performance metrics which showed no improvement or minimal improvement reaching goals for 2021:

- Improvements in Children and Adolescents Well-Care - HHW
  - Percentage of members with well-child visits during first 21 years of life. HEDIS measures, well-child visits in the first 30 months of life and child and adolescent well-care visits for ages 3-21, using hybrid data.
  - Achieve at or above the 90th percentile of the NCQA 2022 Quality Compass improvements in children and adolescent well-child W30 and WCV HEDIS measures.
  - None of the plans reached the 90th percentile, with Anthem, MDwise and CareSource making no change from baseline of 50th percentile and MHS showing less than baseline of 50th percentile.
- Lead Screening in Children - HHW
  - OMPP utilizes HEDIS for tracking the percentage of children two years of age who had one or more capillary or venous blood lead tests for lead poisoning by their second birthday.
  - Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for lead screening in children.
  - None of the plans reached the 75th percentile, with all 4 plans remaining at the baseline of 25th percentile.
- Asthma Medication Ratio - HHW
  - OMPP utilizes HEDIS for tracking the percentage of children aged 5-11 years who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater.
  - Achieve at or above the 90th percentile of the NCQA 2022 Quality Compass for asthma medication ratio.
  - None of the plans reached the 90th percentile, with CareSource and MHS improving to the 50th percentile and MDwise and Anthem showing no improvement from baseline.
- POWER Account Roll-Over (HEDIS AAP) - HIP
  - HIP members who obtain a preventive exam during the measurement year (MY) receive POWER account roll-over. Only codes and code combinations listed in the categories ‘Preventive

Care Counseling Office Visit' and 'Alternative Preventive Care Counseling Visit' apply to this measure.
    - OMPP utilizes HEDIS for tracking the percentage of HIP members who receive a qualifying preventive exam.
    - Achieve rate at or above the 75th percentile of the NCQA 2022 Quality Compass of members who received a preventative exam.
    - None of the plans reached the 75th percentile, with Anthem, MDwise and MHS showing no improvement and CareSource falling below the baseline.
- Completion of Health Needs Screening - HIP
    - Achieve at or above 60% of all new members completing the health needs screening within 90 days of enrollment.
    - MHS and MDwise reached the 60% completion rate; however, Anthem and CareSource fell below the baseline.
- Follow-up after emergency department visit for alcohol and other drug abuse dependence 7 day - HCC
    - Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
    - Neither Anthem nor MHS reached the 75th percentile.
- Follow-up after emergency department visit for alcohol and other drug abuse dependence 30 day - HCC
    - Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
    - Neither Anthem nor MHS reached the 75th percentile.

Quality Strategy Conclusions

OMPP should continue to work with the MCEs and focus on standards that consistently show no improvement or minimal improvement to ensure quality, timeliness, and access to care for the enrollees. OMPP should ensure that the MCEs review their workflows and ensure timely care and reporting of data. OMPP should ensure that all the MCEs are informed of all reporting requirements and reporting timeframes. OMPP should continue to develop reports that follow HEDIS updates, additions, and new guidelines. Overall, the Quality Strategy was an effective tool for measuring and improving OMPP's managed care services, specifically in improving the quality, timeliness, and access to care for the MCE enrollees. The MCEs and the State are making progress towards the Quality Strategy goals and objectives.

EQR Activities

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

2022, in accordance with the CMS *External Quality Review Protocols* (released in 2019).

EQR Mandatory Activities

Following the CMS Protocols published in October 2019, Qsource conducted the EQR activities shown in **Table 5**.

Table 5. EQR Activities Conducted in 2022

Protocol #	Activity Name	Mandatory or Optional	Measurement Period
1	***Validation of Performance Improvement Projects***	Mandatory	January 1, 2021 – December 31, 2021
2	***Validation of Performance Measures***	Mandatory	January 1, 2021 – December 31, 2021
4	***Validation of Network Adequacy***	Mandatory	January 1, 2021– December 31, 2021

Under CMS requirements, Protocol 3 requires MCEs to undergo a review at least once every three years to determine MCE compliance with federal standards as implemented by the state. OMPP has chosen to review all applicable standards every three years. Protocol 3 was performed in 2020 and will be performed again in 2024, assessing all applicable standards.

Qsource maintained ongoing, collaborative communication with OMPP and provided technical assistance to the MCEs in their EQR activities. The technical assistance—an EQR-related activity also defined by 42 CFR § 438.358, consisted of targeted support through phone calls, webinars, written guides, and trainings.

Finally, Qsource provided each MCE with an information packet explaining the EQR activities in greater detail and dates for data submission.

CMS National Quality Strategy

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

Quality of Care

CMS describes quality of care as the degree to which preferred enrollee health outcomes are likely to increase through the efforts of MCEs, along with their organizations and operations that provide enrollee services. OMPP required the MCEs to conduct quality improvement projects (QIPs), which included mechanisms to assess the quality and appropriateness of care provided to enrollees. Each MCE was required to report on performance measures related to quality of care to the State. OMPP asked the MCEs to meet targets for those performance measures. In addition, each MCE was required to report on performance measures related to quality of care to the State. Qsource conducted Performance Measure Validation to

determine if the MCEs were meeting these quality performance measure targets.

Timeliness of Care

For quality care to be effective, it must be delivered in a timely manner. Thus, various standards for timely care were monitored through MCE compliance with federal and state regulations. Multiple QIPs, validated by Qsource, addressed the timeliness of care for enrollees: Follow-up After Emergency Department Visit for Drug Abuse or Dependence, Follow-up After Hospitalization for Mental Illness and Postpartum Timeliness. Qsource's validation of performance measures looked at timeliness measures determined by OMPP. Translation and Interpretation Services measures were evaluated to ensure enrollees were given timely access to Translation services when needed.

Access to Care

Just as quality of care is critical for enrollee health outcomes, so too is access to care. The MCEs' provider capacity is monitored through annual network adequacy evaluation, which assesses the availability of critical provider specialties by time and distance and how quickly enrollees can obtain needed appointments. Network adequacy was analyzed to determine if enrollees' access to care met requirements. Compliance with applicable federal, state, and contractual regulations also addresses access to care requirements, ensuring accessibility for all enrollees, including those with limited English proficiency and physical or mental disabilities. Performance Measure Validation of Translation and Interpretation Services ensure members needing language services are considered and given timely access to care. The MCE's QIPs are evaluated to ensure quality of care and access to care are ensured for all enrollees.

Technical Report Guidelines

Qsource is responsible for the creation and production of this *2022 Annual EQRO Technical Report*, which compiles the results of these EQR activities. To assist both EQROs and state agencies, CMS supplemented the requirements of 42 CFR § 438.364, as incorporated by 42 CFR § 457.1250, and provided guidelines in the 2019 EQR Protocols for producing annual technical reports.

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

- Protocol 1. Validation of Performance Improvement Projects (*MCEs reference these as Quality Improvement Projects (QIPs) and used throughout this report*)
- Protocol 2. Validation of Performance Measures
- Protocol 4. Validation of Network Adequacy

Each activity conducted by Qsource was to monitor each MCEs compliance with federally mandated activities and to assess the quality, timeliness and accessibility of services provided by the MCEs. This report includes the following results of these activities:

1. A brief description of the data collection, aggregation, and analyses for each of the EQR compliance activities;
2. A summary of findings from each review;
3. Strengths and weaknesses demonstrated by each MCE in providing healthcare services to enrollees;
4. Recommendations for improving the quality of these services, including how OMPP can target goals and objectives in achieving the goals of the quality strategy to better support improvement; and
5. Comparative information regarding the MCEs, consistent with CMS EQR Protocol guidance.

The *2022 Annual EQRO Technical Report* provides OMPP with substantive, unbiased data on the MCEs as well as recommendations for action toward far-reaching performance improvement. This report is based on detailed findings that can be reviewed in the individual EQR activity reports provided to OMPP.

Recommendations for how to utilize Qsource's findings can be found in the Conclusions and Recommendations section of this report.

The appendices provide additional EQR activity information:

- **Appendix A** | PMV Measure Rates
- **Appendix B** | ANA Findings
- **Appendix C** | Detailed Analysis of Provider Network Access

EQRO Team

The review team included the following staff:

- Rebel McKnight, Qsource, Indiana EQR Program Manager
- Victoria Warner, Qsource, EQR Operations Leader
- Jazzmin Kennedy, Qsource, Clinical Quality Improvement Advisor
- Albert Kennedy, Qsource, Technical Writer
- Barbara Shipp, Qsource, Healthcare Quality Analyst
- Kathy Haley, Myers and Stauffer
- Catherine Snider, Myers and Stauffer
- Emily Brammer, Axon Advisors, LLC

Quality Improvement Project (QIP) Validation

Overview

The *Balanced Budget Act of 1997* established certain managed care quality safeguards that were described by Title 42 of the *Code of Federal Regulations*, Section 438.320 (42 CFR § 438.320), which defines "external quality review" as the "analysis and evaluation … of aggregated information on quality, timeliness, and access to health care services." These reviews, described in 42 CFR § 438.358, include four required external quality review activities, one of which is the validation of quality improvement projects.

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

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

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

Technical Methods of Data Collection and Analysis

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

Each MCE submitted a continuation of their established QIPs as QIPs are typically conducted over a three-year period. Some of the QIPs were in their initial year with new topics being evaluated. To validate QIPs, Qsource assembled a validation team of experienced

staff specializing in clinical quality improvement and a healthcare data analyst. The validation process included a review of each QIP's study design and approach, an evaluation of each QIP's compliance with the analysis plan, and an assessment of the effectiveness of interventions.

The QIP validation was based on CMS's EQR Protocol 1: Validation of Performance Improvement Projects (October 2019). Qsource developed a QIP Summary Form (with accompanying QIP Summary Form Completion Instructions) and a QIP Validation Tool to standardize the process by which each MCE delivers QIP information to OMPP and how the information is assessed. Using Qsource's QIP Summary Form, each MCE submitted its QIP studies and supplemental information in August 2022. The MY for this validation was January 1, 2021, through December 31, 2021.

Qsource's scoring methodology determines whether a QIP is valid by rating the QIP's percentage of compliance with the *Centers for Medicare & Medicaid Services EQR Protocol 1: Validating Performance Improvement Projects (PIPs) 2019.* Qsource developed a QIP Validation Tool used internally by members of the validation team to standardize the process by which each QIP is evaluated across all MCEs. Each QIP involves nine required activities, and each activity consists of one or more elements essential to the successful completion of a QIP. The elements within each activity are scored as Met, Not Met, or Not Applicable.

Table 6 presents the validation status criteria for the QIPs.

Table 6. QIP Validation Status Criteria

Status	Criteria
High Confidence	Of all elements assessed, 90–100% were met across all activities.
Moderate Confidence	Of all elements assessed, 80–<90% were met across all activities.
Low Confidence	Of all elements assessed, 70–<80% were met across all activities.
No Confidence	Less than 70% of all elements were met.

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

Table 7. QIP Assessment Steps

QIP Activities	
1	State the Selected QIP Topic
2	State the QIP Aim Statement
3	Identify the QIP Population
4	Describe the Sampling Method
5	Describe the Selected QIP Variables and Performance Measures
6	Describe Valid and Reliable Data Collection Procedures
7	Analyze Data and Interpret QIP Results
8	Describe Improvement Strategies
9	Assess for Significant and Sustained Improvement

QIP Topics

The MCEs are required to produce QIPs for all IHCP programs it administers—Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect. Qsource received and assessed QIP Summary forms for the following QIP topics in **Table 8**.

The MCEs have the option to conduct the same QIP across programs and select their own topics. Anthem had 12 QIPs, CareSource had 6 QIPs, MDwise had 5 QIPs, and MHS had 6 QIPs.

Qsource received and assessed QIP Summary forms for the following QIP topics:

Table 8. QIP Topics by MCE

QIP Topic	Anthem			CareSource		MDwise		MHS		
	HIP	HHW	HCC	HIP	HHW	HIP	HHW	HIP	HHW	HCC
Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)	X		X			X	X			
Follow-up After Hospitalization for Mental Illness (FUH)	X	X	X							
Health Needs Screening (HNS)	X	X	X	X	X	X		X	X	X
Childhood Immunization Status		X								
Care Management Engagement	X	X	X	X	X			X	X	X
Improve Lead Testing in Children 12-24 Months					X					
Postpartum Timeliness						X				
Reduce Preventable ER Utilization					X					
Well-Child Visits During the First 15 Months (W15)							X			

Validation Results 2021 QIPs

Table 9 presents each QIP's element percentages and overall validation status by IHCP and QIP.

Table 9. 2021 QIP Validation Results Summary

QIP Activities	Elements Met/Applicable		Validation Status (%)
	Met	Applicable	
Anthem			
Healthy Indiana Plan			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*	15	44	No Confidence - 34%
QIP 2: *Follow-up After Hospitalization for Mental Illness (FUH)*	14	45	No Confidence - 31%
QIP 3: *Health Needs Screening (HNS)*	11	45	No Confidence - 24%
QIP 4: *Care Management Engagement*	11	43	No Confidence - 26%
Hoosier Healthwise			
QIP 2: *Follow-up After Hospitalization for Mental Illness*	14	45	No Confidence - 31%
QIP 2: *Health Needs Screening*	11	45	No Confidence - 24%
QIP 3: *Care Management Engagement*	11	43	No Confidence - 26%
QIP 4: *Childhood Immunization Status (CIS)*	19	51	No Confidence - 37%
Hoosier Care Connect			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence*	14	45	No Confidence - 31%
QIP 2: *Follow-up After Hospitalization for Mental Illness*	21	44	No Confidence - 48%
QIP 3: *Health Needs Screening*	11	45	No Confidence - 24%
QIP 4: *Care Management Engagement*	11	43	No Confidence - 26%
CareSource			
Healthy Indiana Plan			
QIP 1: *Health Needs Screening*	43	46	High Confidence - 93%
QIP 2: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence*	39	44	Moderate Confidence-89%
Hoosier Healthwise			

Table 9. 2021 QIP Validation Results Summary			
QIP Activities	**Elements Met/Applicable**		**Validation Status (%)**
	Met	**Applicable**	
QIP 1: *Health Needs Screening*	43	46	High Confidence - 93%
QIP 2: *Improve Lead Testing in Children 12-24 Months*	40	46	Moderate Confidence-87%
QIP 3: *Reduce Preventable Emergency Department (ED) Utilization*	35	43	Moderate Confidence-81%
QIP 4: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence*	39	44	Moderate Confidence-89%
MDwise			
Healthy Indiana Plan			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence*	21	49	No Confidence - 43%
QIP 2: *Health Needs Screenings*	17	45	No Confidence - 38%
QIP 3: *Postpartum Timeliness*	18	50	No Confidence - 36%
Hoosier Healthwise			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence*	21	49	No Confidence - 43%
QIP 2: *Well-Child Visits During the First 30 Months (W30)*	16	31	No Confidence - 52%
MHS			
Healthy Indiana Plan			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence*	45	46	High Confidence - 98%
QIP 2: *Health Needs Screening*	40	42	High Confidence - 95%
Hoosier Healthwise			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence*	45	46	High Confidence - 98%
QIP 2: *Health Needs Screening*	40	42	High Confidence - 95%
Hoosier Care Connect			
QIP 1: *Follow-up After Emergency Department Visit for Drug Abuse or Dependence*	45	46	High Confidence - 98%
QIP 2: *Health Needs Screening*	40	42	High Confidence - 95%

Strengths, Weaknesses and Recommendations

Table 10 includes strengths and **Table 11** includes weaknesses and recommendations. Strengths for the QIP validation indicate that the MCEs demonstrated proficiency on a given activity and can be identified regardless of validation rating. The lack of an identified strength should not be interpreted as a shortcoming on the part of a MCEs. Weaknesses, or Areas of Noncompliance (AONs), arise from evaluation elements that receive a Not Met score, indicating that those elements were not in full compliance with CMS Protocols. The recommendations were created by Qsource to address the weaknesses evaluated in the QIPs. Strengths, weaknesses, and recommendations are useful to the MCE in determining whether to continue or retire a specific QIP. Any MCE QIP topic that is not listed was determined to have no strengths and/or weaknesses identified.

Table 10. QIP Strengths

CareSource	
Health Needs Screening HIP / HHW	The MCE demonstrated consistent and significant improvement in the HNS completion rate over time, attributable to improvement strategies implemented.
Improve Lead Testing Rates for Children Ages 12-24 Months HHW	The MCE demonstrated consistent and significant improvement in the lead screening for children and measles, mumps, and rubella (MMR) versus just lead screening rates, attributable to improvement strategies implemented.
MHS	
Across All Submitted QIPs	MHS improved their documentation and detailed analysis of the QIPs compared to the previous year.

Table 11. QIP Weaknesses (AONs) and Recommendations

Anthem	
Follow-up After ED Visit for Drug Abuse or Dependence (HIP / HCC)	
Review the Selected QIP Topic	♦ The MCE should provide a comprehensive analysis of enrollee needs, care, and services consistent with the QIP topic, e.g., demographic characteristics, health risks, prevalence of conditions, and need for specific services. ♦ The MCE should consider input from enrollees and/or providers on the QIP topic and, if this input is not solicited, provide the rationale. ♦ The MCE should explicitly state how the QIP topic addresses care of special populations or high-priority services.
Review the QIP AIM Statement	♦ The MCE should ensure improvement strategies noted in each step are consistent. ♦ The MCE should accurately identify the age restriction of the QIP population.
Review the Identified QIP Population	♦ The MCE should identify enrollment requirements for the population.

Table 11. QIP Weaknesses (AONs) and Recommendations

Review the Selected QIP Variables and Performance Measures	♦ The MCE should include a discussion of how the FUA 7-day measure assesses care that will have influence on enrollee health. ♦ The MCE should address the appropriateness of the performance measure based on availability of data and resources to collect the data. ♦ The MCE should discuss how the performance measure will be tracked over time and compared to benchmarks.
Review the Data Collection Procedures	♦ The MCE should describe a systematic method for collecting valid and reliable data. ♦ The MCE should ensure all data sources are noted. ♦ The MCE should address the data elements collected. ♦ The MCE should include the name of the NCQA-certified HEDIS software vendor. ♦ The MCE should provide evidence of the analyses that resulted in a 100% administrative date completeness estimate.
Review the Data Analysis and Interpretation of QIP Results	♦ The MCE should include a comprehensive analysis and interpretation of results consistent with the data analysis plan. ♦ The MCE should include a discussion of the baseline and remeasurement rates. ♦ The MCE should include a discussion of the statistical significance of the differences in the baseline and remeasurement rates. ♦ The MCE should indicate if any factors could have influenced comparability of initial and repeat measurements. ♦ The MCE should explain the external factors impacting rates. ♦ The MCE should present results in a clear manner. ♦ The MCE should include the lessons learned about the less-than-optimal performance in this step.
Assess the Improvement Strategies	♦ The MCE should address the evidence basis of the improvement strategies selected. ♦ The MCE should describe how the strategies were related to causes/barriers identified through data analysis. ♦ The MCE should include evidence of how the strategies were implemented on a Plan-Do-Study-Act (PDSA) cycle. ♦ The MCE should describe how the member-focused strategies were culturally and linguistically appropriate. ♦ The MCE should address how the improvement strategies accounted for major confounding factors identified. ♦ The MCE should describe the level of success of the strategies and identify follow-up activities planned.
Assess the Likelihood that Significant and Sustained Improvement Occurred	♦ The MCE should identify if the baseline and remeasurement methodologies were the same. ♦ The MCE should discuss the lack of quantitative evidence of improvement in the performance measure.
Follow-up After Hospitalization for Mental Illness (HHW / HIP / HCC)	
Review the Selected QIP Topic	♦ The MCE should provide a comprehensive analysis of enrollee needs, care, and services consistent with the QIP topic, e.g., demographic characteristics, health risks, prevalence of conditions, and need for specific services. ♦ The MCE should consider input from enrollees and/or providers on the QIP topic and, if this input is not solicited, provide the rationale.

Table 11. QIP Weaknesses (AONs) and Recommendations

	♦ The MCE should explicitly state how the QIP topic addresses care of special populations or high-priority services.
Review the QIP AIM Statement	♦ The MCE should ensure improvement strategies are consistent.
Review the Identified QIP Population	♦ The MCE should identify enrollment requirements for the population.
Review the Selected QIP Variables and Performance Measures	♦ The MCE should accurately define the variable. ♦ The MCE should include a discussion of how the FUH 7-day measure assesses care that will have influence on enrollee health. ♦ The MCE should address the appropriateness of the performance measure based on availability of data and resources to collect the data. ♦ The MCE should discuss how the performance measure will be tracked over time and compared to benchmarks.
Review the Data Collection Procedures	♦ The MCE should describe systematic method for collecting valid and reliable data. ♦ The MCE should ensure all data sources are noted. ♦ The MCE should address the data elements collected. ♦ The MCE should include the name of the NCQA-certified HEDIS software vendor. ♦ The MCE should provide evidence of the analyses that resulted in a 100% administrative date completeness estimate.
Review the Data Analysis and Interpretation of QIP Results	♦ The MCE should include a comprehensive analysis and interpretation of results consistent with the data analysis plan. ♦ The MCE should include a discussion of the baseline and remeasurement rates. ♦ The MCE should include a discussion of the statistical significance of the differences in the baseline and remeasurement rates. ♦ The MCE should indicate if any factors could have influenced comparability of initial and repeat measurements. ♦ The MCE should explain the external factors impacting rates. ♦ The MCE should present results in a clear manner. ♦ The MCE should include the lessons learned about the less-than-optimal performance in this step.
Assess the Improvement Strategies	♦ The MCE should address the evidence basis of the improvement strategies selected. ♦ The MCE should describe how the strategies were related to causes/barriers identified through data analysis. ♦ The MCE should include evidence of how the strategies were implemented on a PDSA basis. ♦ The MCE should describe how the member-focused strategies were culturally and linguistically appropriate. ♦ The MCE should address how the improvement strategies accounted for major confounding factors identified. ♦ The MCE should describe the level of success of the strategies and identify follow-up activities planned.

Table 11. QIP Weaknesses (AONs) and Recommendations

Assess the Likelihood that Significant and Sustained Improvement Occurred	♦ The MCE should identify if the baseline and remeasurement methodologies were the same. ♦ The MCE should discuss the quantitative evidence of improvement in the performance measure. ♦ The MCE should describe if the slight improvement in the FUH 7-day rate could be the result of the improvement strategies. ♦ The MCE should discuss statistical testing results for the change in the FUH 7-day rate from baseline to remeasurement.
Health Needs Screening (HIP / HHW / HCC)	
Review the Selected QIP Topic	♦ The MCE should provide a comprehensive analysis of enrollee needs, care, and services consistent with the QIP topic, e.g., demographic characteristics, health risks, prevalence of conditions, and need for specific services. ♦ The MCE should consider input from enrollees and/or providers on the QIP topic and, if input is not solicited, provide the rationale. ♦ The MCE should explicitly state how the QIP topic addresses care of special populations or high-priority services. ♦ The MCE should describe how the HNS topic aligns with HHS and/or CMS priorities.
Review the QIP AIM Statement	♦ The MCE should ensure improvement strategies noted are consistent. ♦ The MCE should clearly specify the QIP population.
Review the Identified QIP Population	♦ The MCE should identify enrollment requirements for the population. ♦ The MCE should describe how the QIP population captures all enrollees to whom the aim statement applies.
Review the Selected QIP Variables and Performance Measures	♦ The MCE should describe the availability of data and resources to collect the data. ♦ The MCE should include a discussion of how the HNS measure assesses care that will have influence on enrollee health or functional status. ♦ The MCE should address the appropriateness of the performance measure based on availability of data and resources to collect the data. ♦ The MCE should include evidence of health services research relevant to the performance measure. ♦ Because the performance measure was internally developed, the MCE should explain how whether it is a process measure meaningfully associated with outcomes.
Review the Data Collection Procedures	♦ The MCE should describe the systematic method for collecting valid and reliable data. ♦ The MCE should clearly specify the data sources. ♦ The MCE should include the data elements collected to calculate the performance measure. ♦ The MCE should describe the data collection instrument. ♦ The MCE should provide evidence of the analyses that resulted in a 100% administrative date completeness estimate.
Review the Data Analysis and Interpretation of QIP Results	♦ The MCE should include a comprehensive analysis and interpretation of results consistent with the data analysis plan. ♦ The MCE should include a discussion of the baseline and remeasurement rates.

Table 11. QIP Weaknesses (AONs) and Recommendations

	♦ The MCE should include a discussion of the statistical significance of the differences in the baseline and remeasurement rates. ♦ The MCE should indicate if any factors could have influenced comparability of initial and repeat measurements. ♦ The MCE should present results in a clear manner. ♦ The MCE should include the lessons learned about the less-than-optimal performance in this step.
Assess the Improvement Strategies	♦ The MCE should address the evidence basis of the improvement strategies selected. ♦ The MCE should describe how the strategies were related to causes/barriers identified through data analysis. ♦ The MCE should include evidence of how the strategies were implemented on a PDSA basis. ♦ The MCE should describe how the member-focused strategies were culturally and linguistically appropriate. ♦ The MCE should address how the improvement strategies accounted for major confounding factors identified. ♦ The MCE should describe the level of success of the strategies and identify follow-up activities planned.
Assess the Likelihood that Significant and Sustained Improvement Occurred	♦ The MCE should identify if the baseline and remeasurement methodologies were the same. ♦ The MCE should discuss the quantitative evidence of improvement in remeasurement one. ♦ The MCE should specify if reported improvement was a result of the improvement strategies. ♦ The MCE should conduct and discuss results of statistical testing on rate changes. ♦ The MCE should discuss why sustained improvement was not achieved in remeasurement two.
Care Management Engagement (HHW / HIP / HCC)	
Review the Selected QIP Topic	♦ The MCE should provide a comprehensive analysis of enrollee needs, care, and services consistent with the QIP topic, e.g., demographic characteristics, health risks, prevalence of conditions, and need for specific services. ♦ The MCE should consider input from enrollees and/or providers on the QIP topic and, if this input is not solicited, provide the rationale. ♦ The MCE should explicitly state how the QIP topic addresses care of special populations or high-priority services. ♦ The MCE should describe how the CM topic aligns with HHS and/or CMS priorities.
Review the QIP AIM Statement	♦ The MCE should specify the QIP population. ♦ The ME should include a clear definition of what the QIP is measuring in the aim statement to be answerable and measurable.
Review the Identified QIP Population	♦ The MCE should describe how the QIP population captures all enrollees to whom the aim statement applies.
Review the Selected QIP Variables and Performance Measures	♦ The MCE should accurately define the QIP variable. ♦ The MCE should describe the availability of data and resources to collect the data.

Table 11. QIP Weaknesses (AONs) and Recommendations

	♦ The MCE should include a discussion of how the care management measure assesses care that will have influence on enrollee health or functional status. ♦ The MCE should address the appropriateness of the performance measure based on availability of data and resources to collect the data. ♦ The MCE should include evidence of health services research relevant to the performance measure. ♦ Because the performance measure was internally developed, the MCE should explain how it is a process measure meaningfully associated with outcomes
Review the Data Collection Procedures	♦ The MCE should describe the systematic method for collecting valid and reliable data. ♦ The MCE should include the data elements collected to calculate the performance measure. ♦ The MCE should describe the data collection instrument.
Review the Data Analysis and Interpretation of QIP Results	♦ The MCE should include a comprehensive analysis and interpretation of results consistent with the data analysis plan. ♦ The MCE should include the denominators and performance measure rate results (percentage of members engaged in care management) and a discussion of the baseline and remeasurement rates. ♦ The MCE should include a discussion of the statistical significance of the differences in the baseline and remeasurement rates. ♦ The MCE should indicate if any factors could have influenced comparability of initial and repeat measurements. ♦ The MCE should explain the internal or external factors impacting rates. ♦ The MCE should present results in a clear manner. ♦ The MCE should include the lessons learned about the less-than-optimal performance in this step.
Assess the Improvement Strategies	♦ The MCE should address the evidence basis of the improvement strategies selected. ♦ The MCE should describe how the strategies were related to causes/barriers identified through data analysis. ♦ The MCE should include evidence of how the strategies were implemented on a PDSA basis. ♦ The MCE should describe how the member-focused strategies were culturally and linguistically appropriate. ♦ The MCE should address how the improvement strategies accounted for major confounding factors identified. ♦ The MCE should describe the level of success of the strategies and identify follow-up activities planned.
Assess the Likelihood that Significant and Sustained Improvement Occurred	♦ The MCE should identify if the baseline and remeasurement methodologies were the same. ♦ The MCE should discuss the lack of quantitative evidence of improvement in the performance measure.
CIS-Combo 10 (Childhood Immunizations) (HHW)	
Review the Selected QIP Topic	♦ The MCE should provide a comprehensive analysis of enrollee needs, care, and services consistent with the QIP topic, e.g., demographic characteristics, health risks, prevalence of conditions, and need for specific services.

Table 11. QIP Weaknesses (AONs) and Recommendations

	♦ The MCE should consider input from enrollees and/or providers on the QIP topic and, if this input is not solicited, provide the rationale. ♦ The MCE should explicitly state how the QIP topic addresses care of special populations or high-priority services.
Review the QIP AIM Statement	♦ The MCE should accurately identify the QIP population as children turning two years of age during the measurement year.
Review the Identified QIP Population	♦ The MCE should accurately identify the QIP population as only those members turning two years of age in the measurement year and the enrollment requirements for the population. ♦ The MCE should specify that the QIP included a representative and generalizable sample of the entire population.
Review the Selected QIP Variables and Performance Measures	♦ The MCE should accurately define the QIP variable and the numerator of the performance measure. ♦ The MCE should include a discussion of how the CIS-Combo 10 measure assesses care that will have influence on enrollee health. ♦ The MCE should address the appropriateness of the performance measure based on availability of data and resources to collect the data. ♦ The MCE should discuss how the performance measure will be tracked over time and compared to benchmarks. ♦ The MCE should include the strategy for inter-rater reliability for hybrid data collection.
Review the Data Collection Procedures	♦ The MCE should describe the systematic method for collecting valid and reliable data. ♦ The MCE should ensure all data sources are noted. ♦ The MCE should address the data elements collected. ♦ The MCE should include the name of the NCQA-certified HEDIS software vendor. ♦ The MCE should indicate who is responsible for the inter-rater reliability process. ♦ The MCE should include the abstraction staff guidelines for the performance measure.
Review the Data Analysis and Interpretation of QIP Results	♦ The MCE should include a comprehensive analysis and interpretation of results consistent with the data analysis plan. ♦ The MCE should include a discussion of the baseline and remeasurement rates. ♦ The MCE should include a discussion of the statistical significance of the differences in the baseline and remeasurement rates. ♦ The MCE should indicate if any factors could have influenced comparability of initial and repeat measurements. ♦ The MCE should explain the external factors impacting rates. ♦ The MCE should present results in a clear manner. ♦ The MCE should include the lessons learned about the less-than-optimal performance in this step.
Assess the Improvement Strategies	♦ The MCE should address the evidence basis of the improvement strategies selected. ♦ The MCE should describe how the strategies were related to causes/barriers identified through data analysis.

Table 11. QIP Weaknesses (AONs) and Recommendations

	♦ The MCE should include evidence of how the strategies were implemented on a PDSA basis. ♦ The MCE should describe how the member-focused strategies were culturally and linguistically appropriate. ♦ The MCE should address how the improvement strategies accounted for major confounding factors identified. ♦ The MCE should describe the level of success of the strategies and identify follow-up activities planned.
Assess the Likelihood that Significant and Sustained Improvement Occurred	♦ The MCE should identify if the baseline and remeasurement methodologies were the same. ♦ The MCE should discuss the lack of quantitative evidence of improvement in the performance measure.
CareSource	
Health Needs Screening (HIP / HHW)	
Review the Selected QIP Variables and Performance Measures	♦ The MCE should specifically address consideration for existing measures or indicate why an existing measure was not appropriate for the QIP. ♦ The MCE should cite specific health services research supporting the appropriateness of the HNS completion measure. ♦ The MCE should address how the HNS completion rate, as a process measure, is meaningfully associated with health outcomes.
Improve Substance Use Follow-Up and Treatment Outcomes through Care/Case Management (HIP / HHW)	
Review the Selected QIP Variables and Performance Measures	♦ The MCE should address the availability of data and resources to collect the data for the three performance measures. ♦ The MCE should specifically define the criteria that measure care-case management engagement.
Review the Data Collection Procedures	♦ The MCE should specify the data elements to be collected, in addition to the numerator and denominator for the care-case management measure. ♦ The MCE should accurately define the numerator and denominator of the care-case management measure. ♦ The MCE should include an adequate basis for the 100% estimated claims data completeness.
Review the Data Analysis and Interpretation of QIP Results	♦ The MCE should explain how the factors identified (change in population and a significant change in enrollment) could threaten internal or external validity of the project.
Improve Lead Testing Rates for Children Ages 12-24 Months (HHW)	
Review the Selected QIP Topic	♦ The MCE should provide a more comprehensive analysis of enrollee needs, care, and services consistent with the QIP topic, e.g., demographic characteristics, health risks, prevalence of conditions, and need for specific services. ♦ The MCE should consider input from enrollees and/or providers on the QIP topic and, if this input is not solicited, provide the rationale. ♦ The MCE should accurately describe how the QIP topic aligns with HHS and CMS priorities.
Review the Data Collection Procedures	♦ The MCE should indicate all data sources used in measure calculation in addition to claims. ♦ The MCE should include an adequate basis for the 100% estimated claims data completeness.

Table 11. QIP Weaknesses (AONs) and Recommendations

Assess the Improvement Strategies	♦ The MCE should indicate how strategies were adapted to reflect the major confounding factor (COVID-19) identified.
Reduce Preventable ED Utilization (HHW)	
Review the Selected QIP Topic	♦ The MCE should consider input from enrollees and/or providers on the QIP topic and, if this input is not solicited, provide the rationale.
Review the Selected QIP Variables and Performance Measures	♦ The MCE should address how the AMB measure assessed an aspect of care significant to enrollee health or functional status. ♦ The MCE should address the availability of data and resources to collect the date for the AMB measure. ♦ The MCE should address the QIP topic is based on clinical knowledge or health services research.
Review the Data Collection Procedures	♦ The MCE should include an adequate basis for the 100% estimated claims data completeness.
Review the Data Analysis and Interpretation of QIP Results	♦ The MCE should identify QIP-specific factors that could threaten the validity of findings. ♦ The MCE should address lessons learned about less-than-optimal performance.
Assess the Improvement Strategies	♦ The MCE should indicate how strategies were adapted to reflect the major confounding factors identified.
MDwise	
Follow-up After ED Visit for Drug Abuse or Dependence (HHW / HIP)	
Review the Selected QIP Topic	♦ The MCE should identify related CMS or HHS (Department of Health and Human Services) priority areas and explain how the QIP topic aligns with HHS and CMS priority areas.
Review the QIP AIM Statement	♦ The MCE should provide an aim statement that clearly specifies the improvement strategy. ♦ The MCE should ensure that the QIP aim statement is written concisely, preferably reflecting the format “will X result in Y.”
Review the Identified QIP Population	♦ The MCE should address any age specifications or enrollment requirements or acknowledge the lack of any requirements as applied to the QIP population.
Review the Selected QIP Variables and Performance Measures	♦ The MCE should describe how the QIP performance measures are an important aspect of care and how it will have influence on enrollees’ health or functional status. ♦ The MCE should include a description of the availability of data and resources used for data collection. ♦ The MCE should describe the process of addressing and tracking performance measures at a point in time, including how often data is assessed, compared to benchmarks, and utilized to influence quality improvement strategies.
Review the Data Collection Procedures	♦ The MCE should identify the specific data elements collected for QIP evaluation. ♦ The MCE should include a description of the data analysis plan to monitor and assess performance. ♦ The MCE should include all data instruments used to ensure the QIP’s data accuracy and availability over time.

Table 11. QIP Weaknesses (AONs) and Recommendations

Review the Data Analysis and Interpretation of QIP Results	♦ The MCE should provide a discussion of the analysis conducted in accordance with the data analysis plan. ♦ The MCE should include discussion of the baseline measurement and remeasurement(s) of performance measures. ♦ The MCE should include a discussion of the statistical significance of any differences between baseline and repeat measurement(s). ♦ The MCE should identify any factors that may influence comparability of initial and repeat measurements. ♦ The MCE should identify factors that threaten internal or external validity of findings. ♦ The MCE should ensure that data analysis is presented in a concise and easily understood manner. ♦ The MCE should include a discussion of lessons learned about less-than-optimal performance.
Assess the Improvement Strategies	♦ The MCE should provide a discussion to indicate the QIP improvement strategies as evidence based. ♦ The MCE should address causes/barriers related to improvement strategies that were identified using data analysis and quality improvement processes. ♦ The MCE should provide evidence that improvement strategies were implemented on a rapid-cycle, PDSA basis. ♦ The MCE should include an assessment of cultural and linguistic appropriateness for the applied interventions. ♦ The MCE should address how improvement strategies are reflective of major confounding factors that could potentially impact QIP outcomes. ♦ The MCE should provide a detailed discussion of the success of QIP interventions and indicate related follow-up activities planned as a result.
Assess the Likelihood that Significant and Sustained Improvement Occurred	♦ The MCE should provide a discussion to specifically state if the baseline and remeasurement methodologies were the same and describe differences that may impact the ability to assess real improvement. ♦ The MCE should address whether there is quantitative evidence of improvement in processes or outcomes of care, or lack thereof. ♦ The MCE should provide a detailed discussion to show how improvements made in QIP performance are the result of selected improvement strategies. ♦ The MCE should include statistical analyses, such as significance tests, to show how improvements made in the QIP's performance are the result of improvement strategies. ♦ The MCE should include a detailed discussion demonstrating the sustainability of QIP improvement through repeated measurements over time.
Health Needs Screening (HIP)	
Review the Selected QIP Topic	♦ The MCE should explain how the QIP topic aligns with HHS and/or CMS priority areas.
Review the QIP AIM Statement	♦ The MCE should ensure that the QIP aim statement is answerable, preferably in a question format, which includes a realistic and unambiguous goal.

Table 11. QIP Weaknesses (AONs) and Recommendations

Review the Selected QIP Variables and Performance Measures	♦ The MCE should specifically describe how variable data is collected, and how improvement is tracked over time. ♦ The MCE should describe how the performance measure addresses an important aspect of care that will make a difference in enrollee's health or functional status. ♦ The MCE should provide a discussion of how performance measures are appropriate based on the availability of data and resources used for data collection. ♦ The MCE should address clinical guidelines for internally developed measures and address the importance of HNS-associated referrals to enrollee care, identify data sources, and include clearly defined inclusion criteria.
Review the Data Collection Procedures	♦ The MCE should describe the data collection process in detail including the technical specifications used to collect valid and reliable data that specifically represents the targeted QIP population. ♦ The MCE should include a clear definition of the data elements collected in relation to the outlined data collection process. ♦ The MCE should include a detailed data analysis plan that indicates how data collection, tracking, and assessment are performed to influence quality improvement strategies. ♦ The MCE should identify data collection instruments utilized to ensure valid and reliable data analysis. ♦ The MCE should the intra- and inter-rater reliability processes in place for data collection that utilizes a medical record review. ♦ The MCE should include a detailed description of the data abstraction process used during medical record reviews.
Review the Data Analysis and Interpretation of QIP Results	♦ The MCE should include a discussion of the QIP's data analysis plan used to support and influence quality improvement strategies. ♦ The MCE should include a discussion of baseline measurement and remeasurement results related to performance measures. ♦ The MCE should complete statistical testing on the significance of variation in the baseline and remeasurement rates. ♦ The MCE should note factors that may affect comparability of the baseline and remeasurement rates. ♦ The MCE should identify factors that may influence internal or external validity of results. ♦ The MCE should include a discussion and demonstration of data analysis for QIP results presented in a concise and understandable manner. ♦ The MCE should include lessons learned over the QIP period related to suboptimal performance.
Assess the Improvement Strategies	♦ The MCE should include evidence to support the likelihood of success for each improvement strategy implemented. ♦ The MCE should identify causes and/or barriers related to care that resulted in the selection of interventions. ♦ The MCE should document the implementation of interventions within a rapid-cycle, PDSA process. ♦ The MCE should address any cultural or linguistic needs or barriers related to member outreach interventions. ♦ The MCE should include a detailed discussion of each intervention's success and any follow-up planned.

Table 11. QIP Weaknesses (AONs) and Recommendations

Assess the Likelihood that Significant and Sustained Improvement Occurred	♦ The MCE should specifically state if the baseline and remeasurement methodologies were the same and describe differences that may impact the ability to assess real improvement. ♦ The MCE should address quantitative evidence of improvement in processes or outcomes of care. ♦ The MCE should provide a detailed discussion to show how improvements made in QIP performance are the result of selected improvement strategies. ♦ The MCE should describe or address a lack of statistical evidence, such as significance tests, to show how improvements made in QIP performance are the result of improvement strategies. ♦ The MCE should include a detailed discussion demonstrating the sustainability of QIP improvement through repeated measurements over time.
Postpartum Timeliness (HIP)	
Review the Selected QIP Topic	♦ The MCE should identify CMS or HHS priority areas and explain how the QIP topic aligns with them.
Review the QIP AIM Statement	♦ The MCE should provide an aim statement that clearly specifies the improvement strategy. ♦ The MCE should indicate the specific period for the QIP within the aim statement. ♦ The MCE should ensure that the QIP aim statement is written concisely, preferably in the format “will X result in Y?”
Review the Identified QIP Population	♦ The MCE should address any age specifications or enrollment requirements or acknowledge the lack of any requirements as applied to the QIP population.
Review the Selected QIP Variables and Performance Measures	♦ The MCE should objectively define each variable. ♦ The MCE should describe the process of how the variable is available to measure and track over time. ♦ The MCE should include evidence that demonstrates how the performance measure will impact enrollees’ health or functional status. ♦ The MCE should address evaluation of performance measures and discuss how results are used to influence quality improvement strategies.
Review the Data Collection Procedures	♦ The MCE should describe the data collection process including technical specifications used to collect valid and reliable data that specifically represents the targeted QIP population. ♦ The MCE should include a clear definition of the data elements collected in relation to the outlined data collection process. ♦ The MCE should include a detailed data analysis plan that indicates how data collection, tracking, and assessment is performed to influence quality improvement strategies. ♦ The MCE should identify data collection instruments utilized to ensure valid and reliable data analysis. ♦ The MCE should identify the intra- and inter-rater reliability processes in place for data collection that utilizes a medical record review. ♦ The MCE should include a detailed description of the data abstraction process used during medical record reviews.

Table 11. QIP Weaknesses (AONs) and Recommendations

Review the Data Analysis and Interpretation of QIP Results	♦ The MCE should include a discussion of the QIP's data analysis plan used to support and influence quality improvement strategies. ♦ The MCE should include a discussion of baseline measurement and remeasurement results related to performance measures. ♦ The MCE should conduct statistical testing on the significance of variation in the baseline and remeasurement rates. ♦ The MCE should note factors that may affect comparability of the baseline and remeasurement rates. ♦ The MCE should identify factors that may influence internal or external validity of results. ♦ The MCE should include a discussion and demonstration of data analysis for QIP results presented in a concise and understandable manner. ♦ The MCE should include lessons learned over the QIP period related to suboptimal performance.
Assess the Improvement Strategies	♦ The MCE should include evidence to support the likelihood for success of the improvement strategy implemented. ♦ The MCE should identify causes and/or barriers related to care that resulted in the selection of the intervention. ♦ The MCE should document the implementation of improvement strategies within a rapid-cycle, PDSA process. ♦ The MCE should address any cultural or linguistic needs or barriers related to member outreach interventions. ♦ The MCE should include a detailed discussion of the improvement strategy's success including any plans for follow-up activity.
Assess the Likelihood that Significant and Sustained Improvement Occurred	♦ The MCE should provide a discussion to specifically state if the baseline and remeasurement methodologies were the same and describe differences that may impact the ability to assess real improvement. ♦ The MCE should address quantitative evidence of improvement in processes or outcomes of care. ♦ The MCE should provide a detailed discussion to show how improvements made in QIP performance are the result of selected improvement strategies. ♦ The MCE should include statistical evidence, such as significance tests, to show how improvements made in QIP performance are the result of improvement strategies. ♦ The MCE should include a detailed discussion demonstrating the sustainability of QIP improvement through repeated measurements over time.
Well-Child Visits During the First 30 Months (HHW)	
Review the Selected QIP Topic	♦ The MCE should provide documented considerations of current CMS Child Core Set measures.
Review the QIP AIM Statement	♦ The MCE should include the measurement year period within the aim statement. ♦ The MCE should include an aim statement that is concise and reflects a question format. ♦ The MCE should ensure that the QIP aim statement is answerable and includes a realistic and unambiguous goal.

Table 11. QIP Weaknesses (AONs) and Recommendations

Review the Selected QIP Variables and Performance Measures	♦ The MCE should describe how the performance measure will have influence on enrollee health status. ♦ The MCE should describe how data and resources are available to produce the performance measure. ♦ The MCE should address accepted clinical guidelines relevant to the QIP aim statement and address the importance of HNS-associated referrals to enrollee care, identify data sources, and include clearly defined inclusion criteria.
Review the Data Collection Procedures	♦ The MCE should include a clear definition of the data elements collected in relation to the outlined data collection process. ♦ The MCE should include a detailed data analysis plan that indicates how data collection, tracking, and assessment is performed to influence quality improvement strategies. ♦ The MCE should identify data collection instruments utilized to ensure valid and reliable data analysis.
Assess the Improvement Strategies	♦ The MCE should include evidence to support the likelihood of success for each improvement strategy implemented. ♦ The MCE should identify causes and/or barriers related to care that resulted in the selection of interventions. ♦ The MCE should document the implementation of interventions within a rapid-cycle, PDSA process. ♦ The MCE should address any cultural or linguistic needs or barriers related to member outreach interventions. ♦ The MCE should include a detailed discussion of each intervention's success and any follow-up planned.
MHS	
Follow-up after Emergency Department Visit for Drug Abuse or Dependence (HIP / HHW / HCC)	
Review the QIP AIM Statement	♦ The MCE should be specific and describe interventions in the aim statement.
Health Needs Screening (HIP / HHW / HCC)	
Review the QIP AIM Statement	♦ The MCE should be specific and describe interventions in the aim statement.
Review the Selected QIP Variables and Performance Measures	♦ The MCE should provide evidence of how the performance measure impacts enrollees' health or functional status. ♦ The MCE should address how the HNS completion rate, is a process measure, is meaningfully associated with health outcomes.

Interventions

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

Table 12. 2021 QIP Interventions

MCE	QIP Title	Interventions
Anthem	*Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)* *HIP / HHW / HCC*	Incentivized providers to schedule and assist in completing FUA 7-day appointments.
		Post-ED visit reminder text. Text campaigns reminding members who need to follow up with the PMP and/or Behavioral Health (BH) Provider post-ED visit.
		FUA reminder call campaign. Call campaigns reminding members who need to follow up with the PMP and/or BH Provider post-ED visit.
		Improved data sources and continue to expand data sets to capture all ED visits for alcohol and/or substance abuse.
	Follow-up After Hospitalization for Mental Illness (FUH) *HIP / HHW / HCC*	Incentivized providers to schedule and assist in completing FUH 7-day appointments.
		Live outreach. Face-to-face campaigns reminding members who need to follow up with a BH Provider post-inpatient visit for mental illness and/or self-harm.
		Community Mental Health Center (CMHC) referrals. Send referrals to participating CMHCs alerting them to their members that were recently discharged from an inpatient stay.
		Improved data sources and continue to expand data sets to capture all inpatient visits for mental illness or self-harm.
	Health Needs Screening (HNS) *HIP / HHW / HCC*	Provider Incentive Programs. Incentivized providers to assist members with completing their HNS in the first 90 days of their enrollment to improve HNS rates.
		Live outreach. Face-to-face campaigns through a Welcome Team to improve engagement rates and HNS completion rates.
		Increased HNS call attempts and overall call attempts during evening hours and on the weekends.
	Care Management Engagement *HIP / HHW / HCC*	Increased care management call attempts during evening hours and on the weekends.
		Live Outreach. Face-to-face campaigns finding members who qualify for care management, but we were unable to reach via phone or text.
	Childhood Immunization Status (CIS) *HHW*	Provider Incentive Programs. Incentivized providers to schedule and assist in completion of CIS vaccinations to improve the rates of members whose providers are enrolled in program vs. those whose providers are not enrolled.
		CIS reminder text and email. Text and email campaigns reminding members who have not yet had CIS vaccination to do so with the intention of increasing the overall CIS rate.

Table 12. 2021 QIP Interventions

MCE	QIP Title	Interventions
		CIS reminder call campaign. Call campaigns reminded members who have not yet had CIS vaccination to do so with the intention of increasing the overall CIS rate.
		Improve data sources and continue to expand data sets to capture all completed member vaccinations.
CareSource	*Health Needs Screening* *HIP / HHW*	The 30-60-90-day protocol was an outreach strategy which staggered modalities, allowing the MCE to track and monitor the time period between enrollment and HNS completion.
		Implementation of a standardized member location strategy for new members identified as unreachable during initial telephonic attempts due to wrong, invalid, or disconnected numbers and/or exhausted attempts. A standardized approach is used to search for updated member contact information using Whitepages, pharmacy and encounter data, outreach to provider offices, etc. Upon locating members, CareSource representatives will attempt to complete the HNS during the outreach call.
	Follow-up After Emergency Department Visit for Drug Abuse or Dependence *HIP / HHW*	Use of dedicated community health workers (CHWs) to facilitate timely outreach and care-case (CM) engagement within 28 days following an ED visit for substance use disorder. CHWs identify members through Indiana Health Information Exchange (IHIE) daily reporting, ED claims, ED facility staff, providers, UM team and referrals. Upon reaching the member, the CHW assists with arranging appointments, transportation, and referrals for ongoing case management. CM referrals and engagement are analyzed monthly.
		Improved Peer Recovery Specialist (PRS) member notification and handoffs for care-case management within 28 days following a substance use disorder (SUD)-related ED visit.
		Impacted care coordination and handoffs of high-volume ED facilities through use of peer comparison reports. Peer comparison reports will be used to prompt provider practice change and will be shared quarterly including facility specific FUA compliance rates. Providers meet with the CareSource BH Initiative Leads to refresh education on handoffs to care management, outpatient, and treatment providers.
	Improve Lead Testing in Children 12-24 Months *HHW*	All planned QIP interventions/strategies are active, and each provider intervention group have received: 1) one-on-one education on reducing missed opportunities between MMR and lead testing; 2) provider missed opportunity scorecards; and 3) quarterly lead gap lists.
	Reduce Preventable Emergency Department (ED) Utilization *HHW*	CareSource Population Health Analytics Team developed the ED Index Score (EDIS) to identify hot spot counties with high ED utilization related to three or more non-emergent visits. There was a total of 12 counties with an EDIS greater than 1.0 for calendar year (CY) 2021; thus, this intervention focused on the top 12 counties. This intervention involves CHW telephonic engagement and educational mailers to members in targeted ED hot spot counties.
		Intervention effectiveness is determined through comparison of ED visit rates pre- and post-telephonic engagement/education among members successfully outreached with three or more non-emergent ED visits in targeted hot spot counties.
MDwise		Referred Inpatient, Intensive Outpatient (IOP), Partial Hospitalization (PHP), and Residential prior authorization requests related to SUD automatically into care management (CM).

Table 12. 2021 QIP Interventions

MCE	QIP Title	Interventions
	Follow-up after Emergency Department Visit for Drug Abuse or Dependence *HIP / HHW*	CM outreached to all members seen in the ER with a principal diagnosis of alcohol and other drug abuse/dependence (AOD) to assist in securing a follow-up visit within 7 days and another visit within 30 days.
		Offered a member reward incentive for members accepting and participating in a call from CM at least twice monthly while engaged in CM.
	Health Needs Screenings *HIP*	Collaborated with both customer service and care management as they completed the HNS to ensure our goals are being met, as well as identify any potential risks that may prevent that.
		Outreached to all new members to MDwise to complete the HNS with our automated system and warm transfers.
	Postpartum Timeliness *HIP*	Utilized Care Management department to assist pregnant members in securing timely postpartum care.
	Well-Child Visits During the First 30 months (W30) *HHW*	Utilized Care Management in scheduling appointments.
		Utilized member and provider education, including provider relations and member outreach efforts.
		Providers accessed non-compliant members via the portal.
MHS	*Follow-up After Emergency Department Visit for Drug Abuse or Dependence* *HIP / HHW / HCC*	Telephonic outreach by Care Engagement Team (CET) to members.
		Referred member to the Behavioral Health disease management team to follow up and engage member with care-case manager.
		Letter to member that includes reason for outreach with instructions to connect with a care-case manager.
		Member incentive to initiate Indiana Intensive Outpatient (IOP) treatment and maintain treatment for SUD.
	Health Needs Screening *HIP / HHW / HCC*	Telephonic outreach by CET to members to complete HNS.
		Email to members with a link to HNS form.
		Kiosks at Walmart and participating CVS stores.
		Paper copy in Welcome packet.
		Member can send digital copy of completed HNS by email to MHS.
		Second copy of paper HNS mailed, if CET unable to connect with member.

Comparison QIP Improvements

Table 13 presents a comparison between the QIP scores in MY 2020 and MY 2021. Notable improvements from the previous measurement year are indicated using an upward arrow (↑) and notable decreases in performance are indicated using a downward arrow (↓).

Table 13. QIP Performance Comparison

MCE	QIP Name	MY 2021 Validation Rating	MY 2020 Validation Rating	MY 2021 Overall Score	MY 2020 Overall Score
Anthem - HIP	*Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)*	No Confidence	No Confidence	34.0% ↑	29.0%
	Follow-up After Hospitalization for Mental Illness (FUH)	No Confidence	No Confidence	31.0% ↑	24.0%
	Health Needs Screening (HNS)	No Confidence	No Confidence	24.0% ↑	21.0%
	Care Management Engagement	No Confidence	N/A	26.0%	N/A
Anthem - HHW	*Follow-up After Hospitalization for Mental Illness*	No Confidence	No Confidence	31.0% ↑	29.0%
	Health Needs Screening	No Confidence	No Confidence	24.0%	24.0%
	Care Management Engagement	No Confidence	N/A	26.0%	N/A
	Childhood Immunization Status (CIS)	No Confidence	N/A	37.0%	N/A
Anthem - HCC	*Follow-up After Emergency Department Visit for Drug Abuse or Dependence*	No Confidence	No Confidence	31.0% ↑	29.0%
	Follow-up After Hospitalization for Mental Illness	No Confidence	No Confidence	48.0% ↑	24.0%
	Health Needs Screening	No Confidence	No Confidence	24.0% ↑	21.0%
	Care Management Engagement	No Confidence	N/A	26.0%	N/A

Table 13. QIP Performance Comparison

MCE	QIP Name	MY 2021 Validation Rating	MY 2020 Validation Rating	MY 2021 Overall Score	MY 2020 Overall Score
CareSource - HIP	*Health Needs Screening*	High Confidence	High Confidence	93.0% ↑	90.0%
	Follow-up After Emergency Department Visit for Drug Abuse or Dependence	Moderate Confidence	High Confidence	89.0% ↓	97.0%
CareSource - HHW	*Health Needs Screening*	High Confidence	High Confidence	93.0%	93.0%
	Improve Lead Testing in Children 12-24 Months	Moderate Confidence	High Confidence	87.0% ↓	97.0%
	Reduce Preventable Emergency Department Utilization	Moderate Confidence	Moderate Confidence	81.0% ↓	86.0%
	Follow-up After Emergency Department Visit for Drug Abuse or Dependence	Moderate Confidence	Moderate Confidence	89.0% ↓	97.0%
MDwise - HIP	*Follow-up After Emergency Department Visit for Drug Abuse or Dependence*	No Confidence	No Confidence	43.0% ↑	29.0%
	Health Needs Screening	No Confidence	No Confidence	38.0%	38.0%
	Postpartum Timeliness	No Confidence	No Confidence	36.0% ↑	14.0%
MDwise - HHW	*Follow-up After Emergency Department Visit for Drug Abuse or Dependence*	No Confidence	No Confidence	43.0% ↑	29.0%
	Well-Child Visits During the First 30 Months (W30)	No Confidence	No Confidence	52.0% ↑	33.0%
MHS - HIP	*Follow-up After Emergency Department Visit for Drug Abuse or Dependence*	High Confidence	No Confidence	98.0% ↑	57.0%
	Health Needs Screening	High Confidence	No Confidence	95.0% ↑	55.0%
MHS - HHW	*Follow-up After Emergency Department Visit for Drug Abuse or Dependence*	High Confidence	No Confidence	98.0% ↑	52.0%

Table 13. QIP Performance Comparison					
MCE	**QIP Name**	**MY 2021 Validation Rating**	**MY 2020 Validation Rating**	**MY 2021 Overall Score**	**MY 2020 Overall Score**
MHS - HCC	*Health Needs Screening*	High Confidence	No Confidence	95.0% ↑	55.0%
	Follow-up After Emergency Department Visit for Drug Abuse or Dependence	High Confidence	No Confidence	98.0% ↑	45.0%
	Health Needs Screening	High Confidence	No Confidence	95.0% ↑	55.0%

Table 14 presents how the plans addressed recommendations from MY 2020 in MY 2021.

Table 14: MY 2020 Recommendations Addressed in MY 2021	
Anthem **MY 2020 AON**	In MY 2020, Anthem submitted QIPs containing partial and incomplete information for all the QIP steps and study activities. Detailed analysis and statistical analysis were missing in all QIPs; therefore, true improvement could not be assessed. Overall, Anthem's QIPS for MY 2020 averaged a validation score of 25.12%. Qsource recommendations included: 1. The MCE should determine a study question(s) that identifies the focus of the QIP topic and establish the framework for data collection, analysis, and interpretation. 2. The MCE study question(s) should be clear, simple, and answerable. The question should be stated in a way that supports their ability to determine whether the intervention(s) have a measurable impact for a clearly defined population. 3. The MCE should indicate the type of sampling used to ensure valid and reliable information. 4. The MCE should define their data collection procedures to ensure that the data used to measure performance is valid and reliable. 5. The MCE should create a data collection plan that includes: ▪ The data to be collected; ▪ The data sources; ▪ How and when the data are to be collected; ▪ Who will collect the data; and ▪ Instruments used to collect the data. 6. The MCE must conduct statistical analysis, and present for baseline and each remeasurement period.
Results from MY 2021 Validation	In MY 2021, Anthem improved their QIP average score from 25.12% in MY 2020 to 30.87%. However, Anthem's QIPs continued to be missing information compromising the QIP results and the validity of the studies. The recommendations from 2020 were not followed. Qsource engaged Anthem in 2021 for additional training and technical assistance with OMPP participating and offering feedback. Qsource discussed each of the recommendations and how Anthem needs to address.

Table 14: MY 2020 Recommendations Addressed in MY 2021

CareSource **MY 2020 AON**	In MY 2020, CareSource's AONs occurred in the following steps: ♦ Step 1: State the Study Topic - 2 out of 6 QIPs ♦ Step 2: Define the Study Question - 5 out of 6 QIPs ♦ Step 7: Analyze Data and Interpret Study Results - 1 out of 6 QIPs ♦ Step 8: Describe Improvement Strategies - 1 out of 6 QIPs ♦ Step 9: Assess for Real Improvement - 1 out of 6 QIPs Qsource's recommendations included: 1. Ensure that all statistical testing is done correctly, and the documentation of the statistical testing outcomes is accurate and consistent throughout the QIP. 2. Conduct cause and barrier analyses more frequently and incorporate quality improvement science such as PDSA cycles into its improvement strategies and action plans. The data and results of specific PDSA cycles should be included in the QIP documentation. 3. Identify barriers through quantitative data analysis. Data to support identified barriers should be documented in the QIP Summary Form. 4. A QIP topic should be clear and understandable. The QIP study question should be clear and answerable. 5. The MCE should determine a study question(s)that identifies the focus of the QIP topic and establish a framework for data collection, analysis, and interpretation.
Results from MY 2021 Validation	In MY 2021, CareSource followed Qsource's recommendations and received met scores on all the QIPs for steps 1, 2, 7, 8 and 9. Each of the AONs were addressed by CareSource.
MDwise **MY 2020 AON**	In MY 2020, MDwise's AONs occurred in the following steps: ♦ Step 1: State the Study Topic - 4 out of 5 QIPs ♦ Step 2: Define the Study Question - 4 out of 5 QIPs ♦ Step 3. Use a Representative and Generalizable Study Population - 4 out of 5 QIPs ♦ Step 4. State the Study Indicators - 3 out of 5 QIPs ♦ Step 6. Review Data Collection Procedures - 5 out of 5 QIPs ♦ Step 7: Analyze Data and Interpret Study Results - 5 out of 5 QIPs Qsource recommendations included: 1. The MCE should determine a study question(s) that identifies the focus of the QIP topic and establish the framework for data collection, analysis, and interpretation. 2. The MCE study question(s) should be clear, simple, and answerable. The question should be stated in a way that supports their ability to determine whether the intervention(s) have a measurable impact for a clearly defined population.

Table 14: MY 2020 Recommendations Addressed in MY 2021

	3. The MCE should indicate the type of sampling used to ensure valid and reliable information. 4. The MCE should define their data collection procedures to ensure that the data used to measure performance is valid and reliable. 5. The MCE should create a data collection plan that includes: ▪ The data to be collected; ▪ The data sources; ▪ How and when the data are to be collected; ▪ Who will collect the data; and ▪ Instruments used to collect the data. 6. The MCE needs to conduct statistical analysis, and present for baseline and each remeasurement period.
Results from MY 2021 Validation	In MY 2021, MDwise followed Qsource's recommendations and improved their QIP scores from 28.60% in MY 2020 to an average 42.40% in MY 2021. To improve their scores in the future, Qsource and OMPP gave technical assistance to the MCEs in 2021, answering questions, giving recommendations, and explaining processes.
MHS **MY 2020 AON**	In MY 2020, MHS's AONs occurred in the following steps: ♦ Step 1: State the Study Topic - 6 out of 11 QIPs ♦ Step 2: Define the Study Question - 4 out of 11 QIPs ♦ Step 3. Use a Representative and Generalizable Study Population – 5 out of 11 QIPs ♦ Step 4. State the Study Indicators – 5 out of 11 QIPs ♦ Step 6. Review Data Collection Procedures – 6 out of 11 QIPs ♦ Step 7: Analyze Data and Interpret Study Results – 7 out of 11 QIPs ♦ Step 8: Describe Improvement Strategies - 9 out of 11 QIPs ♦ Step 9: Assess for Real Improvement - 8 out of 11 QIPs Qsource recommendations included: 1. The MCE should determine a study question(s) that identifies the focus of the QIP topic and establish the framework for data collection, analysis, and interpretation. 2. The MCE study question(s) should be clear, simple, and answerable. The question should be stated in a way that supports their ability to determine whether the intervention(s) have a measurable impact for a clearly defined population. 3. The MCE should indicate the type of sampling used to ensure valid and reliable information. 4. The MCE should define their data collection procedures to ensure that the data used to measure performance is valid and reliable. 5. The MCE should create a data collection plan that includes: ▪ The data to be collected; ▪ The data sources; ▪ How and when the data are to be collected;

Table 14: MY 2020 Recommendations Addressed in MY 2021	
	▪ Who will collect the data; and ▪ Instruments used to collect the data. 6. The MCE needs to conduct statistical analysis, and present for baseline and each remeasurement period.
Results from MY 2021 Validation	In MY 2021, MHS followed Qsource's recommendations and improved their QIP scores to an average of 96.50%. MHS did an excellent job ensuring all step elements were captured and well communicated throughout the QIPs.

Conclusions and Recommendations

Anthem

Anthem received an average score of 30.87% for the 12 submitted QIPS for 2021. Anthem's QIP topics, Follow-up After Emergency Department Visit for Drug Abuse or Dependence, Follow-up After Hospitalization for Mental Illness assess quality of care and timeliness of care for enrollees. Health Needs Screening and Care Management QIPs assess quality of care and Childhood Immunization QIP assesses quality of care and access to care. The scores obtained for each submitted QIP indicated that Anthem must address the suggestions noted by Qsource before the QIP can aid in increasing quality of care, timeliness of care and access of care for enrollees.

The majority of submitted evidence contained partial or incomplete information for the study activities. Detailed analysis and statistical testing were missing in all the QIPs; therefore, any reported improvement could not be proven valid. In addition, it is a protocol requirement to report the statistical test results between baseline and remeasurements to conclude the probability that an improvement was a direct result of the intervention and was not attributable to random or intervening factors.

The missing information compromised the QIP results and the validity of the studies. The MCE should use the CMS guidance for clarification and to increase understanding of the protocol requirements.

The following recommendations should be incorporated into the HIP, HHW and HCC QIP activities:

1. The MCE should indicate the type of sampling used to ensure valid and reliable information.
2. The MCE should define their data collection procedures to ensure that the data used to measure performance is valid and reliable.
3. The MCE should create a data collection plan that includes:

▪ data to be collected;

- data sources;
- how and when the data are to be collected;
- who will collect the data; and
- instruments used to collect the data.

4. The MCE needs to conduct statistical analysis, and present for baseline and each remeasurement period.
5. The MCE could use the CMS guidance for clarification and understanding of each element related to the study.

CareSource

CareSource demonstrated a sound study design for their six QIPs and created the foundation for CareSource to continue implementing improvement strategies and achieving real, sustainable study outcomes. Each of the QIPs received a score above or greater than 80% and therefore received a Met status across all the QIPs with the HNS QIP receiving the highest percentage of 93% Met and the ED QIP receiving the lowest at 81%.

CareSource's QIP topics, Follow-up After Emergency Department Visit for Drug Abuse or Dependence, Improve Lead Testing in Children 12-24 Months and Reduce Preventable Emergency Department Utilization assessed quality of care and timeliness of care. The Health Needs Screening QIP assessed quality of care.

CareSource appropriately conducted and selected the sampling and data collection activities. These activities ensured that CareSource correctly defined and collected the necessary data to produce accurate study indicator results. Although CareSource demonstrated sound study designs for its QIPs, it achieved real and sustained improvement for only one of the six QIPs. The documentation of the barrier identification process did not include supporting data or analysis results. CareSource also failed to identify priority barriers which failed to narrow the focus of interventions toward specific barriers. In general, the MCE utilized accurate methodology across all the QIPs, which factored into improvement over the course of 2021.

CareSource plans to incorporate new interventions to achieve sustained, real improvement as the QIP evolves over the course of implementation.

The following recommendations should be incorporated into the HIP and HHW QIP activities:

1. Include an estimated degree of data completeness for all administrative data collection.
2. Conduct cause and barrier analyses more frequently and incorporate quality improvement science such as Plan-Do-Study-Act (PDSA) cycles into its improvement strategies and action plans. The data and results of specific PDSA cycles should be included in the QIP documentation.
3. Identify barriers through quantitative data analysis. Data to support identified barriers should be documented in the QIP Summary Form.
4. Address how the performance measure impacts enrollee health or functional status.
5. Tracking and showing a direct correlation between

efforts and benefits is the best way to sustain quality improvement.

MDwise

MDwise received an average score of 42% for the five submitted QIPS for 2021. MDwise's QIP topics addressed quality, timeliness, and access to care. Follow-up After Emergency Department Visit for Drug Abuse or Dependence addresses quality and timeliness of care, Health Needs Screening addresses quality of care, Postpartum Timeliness and Well-Child Visits address all three, quality, timeliness, and access to care. The QIP scores for each submitted QIP indicated that MDwise must address the suggestions noted by Qsource before the QIP can aid in increasing quality of care, timeliness of care and access of care for enrollees.

MDwise's five 2021 QIPs contained partial or incomplete information for the study activities. Detailed analysis and statistical testing were missing in all the QIPs; therefore, any reported improvement could not be proven valid. In addition, it is a protocol requirement to report the statistical test results between baseline and remeasurements to conclude that the probability of the increases was due to the intervention and not a random or intervening factor. The missing information compromised the QIP results and the validity of the studies. The MCE should use the CMS guidance for clarification and to increase understanding of the protocol requirements.

The following recommendations should be incorporated into the HIP and HHW QIP activities:

1. The MCE should review the QIP summary form instructions as a guide for reporting applicable elements included in the protocol.
2. The MCE should indicate whether the QIP is clinical or nonclinical.
3. The MCE should refer to CMS protocol guidance and review examples of an appropriately formatted QIP aim statement.
4. The MCE should ensure that baseline and remeasurement year data represent two consecutive years (example: 2020 & 2021).
5. The MCE should define their data collection procedures to ensure that the data used to measure performance is valid and reliable.
6. The MCE should create a data collection plan that includes:
    - the data elements to be collected;
    - the data sources;
    - how and when the data are to be collected;
    - who will collect the data; and
    - instruments used to collect the data.
7. The MCE should review quality improvement methods that are significant to QIP execution such as rapid-cycle improvement, PDSA, barrier analysis, and the development of a data analysis plan.
8. The MCE should conduct statistical analysis, and present for baseline and each remeasurement period.

MHS

MHS demonstrated a sound study design for their six QIPs and created the foundation for MHS to continue implementing improvement strategies and achieving real and sustained study outcomes. MHS' QIPs were evaluated as met with all the QIPs meeting a 95% or higher. MHS appropriately conducted and selected the sampling and data collection activities. These activities ensured that MHS properly defined and collected the necessary data to produce accurate study indicator rates.

MHS' QIPs, Follow-up After Emergency Department Visit for Drug Abuse or Dependence and Health Needs Screening assessed quality of care and timeliness of care for enrollees.

While MHS demonstrated sound study designs for its QIPs, none of the QIPs met their goal rate for 2021. However, each QIP showed improvement from 2020, with increases being supported with data analysis. The documentation of the barrier identification process did not include supporting data or analysis results. MHS identified barriers but did not narrow the focus of interventions toward those barriers.

The following recommendations should be incorporated into the HIP, HHW and HCC QIP activities:

1. Conduct cause and barrier analyses more frequently and incorporate quality improvement science, such as PDSA cycles, into its improvement strategies and action plans. The data and results of specific PDSA cycles should be included in the QIP documentation.
2. Identify barriers through quantitative data analysis. Data to support identified barriers should be documented in the QIP Summary Form.
3. Tracking and showing a direct correlation between efforts and benefits is the best way to sustain quality improvement.

Performance Measure Validation (PMV)

Overview

The Balanced Budget Act of 1997 established certain managed care quality safeguards that were further described by Title 42 of the Code of Federal Regulations, Section 438.320 (42 CFR § 438.320), which defines "external quality review" as the "analysis and evaluation … of aggregated information on quality, timeliness, and access to health care services. To satisfy CMS Protocols for the MCEs and to meet the requirements set forth in 42 CFR § 438.330(c), OMPP selected a process for an objective, comparative review of performance measures related to quality-of-care outcomes. The primary aims of PMV are to evaluate the accuracy of MCE-reported measures and to determine whether those measures were calculated according to

required technical specifications, which enables OMPP to monitor performance at a point in time, track performance over time, and compare performance among MCEs.

The PMV included validation of performance measures for the MCEs providing care services for enrollees. The measurement year for this validation was January 1, 2021, through December 31, 2021 (MY 2021).

The 2022 PMV, which validates performance measures for MY 2021, was conducted virtually. The validation activities for these measures were conducted as outlined in Centers for Medicare & Medicaid Services' EQR Protocol 2: Validation of Performance Measures (October 2019). Per the protocol, the MCEs should complete an Information Systems Capabilities Assessment Tool (ISCAT) that the EQRO uses to validate information systems, processes, and data. Protocol guidance indicates that the EQRO may review results from a recent comprehensive, independent assessment of the MCE's information systems, such as the HEDIS Compliance Audit, conducted in the previous two years provided that the HEDIS measures were calculated using National Committee for Quality Assurance HEDIS-certified software and all non-HEDIS rates were included under the scope of the HEDIS audit.

This report includes findings from the MCE's ISCAT that the EQRO used to validate information systems, processes, data, and MCE-reported results from the 0511 Translation and Interpretation Services Report.

MCE and IHCP Information

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

Table 15. IHCP Information

Anthem	
IHCP Name	Healthy Indiana Plan / Hoosier Healthwise / Hoosier Care Connect
IHCP Location	Conducted Virtually
Review Date	September 13, 2022
CareSource	
IHCP Name	Healthy Indiana Plan / Hoosier Healthwise
IHCP Location	Conducted Virtually
Review Date	September 14, 2022
MDwise	
IHCP Name	Healthy Indiana Plan/Hoosier Healthwise
IHCP Location	Conducted Virtually
Review Date	September 15, 2022
MHS	
IHCP Name	Healthy Indiana Plan / Hoosier Healthwise / Hoosier Care Connect
IHCP Location	Conducted Virtually
Review Date	September 12, 2022

Description of Performance Measures Data Obtained for Validation

Qsource validated the set of three performance measures identified by OMPP, Translation and Interpretation Services, which are listed in **Table 16**. Qsource accepted the MCE's data submissions from OMPP for each reported measure. The data consisted of MCE-reported totals for each quarter. Based on the instructions for reporting Translation and Interpretation Services, data was measured differently for quarter one of 2021 and was therefore excluded from 2021 yearly analysis. Qsource used the remaining quarterly totals to complete this report (April 2021 – December 2021).

Table 16. MCE Performance Measures

Measure Name	Measure Steward	Domain of Care
Total contacts to language line during the reporting period	OMPP	Quality and Access to Care
Total requests for interpreter services during the reporting period	OMPP	Quality and Access to Care
Total requests for interpretation services requested and fulfilled during the reporting period	OMPP	Quality and Access to Care

Technical Methods of Data Assessment

Pre-Review Strategy

Qsource defined the scope of the validation to include the OMPP required metrics. This validation included data source, reporting frequency, and format of those measures.

Qsource obtained the list of Translation and Interpretation Services measures and technical specifications for the measures from the 2021 OMPP MCE Reporting Manual, Version 2021.02 as required in Activity 2 of the Protocols. The validation team completed review to ensure compliance with measure technical specifications. Areas of deviation were identified to evaluate the impact of the deviation on the measure and assess the degree of bias (if any).

Qsource accepted the MCE's data submissions from OMPP for each reported Translation and Interpretation Services measure. The data consisted of MCE-reported totals for each quarter. OMPP revised the Reporting Manual in quarter two of 2021, which included instructions for reporting 0511: Translation and Interpretation Services. The modifications made to each measure item impacted all MCEs at the same point in quarter two of 2021. Based on the instructions for reporting Translation and Interpretation Services, data was measured differently for quarter one of 2021 and was therefore excluded from 2021 yearly analysis. Qsource used the remaining quarterly totals to complete this report (April 2021 – December 2021).

Methods of Data Collection and Analysis

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

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

Review Activities

The MCE's virtual reviews occurred in September 2022. Qsource conducted interviews with key staff involved in the production of performance measures using questions tailored to the MCE's processes for producing performance measures based on findings from the ISCAT. Qsource observed a live demonstration of the data systems and key processes required for performance measure calculation. Qsource assessed the MCE's ability to link data from multiple sources and the extent to which they have created processes to ensure the accuracy of the calculated performance measures. A data file review was conducted as well as a review of all systems contributing to the performance measure calculations, including:

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

Data Integration, Data Control, and Performance Measure Documentation

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

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

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

Data Integration

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

Data Control

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

Performance Measure Documentation

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

Performance Measure Specific Findings

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

Table 18. Key Performance Measure Review Results

Measure	Key Review Findings and Recommendations
Anthem (HIP / HHW / HCC)	
Total contacts to language line during the reporting period	Met all specifications for the measure.
Total requests for interpreter services during the reporting period	Met all specifications for the measure.
Total requests for interpretation services requested and fulfilled during the reporting period	Met all specifications for the measure.
CareSource (HIP / HHW)	
Total contacts to language line during the reporting period	Met all specifications for the measure.
Total requests for interpreter services during the reporting period	Met all specifications for the measure.
Total requests for interpretation services requested and fulfilled during the reporting period	Met all specifications for the measure.
MDwise (HIP / HHW)	
Total contacts to language line during the reporting period	Met all specifications for the measure.
Total requests for interpreter services during the reporting period	Met all specifications for the measure.
Total requests for interpretation services requested and fulfilled during the reporting period	Met all specifications for the measure.
MHS (HIP / HHW / HCC)	
Total contacts to language line during the reporting period	Met all specifications for the measure.
Total requests for interpreter services during the reporting period	Met all specifications for the measure.
Total requests for interpretation services requested and fulfilled during the reporting period	Met all specifications for the measure.

Strengths, Weaknesses, and Improvements

Strengths and Weaknesses

No strengths or weaknesses were noted among MCEs, as each were independently deemed as fully compliant with all NCQA-defined Information System Standards for HEDIS-applied data and processes. Qsource did not identify any areas for improvement related to any of the MCE's processes for data collection and performance measure reporting during the 2021 CY PMV protocol, as with the 2020 CY PMV activities.

Improvements

As no weaknesses were identified for the MCEs in the 2020 CY PMV, there are no improvements to report for 2021 CY.

Conclusions

Anthem

The MCE prepared a complete and detailed ISCAT which positively facilitated the Virtual Systems Review process. Specific to Protocol 2 and the data provided for review, the MCE met an overall high confidence validation status for performance measures. In the validation of the performance measures, translation, and interpretative services, Qsource determined that Anthem aligned with the goals and objectives of CMS' Quality Strategy related to quality of care and access to care for enrollees. Anthem met all requirements for translation and interpretative services which indicated that Anthem had strategies in place to align with OMPP's goals and objectives relating to access to care for its enrollees and increasing enrollee satisfaction with those services. Anthem displayed a well-developed and complete data receipt, integration, and reporting process to ensure accurate and valid performance measure reporting.

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

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

CareSource

The MCE's ISCAT and documentation submitted for review was complete and detailed which positively facilitated the Virtual Systems Review process. Specific to Protocol 2 and the validation of the performance measure data, translation, and

interpretative services, CareSource met an overall high confidence validation status for performance measures. CareSource displayed a well-developed and complete data receipt, integration, and reporting process to ensure accurate and valid performance measure reporting. Qsource determined that CareSource aligned with the goals and objectives of CMS' Quality Strategy related to quality of care and access to care for enrollees. CareSource had strategies in place to align with OMPP's goals and objectives relating to access to care for its enrollees and increasing enrollee satisfaction with those services.

Overall, the ISCA found that the MCE fully met requirements, indicating that its systems have the capability to provide quality and timely care. Qsource validated data integration and data control processes, ensuring that performance measure documentation was complete and sufficient to support validation activities. The Facets system continued to be the medical claims processing system and only routine upgrades were made during the measurement year. A claim review process was in place and acknowledgement files were used to ensure complete and accurate data transfer. New members' data and state enrollment files were obtained daily and systematically loaded into the Facets membership system. The information was reconciled as subsequent state enrollment files were received. Data quality reports were produced when data extracts were received and after the extracts had been converted to a relational database (Data Mart).

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

MDwise

On July 1, 2021, MDwise was put on a Corrective Action Plan (CAP) for failing to provide alternative language and alternative formats to members. This was noncompliant with the following contractual requirements: Hoosier Healthwise Contract Scope of Work, Section 4.4 Member Information, Outreach and Education and Healthy Indiana Plan Contract Scope of Work, Section 7.4 Member Information, Outreach and Education.

MDwise reviewed its internal processes and identified opportunities to improve efficiency to ensure that, upon request, a member received all future correspondence, plan materials, and translation in their preferred language and/or format. MDwise implemented functioning processes to capture, translate, and fulfill a member's request for materials in an alternate language and/or format. On April 11, 2022, OMPP closed the CAP.

Based on all validation activities, discussion, and live demonstration of improvements to their workflows and how Translation and Interpretation Services are managed daily in their system, Qsource determined MDwise had met all criteria for the Translation and Interpretation Services measures.

Qsource determined that MDwise aligned with the goals and objectives of CMS' Quality Strategy related to quality of care

and access to care for enrollees. MDwise had strategies in place to align with OMPP's goals and objectives relating to access to care for its enrollees and increasing enrollee satisfaction with those services.

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

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

MHS

The MCE prepared a well-documented ISCAT which positively facilitated the Virtual Systems Review process. Specific to Protocol 2 and the data provided for review, translation and interpretative services, the MCE met an overall high confidence validation status for performance measures. MHS displayed a well-developed and complete data receipt, integration, and reporting process to ensure accurate and valid performance measure reporting. Qsource determined that MHS aligned with the goals and objectives of CMS' Quality Strategy related to quality of care and access to care for enrollees. MHS had strategies in place to align with OMPP's goals and objectives relating to access to care for its enrollees and increasing enrollee satisfaction with those services.

Overall, the ISCA review found that MHS fully met requirements, indicating that its systems can provide quality and timely care. Qsource validated data integration and data control processes and ensured performance measure documentation was complete and sufficient to support validation activities. AMISYS Advance 6.2.2 continued to be the medical claims processing system for both medical and behavioral health. Daily (Electronic Data Interchange) EDI dashboard reports were generated to ensure proper claim controls were maintained. Claim code editing software analyzed claims real-time against coding standards set by the state of Indiana, National Correct Coding Initiative, American Medical Association, and medical specialty organizations to ensure provider-coding accuracy. The

data integrity team reconciled membership data monthly. Manual review and correction were performed within the system. The MCE had a Structured Query Language (SQL) Server Integration Services package that extracted data from the Enterprise Data Warehouse and fed into the NCQA-certified software, QSI-XL. The QSI-XL tool provided reports on the files loaded with record counts and rejected records. Data validation queries were also used to assess the completeness of the data loaded.

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

Annual Network Adequacy (ANA)

Overview

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

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

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

Methodology

The 2022 ANA review covered the period of January 1 to December 31, 2021, and measured member access to PMP and OB/GYN providers. Myers and Stauffer analyzed the following:

- Percentage of members who live within 30 miles of a PMP;
- Percentage of female members who live within 60 miles of two OB/GYNs (Obstetricians and Gynecologists);
- PMP accessibility by geography;
- Ratio of providers to members;
- Accuracy of annual network adequacy reports to the state; and
- Completeness of provider directories issued to plan members.

Standards

The ANA review measures whether members have a provider within a reasonable distance from their residence. The 2022 ANA review of calendar year 2021 focused on member access to two provider categories: PMPs and OB/GYNs. The contractual requirement for the accessibility standard for PMPs is one within 30 miles of each health plan member. The contractual requirement for the accessibility standard for OB/GYNs is two within 60 miles of each female health plan member.

Source Data

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

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

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

In addition to including the detailed data outlined above, Qsource's written request to the MCEs specified the listings should include only members and providers who were eligible on October 1, 2021. The written request also specified that the provider listings should include a separate record for each location at which the individual practitioner was eligible to perform services for the plan on that date. Additionally, the written request specified the IHCP provider types and specialties that qualify as providers.

All MCEs were requested to submit copies of the annual reports regarding provider networks submitted to the state as of the assessment time period (October 2021), specifically Report 0902 (Count of Providers) and Report 0903 (Member Access to Providers).

Additionally, all MCEs were requested to submitted copies of the provider directories issued to the MCE members as of the assessment time period (October 2021).

Information provided by the MCEs was assumed to be complete and accurate unless otherwise noted in Appendix A.

Analysis

Esri ArcGIS mapping software was used to assign standardized addresses and geocodes to postal addresses submitted by the MCEs, and to calculate the driving distance from the members' residence to the closest provider, factoring in any patient restrictions reported for providers. Results were validated and further analyzed in Structured Query Language (SQL) in a Microsoft SQL Server database. Duplicative and invalid data records were excluded from the analysis. A summary of these exclusions is found in Appendix B. Results were summarized by county and program to identify potential issues. Underserved members were measured by count and by percentage of members impacted within analysis groupings.

All analyses were conducted based on a specified point in time, October 1, 2021. Results were based on the assumption that all variables utilized in the analyses were consistent across the entire period being reviewed.

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

Technical Methods Utilized for Data Collection, Validation, and Analysis

MCEs are contractually obligated to ensure all members have access to a provider within a reasonable driving distance of the member's residence. The tables in this section measure the MCE's network accessibility by program and provider network category.

Table 19 measures the percentage of MCE members who have sufficient access to PMP and OB/GYN providers.

Table 19. Percentage of Members Having Sufficient Access to Providers

	Provider Network Category	Geographic Accessibility Standard	HHW	HIP	HCC	All Programs
Anthem	PMP	1 within 30 miles	100%	100%	100%	**100%**
	OB/GYN	2 within 60 miles	100%	100%	100%	**100%**
CareSource	PMP	1 within 30 miles	99.90%	99.90%	N/A	**99.90%**
	OB/GYN	2 within 60 miles	100%	100%	N/A	**100%**
MDwise	PMP	1 within 30 miles	100%	100%	N/A	**100%**
	OB/GYN	2 within 60 miles	100%	100%	N/A	**100%**
MHS	PMP	1 within 30 miles	100%	100%	100%	**100%**
	OB/GYN	2 within 60 miles	100%	100%	100%	**100%**

The percent of Anthem members having sufficient access to PMP providers was 100% for all programs. The percent of female Anthem members having sufficient access to OB/GYN providers was also 100% for all programs. Although Anthem's provider networks met contractual requirements for accessibility, a difference was noted between the programs. While Anthem's networks for HHW and HCC were nearly identical and had more PMPs, OBGYNs and service locations than HIP, HIP had more members than either HHW or HCC.

The percent of CareSource members having sufficient access to PMP providers was nearly 100% for both programs except for five members overall. The percent of female CareSource members having sufficient access to OB/GYN providers was 100% for both programs.

The percent of MDwise members having sufficient access to PMP providers was 100% for all programs. Likewise, 100% of MDwise members had sufficient access to OB/GYN providers.

The percent of MHS members having sufficient access to PMP providers was 100% for all programs. Likewise, 100% of MHS members had sufficient access to OB/GYN providers.

Provider Network Adequacy by Geography

The figures in this section graphically depict each MCE's member population by provider network category (PMP or OB/GYN), IHCP program (HHW, HCC and HIP), and county, along with the number of available provider service locations available to them by county. Provider service locations are calculated as each unique combination of provider and address.

The graphic visuals for Anthem show no notable weaknesses.

The figures for CareSource suggest there are multiple counties lacking provider service locations. There are eight counties that have no PMP service locations in either program (HHW or HIP). However, it was determined that all but five of CareSource's members live within 30 miles of a PMP, the contractual standard. There are 21 counties that have no OB/GYN service locations in either program. However, it was determined that all CareSource's female members live within 60 miles of two OB/GYNs, meeting the contractual standard.

The figures for MDwise suggest that there are twenty counties that have no OB/GYN service locations, in either the HHW program or the HIP program. However, we determined that all MDwise's female members live within 60 miles of two OB/GYNs, the contractual standard. Three of the twenty counties that have no OB/GYN service locations have some of the higher counts of female members enrolled with MDwise. The counties in question are Clay County (1,545 members), Ripley County (1,002 members) and Vermillion County (1,090 members.)

These graphic visuals for MHS suggest that there are notably fewer PMP service locations available in the HHW program than either the HIP or HCC programs. In the next section, **Table 20**, Count of Providers, indicates the number of individual providers enrolled does not reflect this same disparity between programs; therefore, it appears that in the HHW program, a fewer number of service locations has been enrolled per provider. Qsource was unable to determine if this reflects the enrollment of PMPs in this program, or an omission from the provider rosters submitted by MHS for this analysis.

These figures depict providers with physical addresses in the state of Indiana. Providers with out-of-state addresses can also be utilized to satisfy network adequacy requirements. All participating or in-network providers were included in the accessibility analysis, including out-of-state providers within contractual distances.

Anthem PMP Network

Anthem Hoosier Healthwise (HHW)

Figure 1. HHW - Member Population

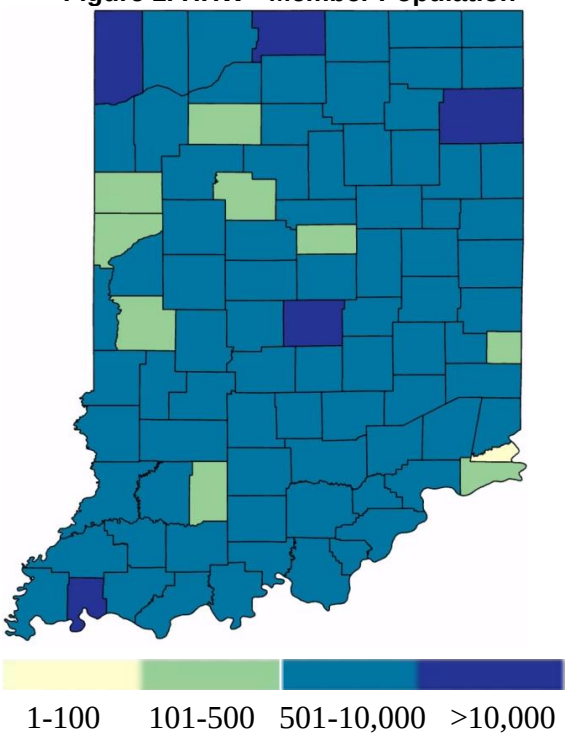
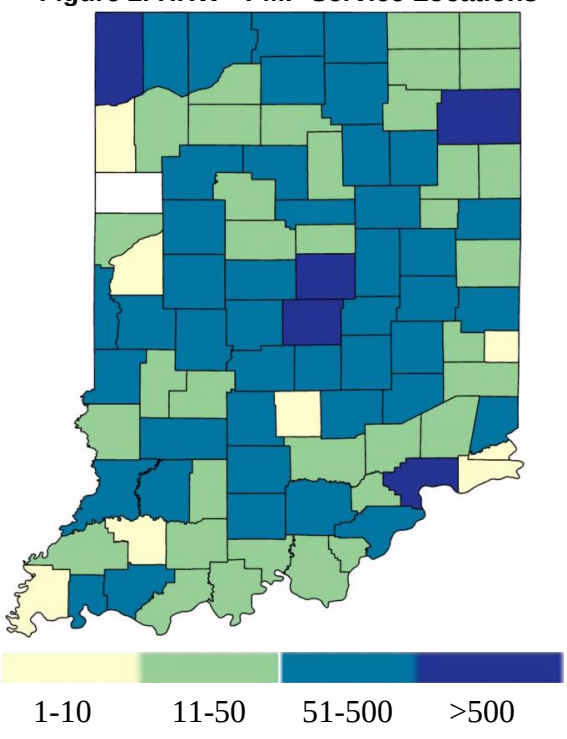


Figure 2. HHW - PMP Service Locations



Anthem Healthy Indiana Plan (HIP)

Figure 3. HIP - Member Population

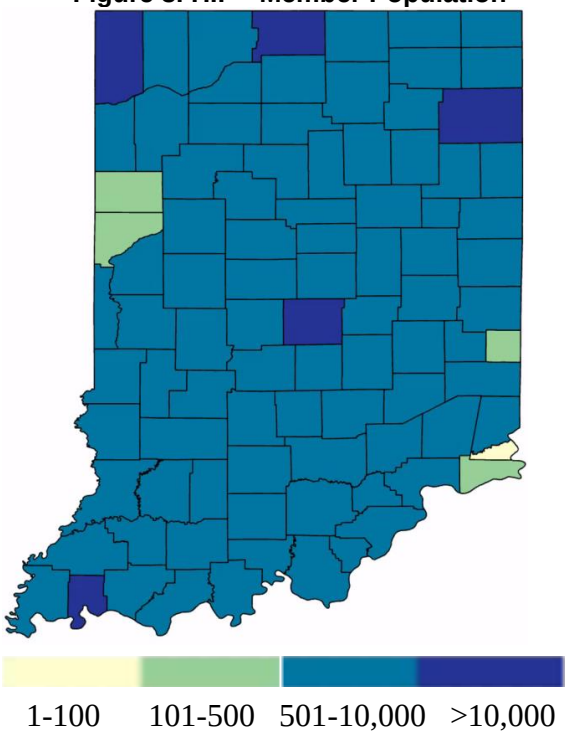
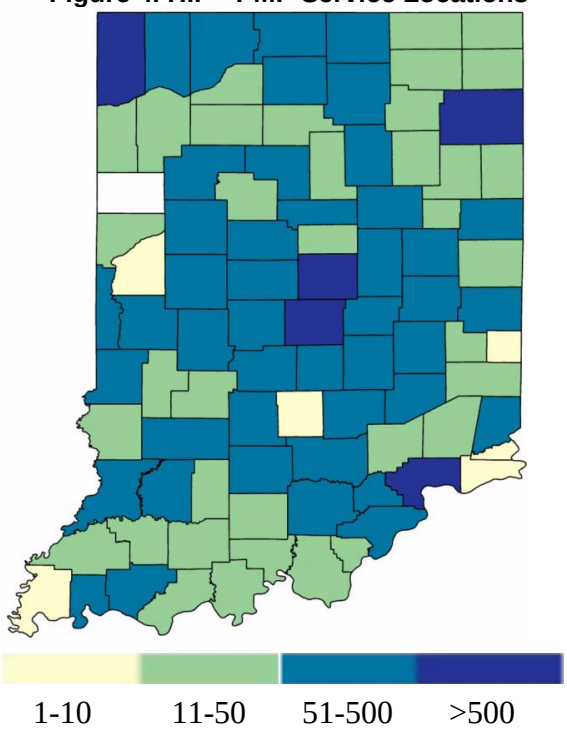


Figure 4. HIP - PMP Service Locations



Anthem Hoosier Care Connect (HCC)

Figure 5. HCC - Member Population

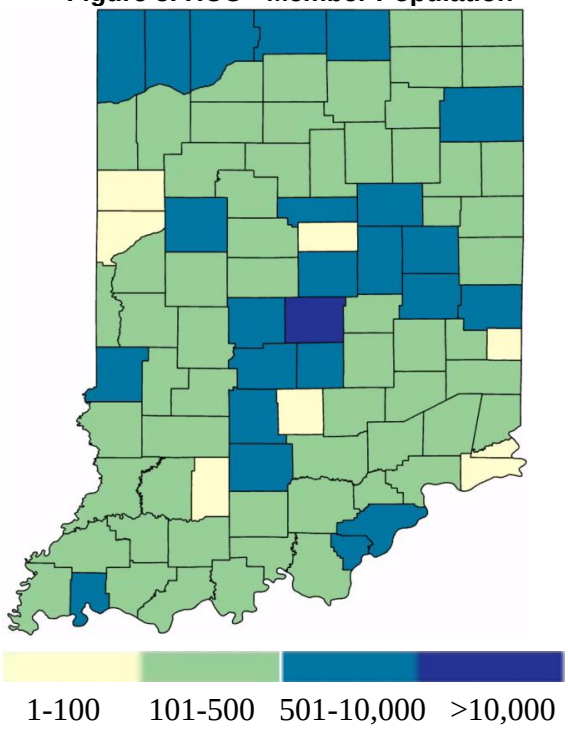
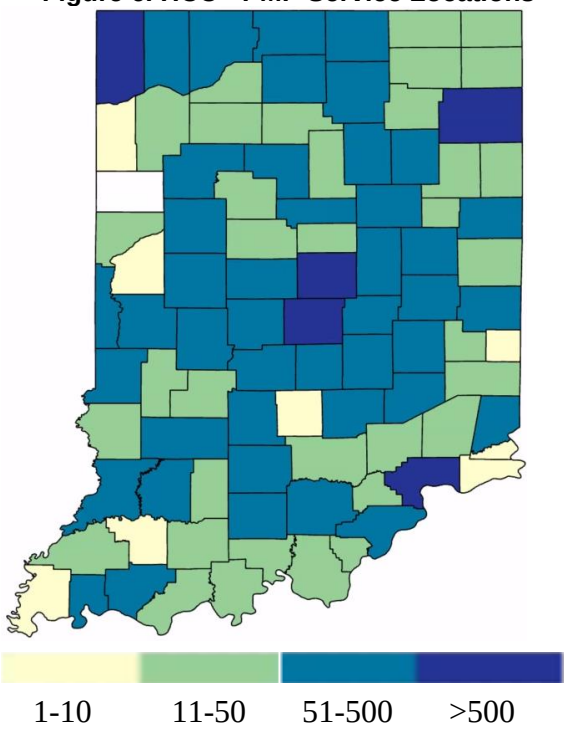


Figure 6. HCC - PMP Service Locations



Anthem OB/GYN Network

Anthem Hoosier Healthwise (HHW)

Figure 7. HHW - Female Population

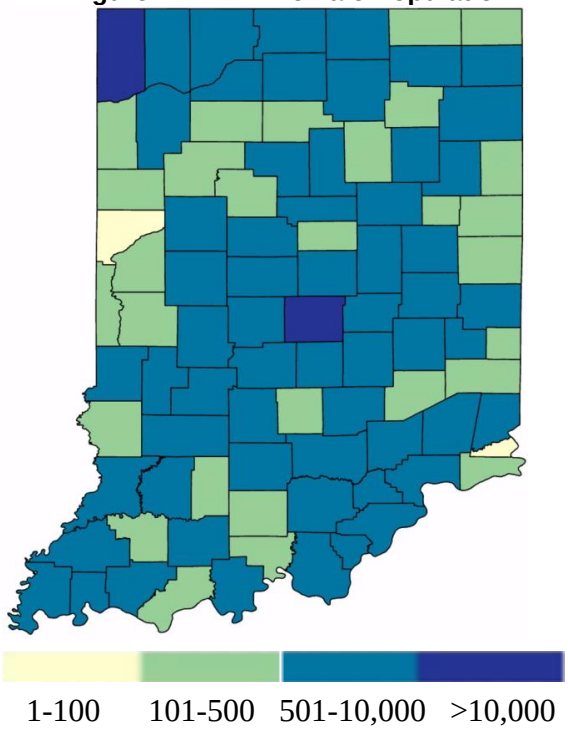
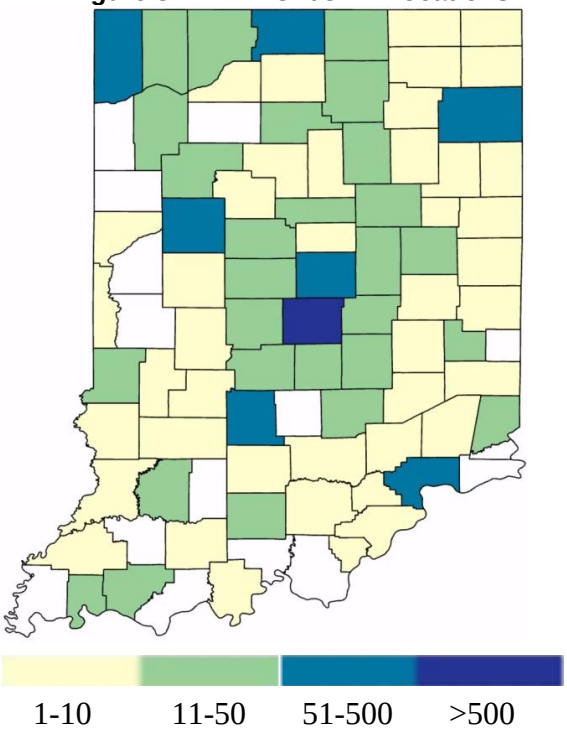


Figure 8. HHW - OB/GYN Locations



Anthem Healthy Indiana Plan (HIP)

Figure 9. HIP - Female Population

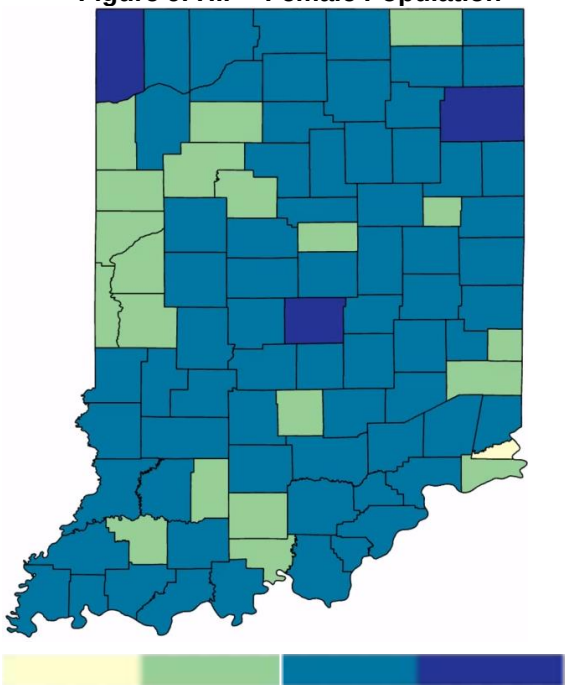
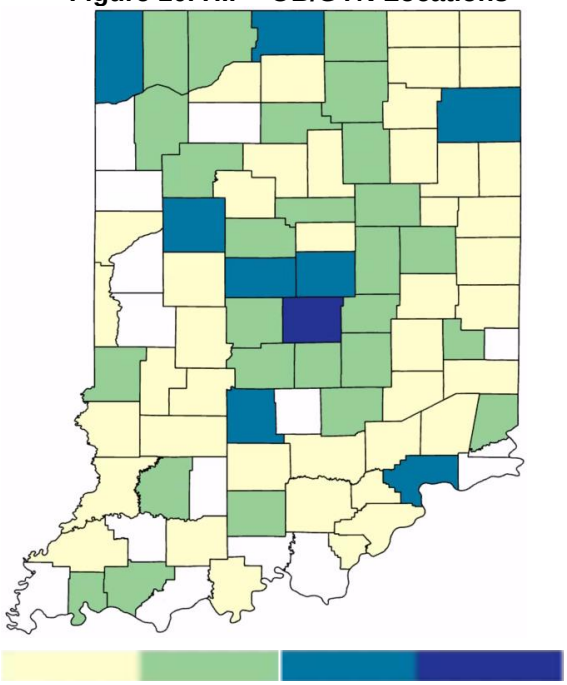


Figure 10. HIP - OB/GYN Locations



Anthem Hoosier Care Connect (HCC)

Figure 11. HCC - Female Population

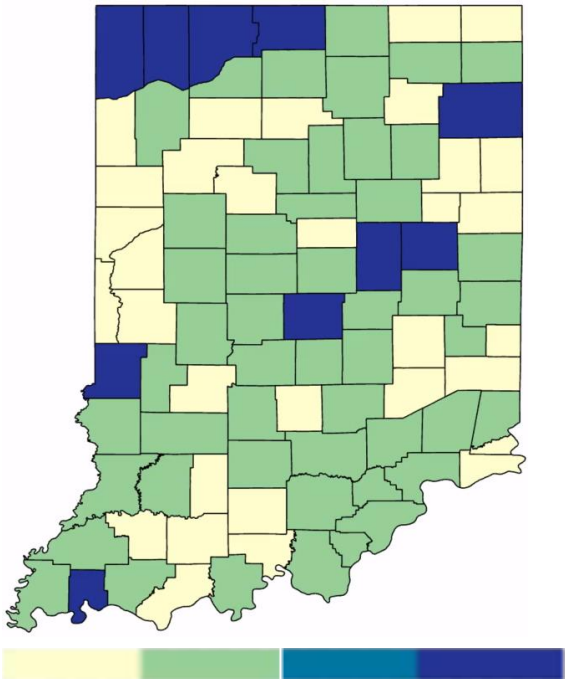
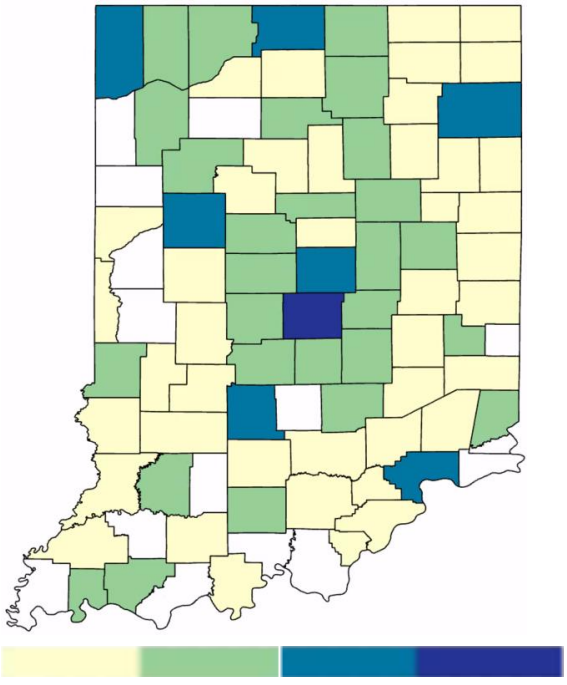


Figure 12. HCC - OB/GYN Locations



CareSource PMP Network

CareSource Hoosier Healthwise (HHW)

Figure 133. HHW - Member Population

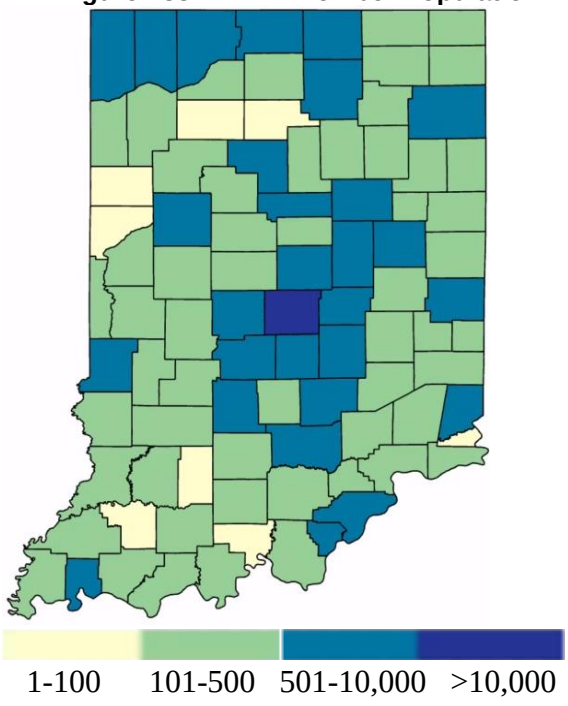
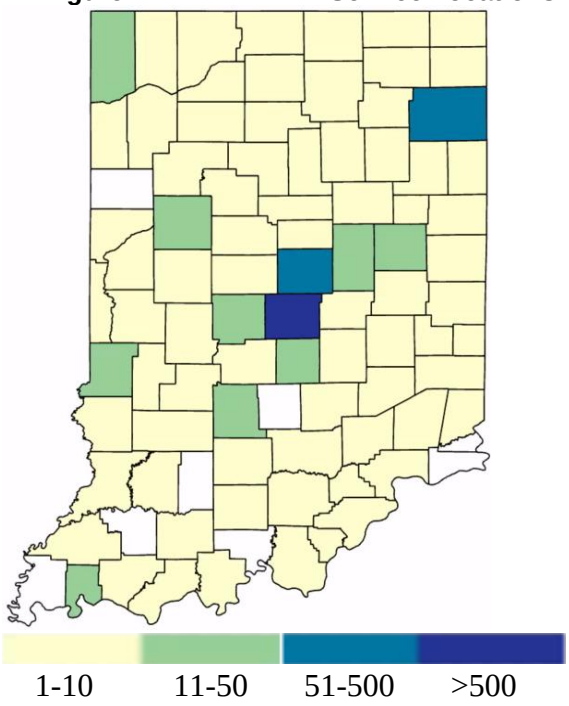


Figure 14. HHW - PMP Service Locations



CareSource Healthy Indiana Plan (HIP)

Figure 15. HIP - Member Population

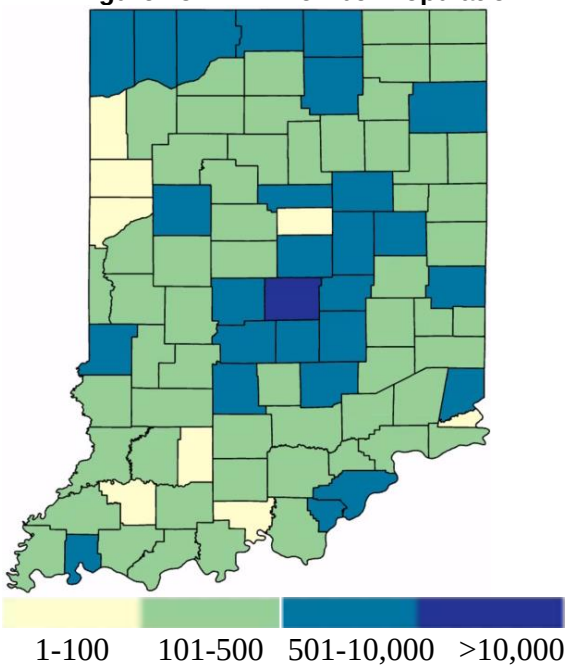
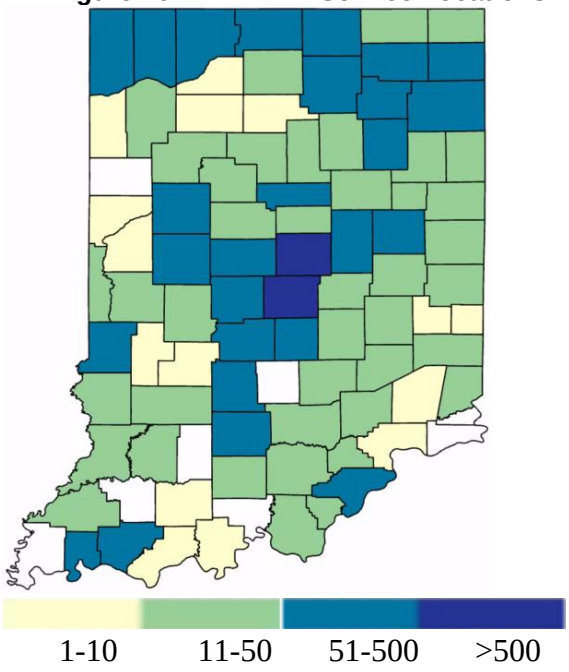


Figure 16. HIP - PMP Service Locations



CareSource OB/GYN Network

CareSource Hoosier Healthwise (HHW)

Figure 17. HHW - Female Population

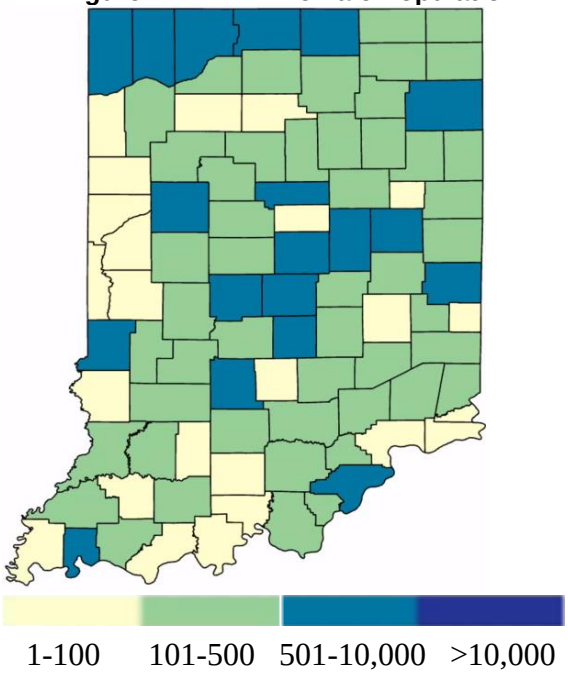
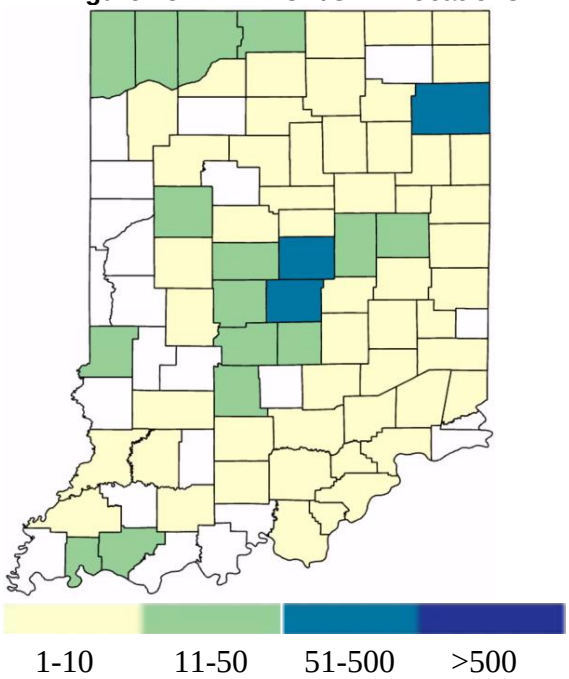


Figure 18. HHW - OB/GYN Locations



CareSource Healthy Indiana Plan (HIP)

Figure 19. HIP - Female Population

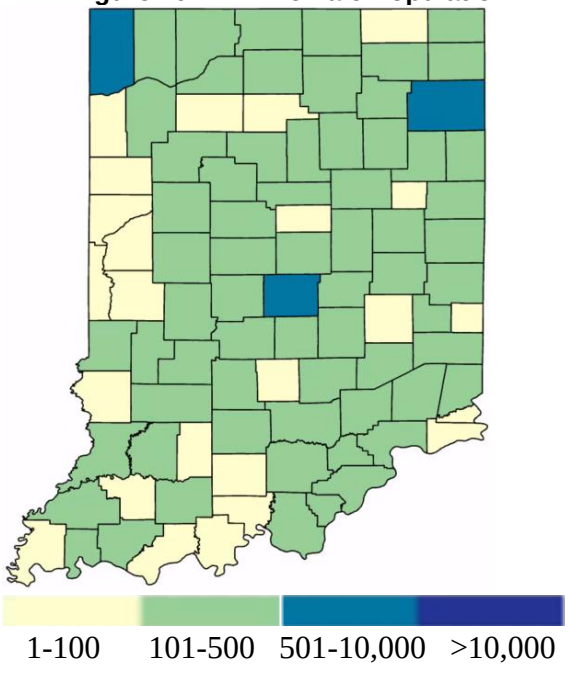
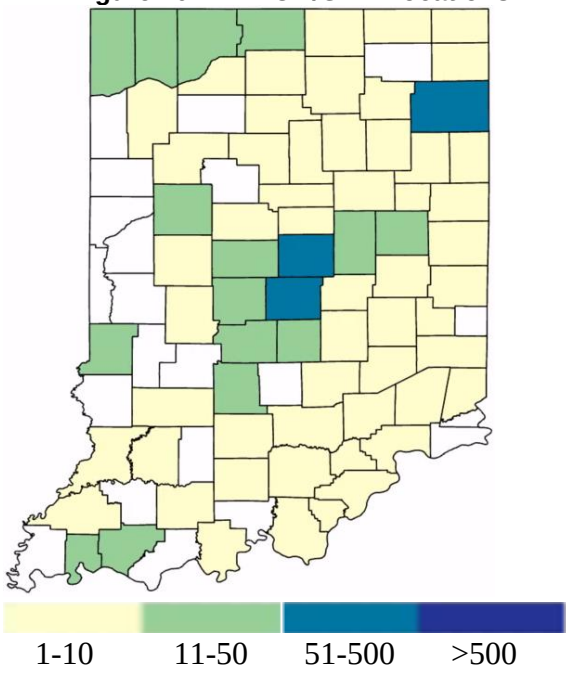


Figure 20. HIP - OB/GYN Locations



MDwise PMP Network

MDwise Hoosier Healthwise (HHW)

Figure 21. HHW - Member Population

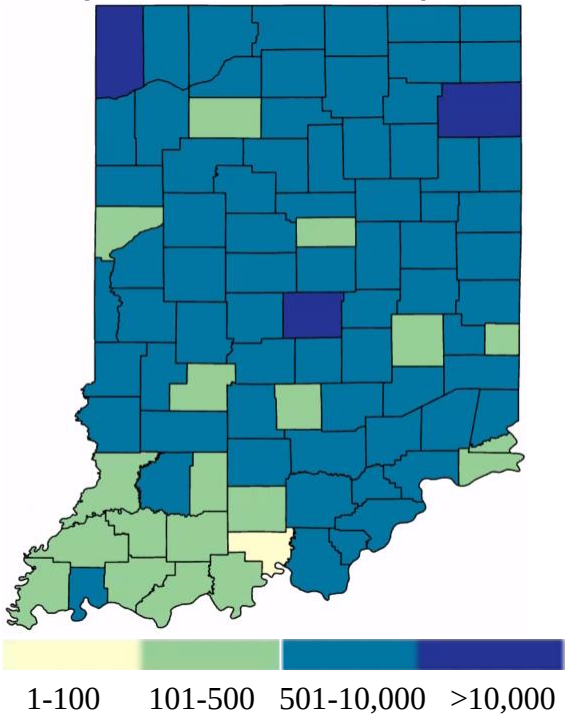
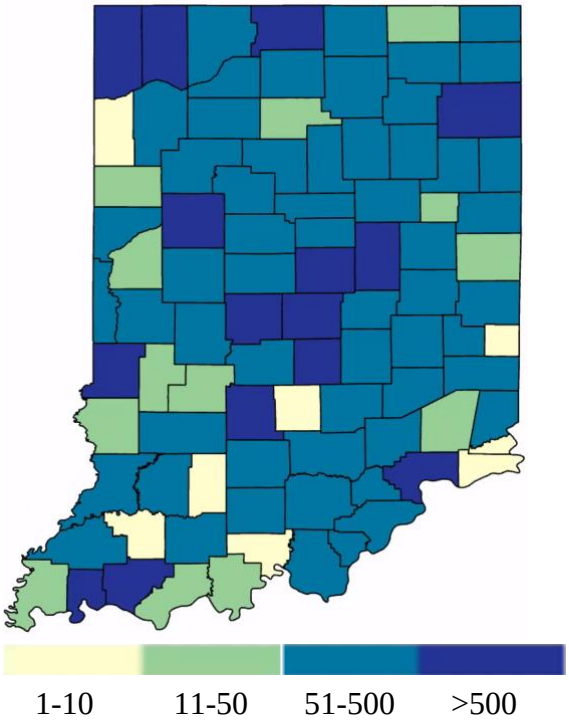


Figure 22. HHW - PMP Service Locations



MDwise Healthy Indiana Plan (HIP)

Figure 23. HIP - Member Population

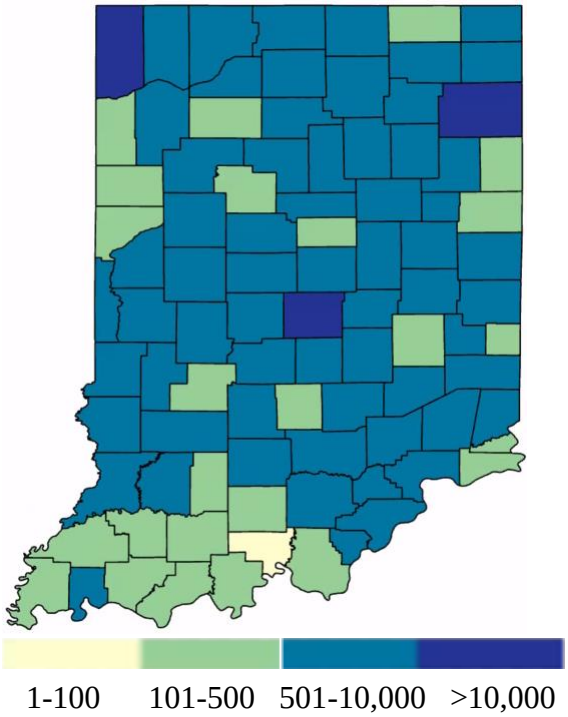
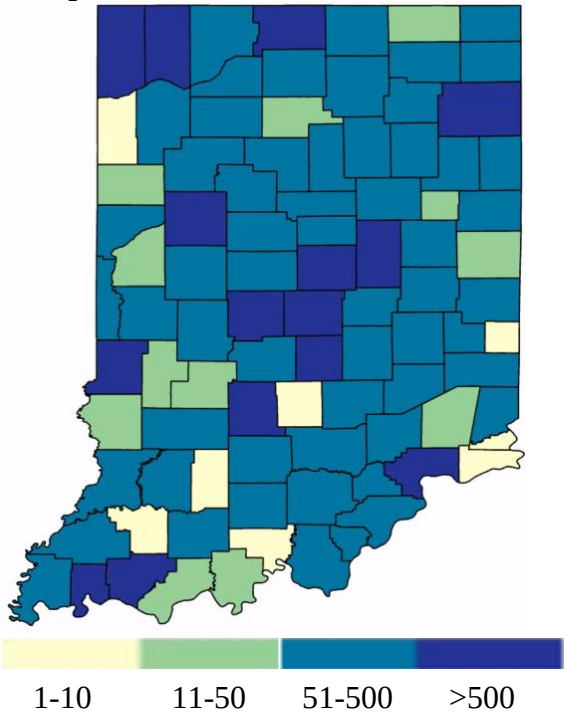


Figure 24. HIP - PMP Service Locations



MDwise OB/GYN Network

MDwise Hoosier Healthwise (HHW)

Figure 25. HHW - Female Population

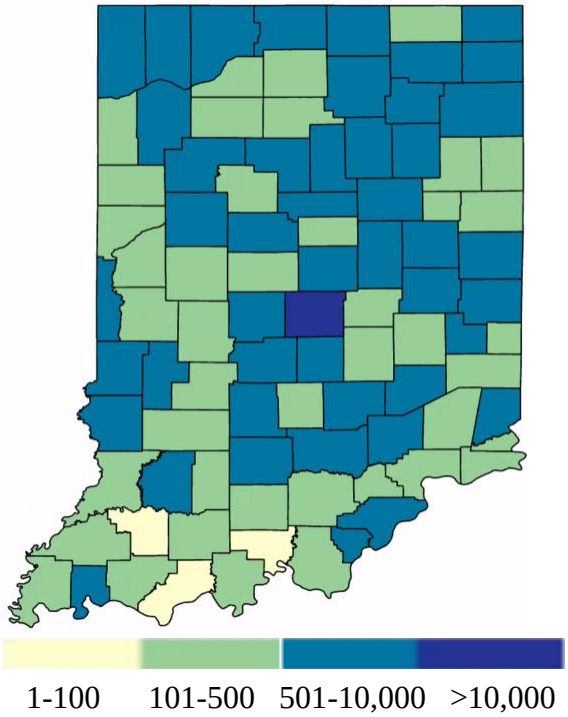
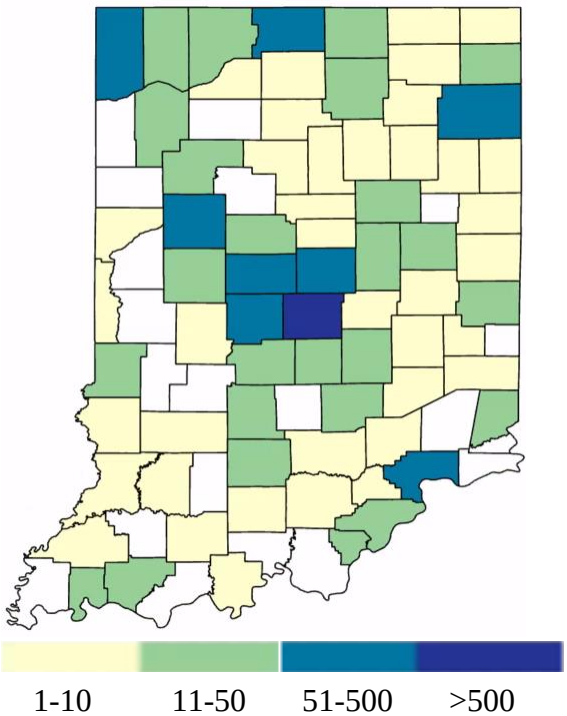


Figure 26. HHW - OB/GYN Locations



MDwise Healthy Indiana Plan (HIP)

Figure 27. HIP - Female Population

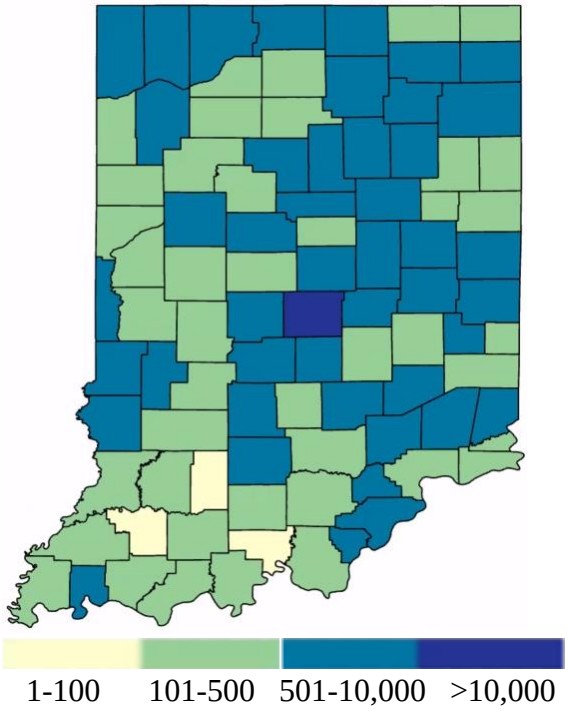
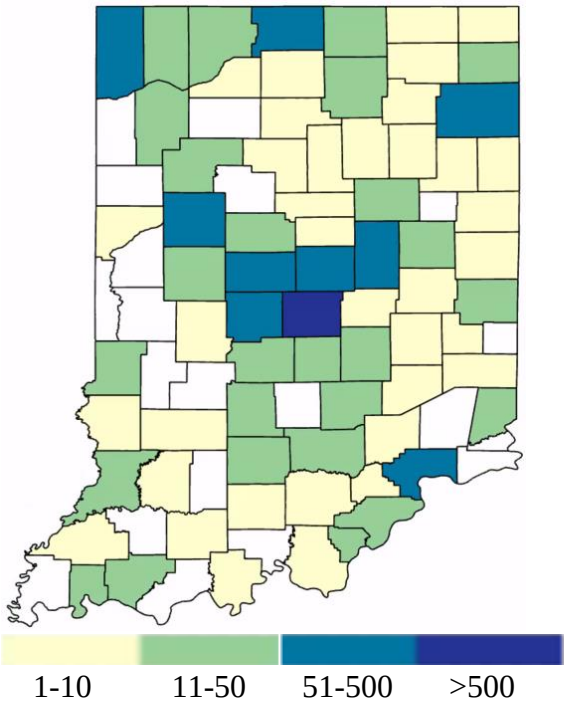


Figure 28. HIP - OB/GYN Locations



Further analysis indicates that 159 MDwise-enrolled providers have 20 or more service locations, with providers having as many as 42 service locations. An additional 529 providers have 10 to 19 service locations. The following figures depict the service locations of two different providers sampled during this analysis. It seems unlikely that a single PMP could provide routine primary care simultaneously at this number of locations spread widely across the state.

Figure 29. Service Locations for a Single PMP - Example 1, 42 Service Locations

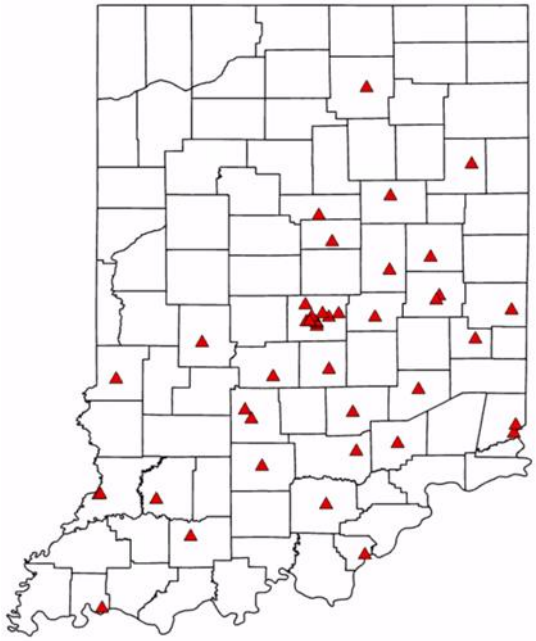
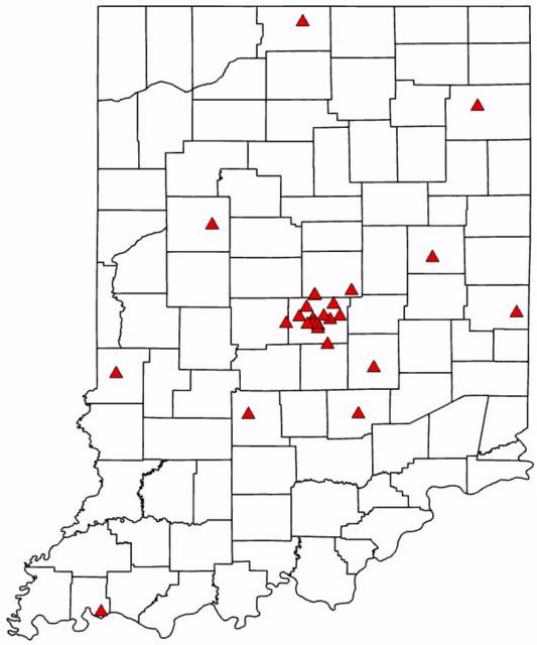


Figure 30. Service Locations for a Single PMP - Example 2, 35 Service Locations



MHS PMP Network

MHS Hoosier Healthwise (HHW)

Figure 31. HHW - Member Population

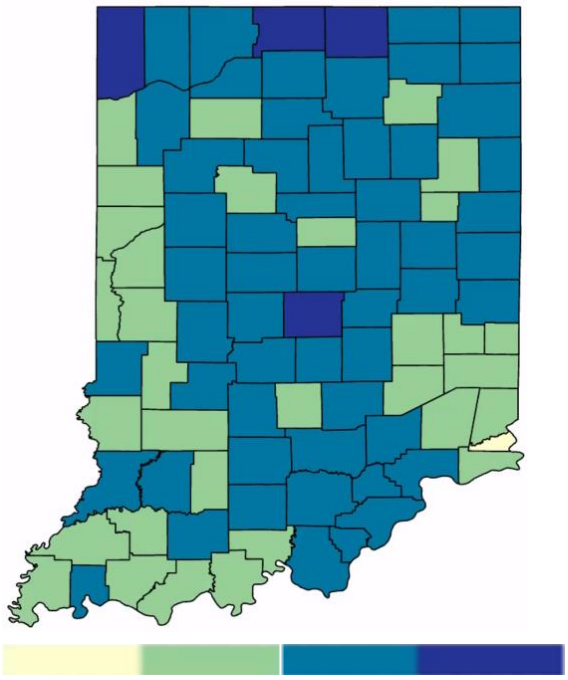
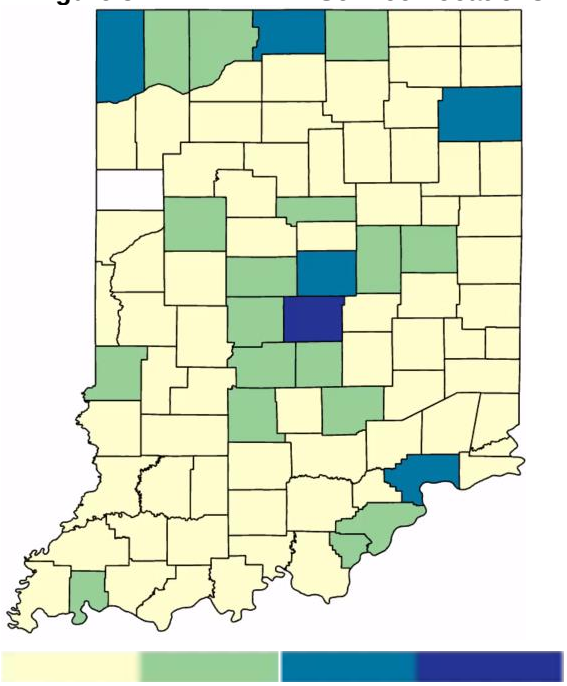


Figure 32. HHW - PMP Service Locations



MHS Healthy Indiana Plan (HIP)

Figure 33. HIP - Member Population

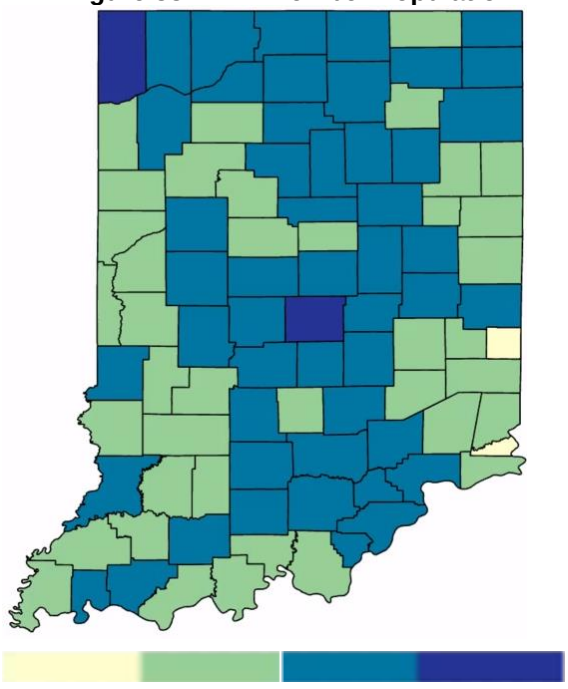
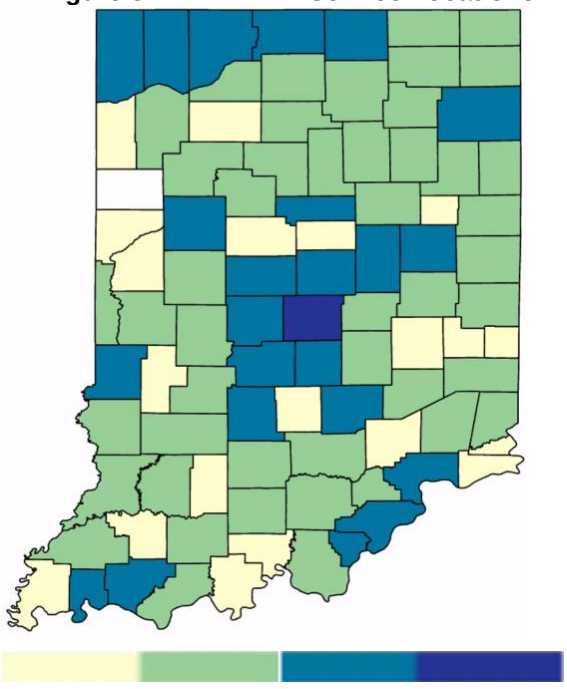


Figure 34. HIP - PMP Service Locations



MHS Hoosier Care Connect (HCC)

Figure 35. HCC - Member Population

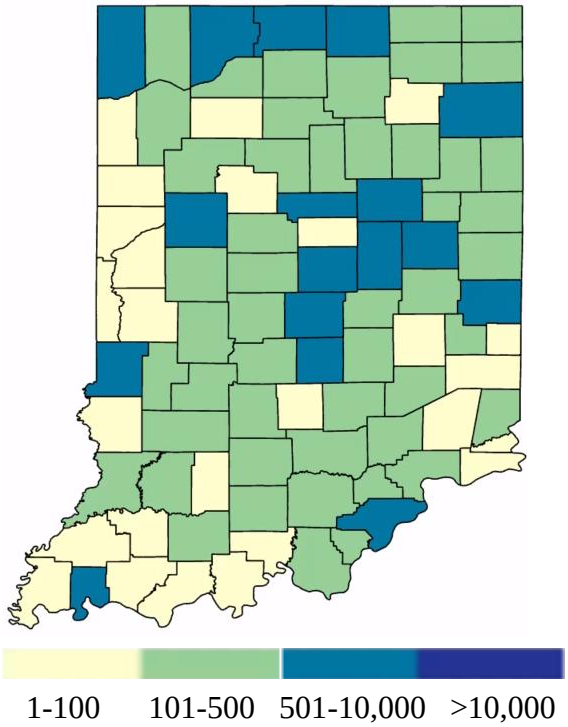
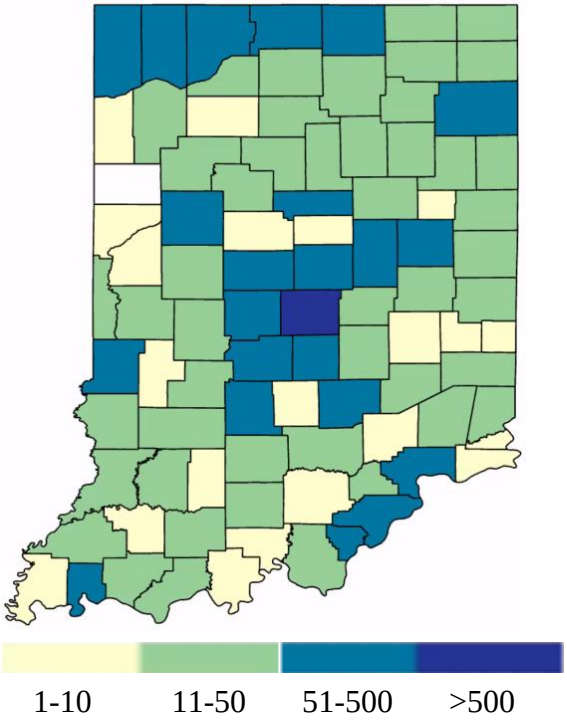


Figure 36. HCC - PMP Service Locations



MHS OB/GYN Network

MHS Hoosier Healthwise (HHW)

Figure 37. HHW - Female Population

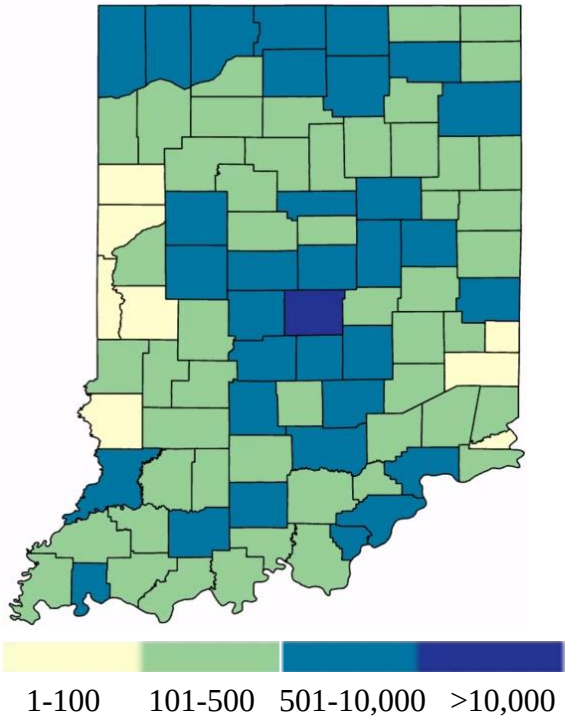
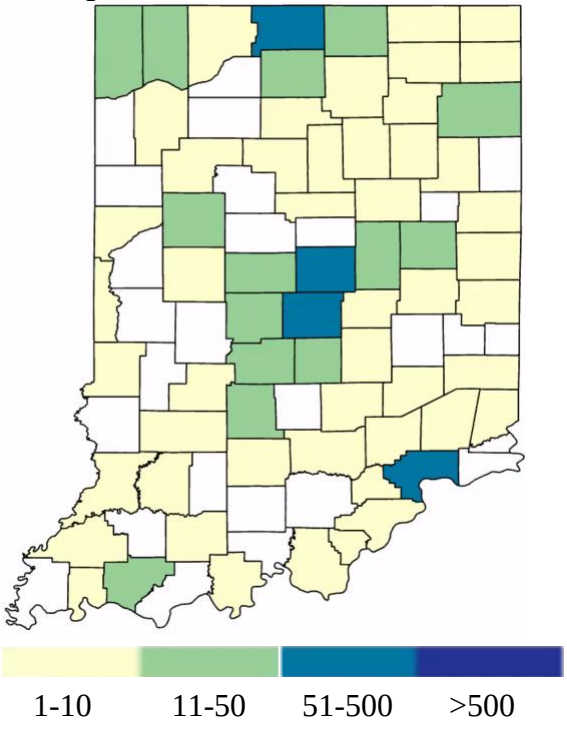


Figure 38. HHW - OB/GYN Locations



MHS Healthy Indiana Plan (HIP)

Figure 39. HIP - Female Population

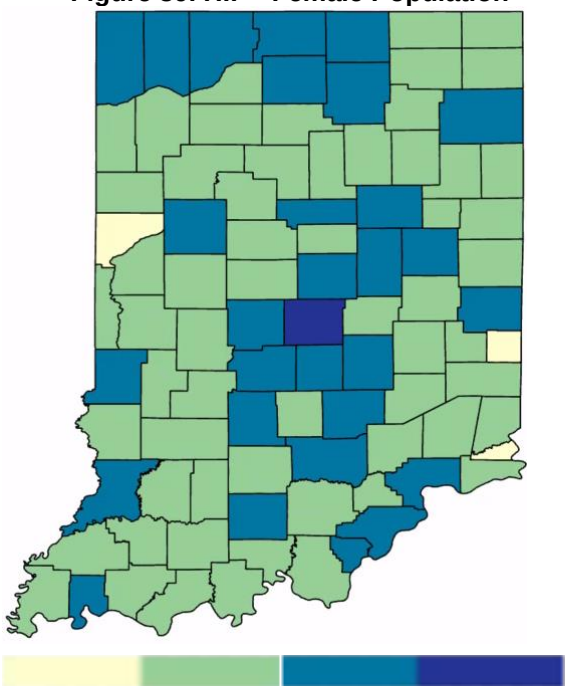
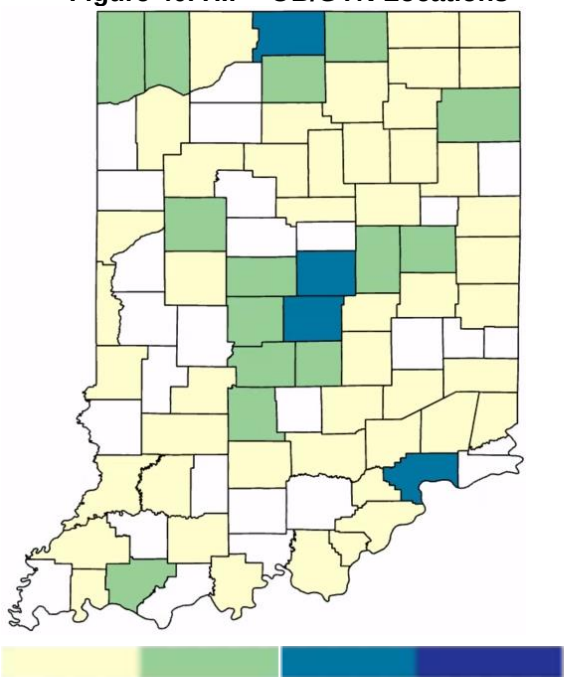


Figure 40. HIP - OB/GYN Locations



MHS Hoosier Care Connect (HCC)

Figure 41. HCC - Female Population

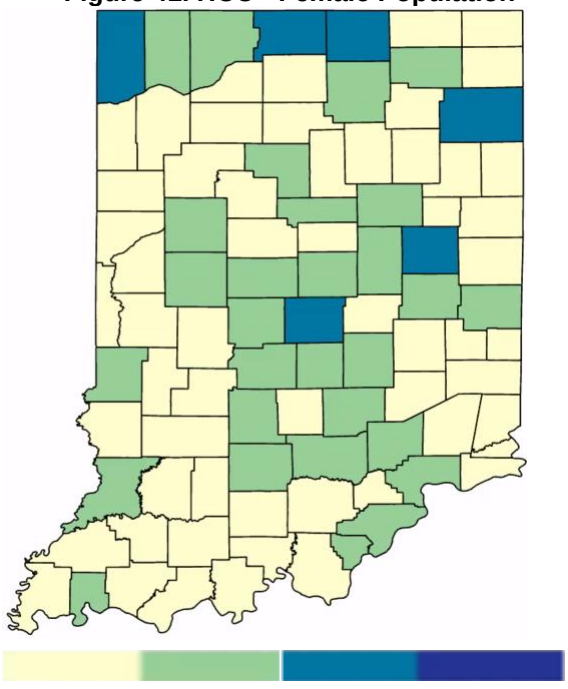
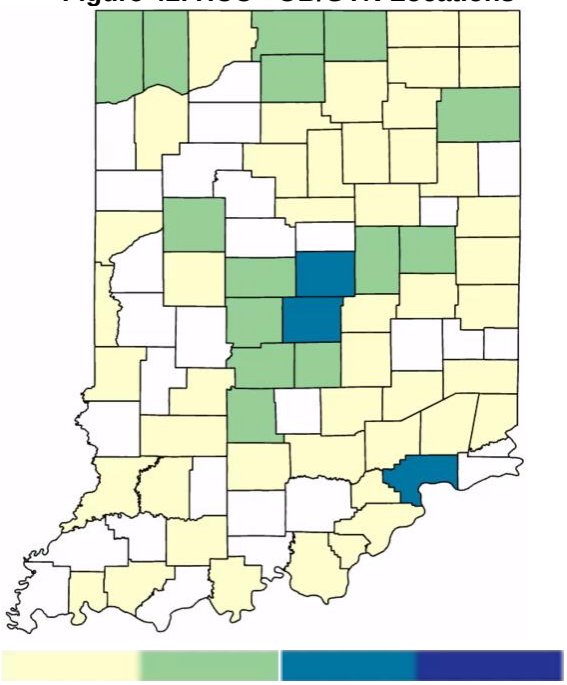


Figure 42. HCC - OB/GYN Locations



Assessment of Annual Reports 0902 and 0903 Issued to the State

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

Table 20. Count of Providers – Verification of Report 0902

MCE	Program	PMP			OB/GYN		
		MCE Report 0902	MSLC Calculated	Over (Under) Reported	MCE Report 0902	MSLC Calculated	Over (Under) Reported
Anthem	HHW	5,029	3,938	1,091	1,014	855	159
	HIP	4,749	3,844	905	1,008	847	161
	HCC	4,872	3,938	934	1,015	855	160
CareSource	HHW	5,117	1,604	3,513	1,079	325	754
	HIP	4,926	1,607	3,319	1,070	325	745
	HCC	N/A	N/A	N/A	N/A	N/A	N/A
MDwise	HHW	3,408	11,020	(7612)	1,722	743	853
	HIP	3,355	11,003	(7648)	1,759	883	876
	HCC	N/A	N/A	N/A	N/A	N/A	N/A
MHS	HHW	3,531	3,614	(83)	1,011	689	322
	HIP	3,329	3,418	(89)	1,005	678	327
	HCC	3,661	3,736	(75)	986	656	330

Counts of providers were higher in Anthem's Report 0902 than those calculated from Anthem's submitted provider rosters for both PMPs and OB/GYNs.

Counts of providers tended to be higher in CareSource's Report 0902 than those calculated from CareSource's submitted provider rosters.

Overall, the counts of PMP providers were under-reported whereas the counts of OB/GYNs were over-reported in MDwise's Report 0902 compared to the counts of providers we calculated from MDwise's submitted provider rosters.

Counts of PMP providers were slightly lower in MHS' Report 0902 than those calculated from MHS' submitted PMP rosters. However, the counts of OB/GYN providers in MHS Report 0902 were markedly higher than those calculated from MHS' submitted OB/GYN rosters.

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

Table 21. Member Access to Providers – Verification of Report 0903

MCE	Program	Number of Members Enrolled			Without Sufficient Access to PMPs			Without Sufficient Access to OB/GYNs		
		MCE Report 0903	MSLC Calculated	Over (Under)	MCE Report 0903	MSLC Calculated	Over (Under)	MCE Report 0903	MSLC Calculated	Over (Under)
Anthem	HHW	291,559	297,134	(5575)	-	-	-	-	-	-
	HIP	307,335	324,157	(16822)	-	-	-	-	-	-
	HCC	58,542	59,955	(1413)	-	-	-	-	-	-
CareSource	HHW	291,559	297,134	(5575)	-	3	(3)	-	-	-
	HIP	307,335	324,157	(16822)	-	2	(2)	-	-	-
	HCC	-	-	-	-	-	-	-	-	-
MDwise	HHW	227,356	226,728	628	-	-	-	-	-	-
	HIP	160,887	162,384	(1497)	-	-	-	-	-	-
	HCC	-	-	-	-	-	-	-	-	-
MHS	HHW	179,273	178,345	928	-	-	-	-	-	-
	HIP	123,004	122,150	854	-	-	-	-	-	-
	HCC	35,822	35,351	471	-	-	-	-	-	-

Anthem's Report 0903 (Member Access to Providers) was compared to the state's counts of members lacking sufficient access to providers by county and to the results of provider network assessments. There were no differences noted in the counts of members who lacked sufficient access to PMPs or OB/GYNs. The count of enrolled members was underreported by no more than five percent.

CareSource's Report 0903 showed slight differences noted in access to PMPs in both programs.

The assessment of MDwise's Report 0903 found no differences noted, as both Report 0903 and our results found no members who lacked sufficient access to either provider network category.

MHS' Report 0903 was assessed with no differences noted in the counts of members who lacked sufficient access to PMPs or OB/GYNs, as both Report 0903 and the results found no such members. The count of enrolled members was over reported by no more than one percent.

Assessment of Provider Directories Issued to Members

Each MCE submitted for the assessment a provider directory in PDF format that was issued for either program (HHW, HCC and HIP). The "Restrictions" section of each provider indicated programs accepted.

Two methods were employed to conduct the assessment for each MCE. A limited manual sampling was conducted, followed by an automated address search of all enrolled PMP and OB/GYN providers.

Anthem submitted six provider directories in PDF format, one for each region (Northwest, Northeast, West Central, Central, Southwest, and Southeast). Providers for all three programs (HHW, HIP, and HCC) are listed in all six provider directories.

A random sample of 72 providers was selected from Anthem's roster of enrolled PMP and OB/GYN providers. These providers were manually searched in the members' provider directory submitted by Anthem; 35 (49.00%) of the 72 randomly sampled providers were located. This sample included a mix of physicians (MD), physician's assistants (PA) and nurse practitioners (NP).

Figure 43. Manual Sampling Results - Anthem

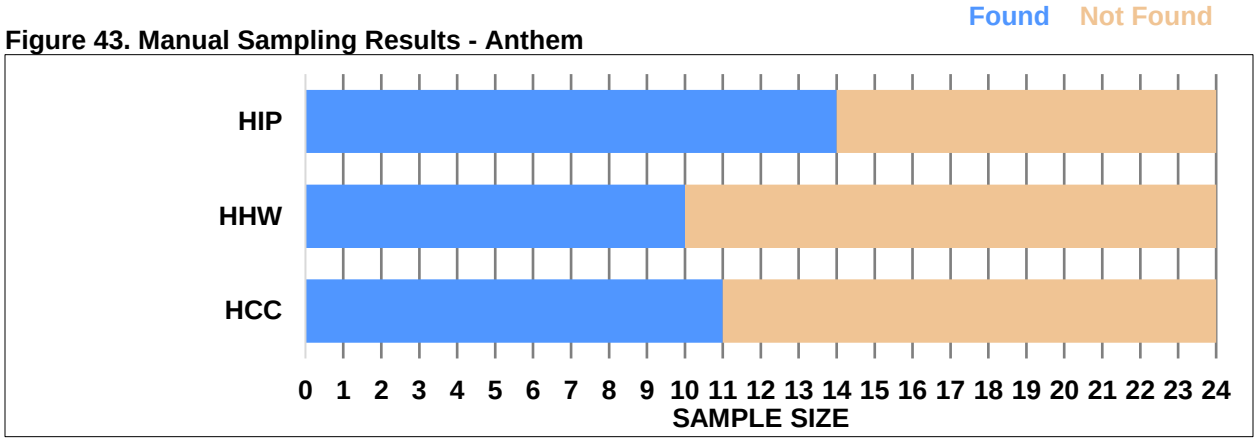
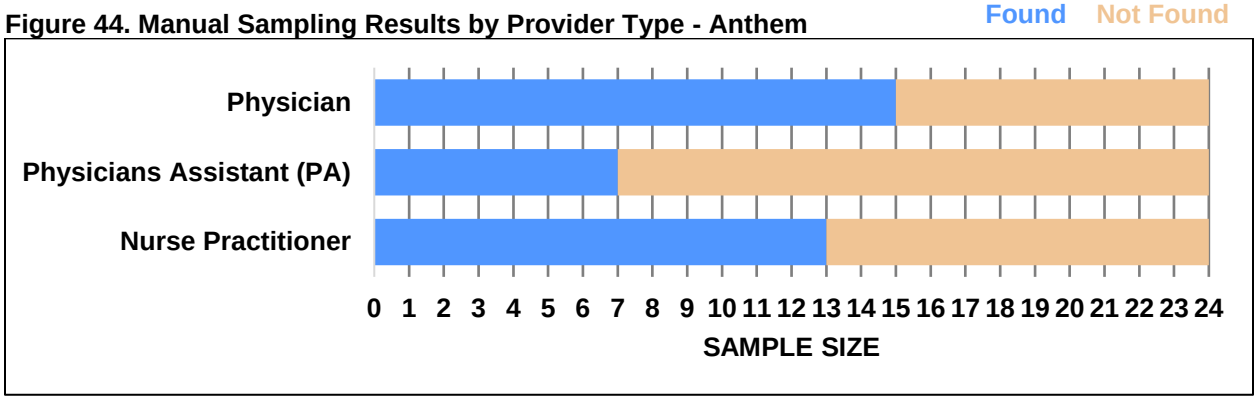


Figure 44. Manual Sampling Results by Provider Type - Anthem



An automated method was used to assess the existence of the service locations of enrolled providers within the members' provider directories. The addresses appearing in the PMP and OB/GYN portions of the provider directories were extracted and geocoded, producing a list of standardized addresses to compare to the addresses in the rosters of Anthem's enrolled providers, which had been geocoded during the geographic accessibility analysis. Using this method, 84.87% of enrolled PMPs' addresses and 80.38% of enrolled OB/GYN addresses were found in members' provider directories.

CareSource submitted for the assessment a single provider directory in PDF format that was issued for either program (HHW and HIP). The "Restrictions" section of each provider indicated programs accepted.

A random sample of 33 providers was selected from CareSource's roster of enrolled PMP and OB/GYN providers. These providers were manually searched in the members' provider directory submitted by CareSource, and 3 (9.00%) of the 33 randomly sampled providers were located. The sample included a mix of physicians (MD), physician's assistants (PA) and nurse practitioners (NP).

Figure 45. Manual Sampling Results - CareSource

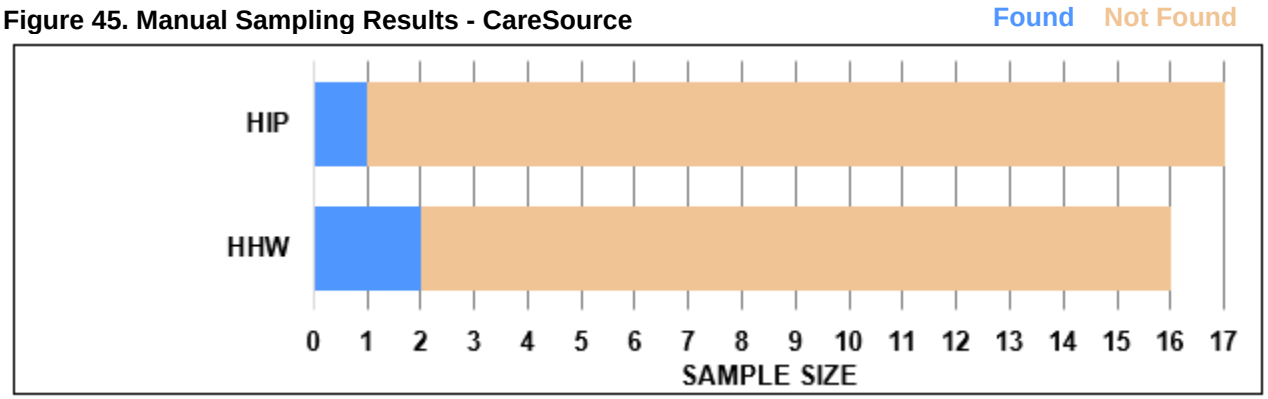
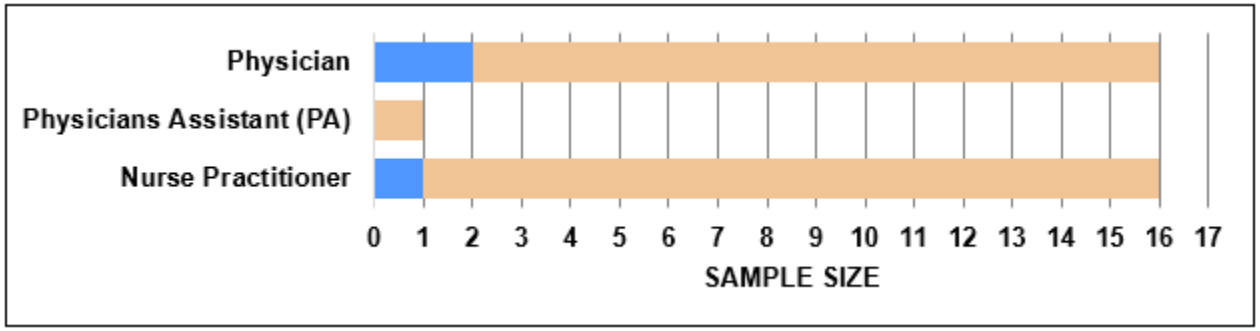


Figure 46. Manual Sampling Results by Provider Type - CareSource



MDwise submitted two provider directories in PDF format for the assessment, one for each program (HHW and HIP). MDwise's provider directories are organized by primary care providers and specialty care providers, with OB/GYNs falling under the second category.

A random sample of 48 providers was selected from MDwise's roster of enrolled PMP and OB/GYN providers. A manual search was performed for these providers in both members' provider directories submitted by MDwise. Of the 48 randomly sampled providers, 25 (52%) were able to be located. This sample included a mix of physicians (MD), physician's assistants (PA) and nurse practitioners (NP). The percentage of physicians (MD) found was lower (38%) than the overall percentage found (52%).

Figure 47. Manual Sampling Results - MDwise

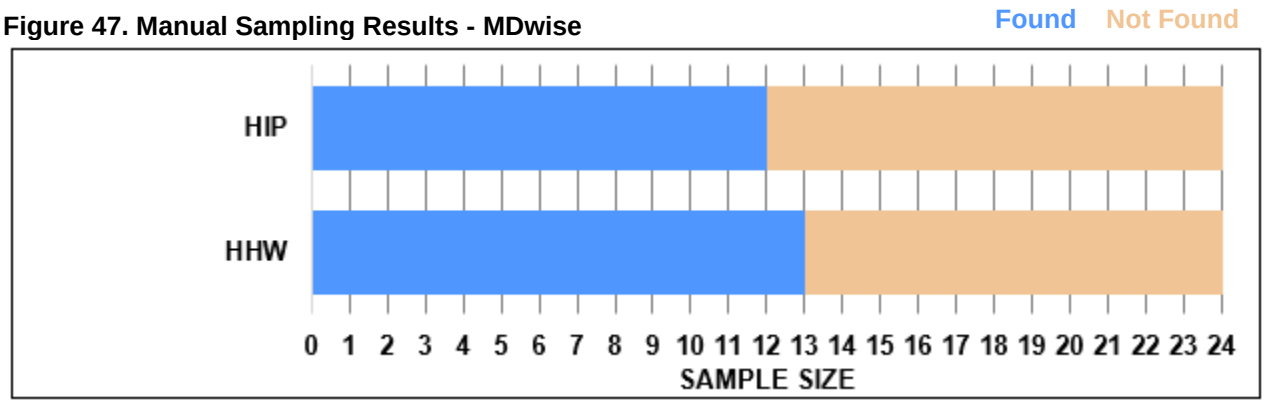
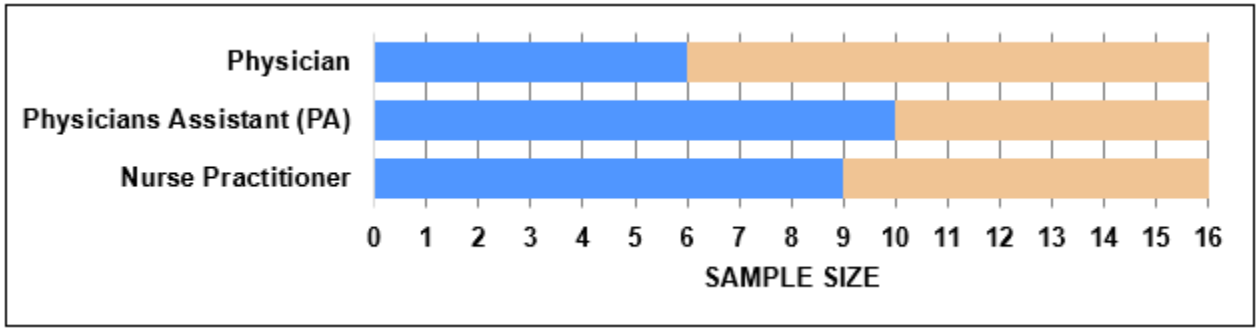


Figure 48. Manual Sampling Results by Provider Type - MDwise



MHS did not submit a complete provider directory for any of their three programs. Rather, they supplied a Uniform Resource Locator (URL) to MHS's "Find a Doctor" website, and two abbreviated provider directories with the following explanation:

"When members request a copy of the provider directory, they are provided current information that is customized to their enrolled Medicaid program, their location, and the requested provider type. Copied below are a couple of directories that were sent to members who were enrolled with the plan on October 1, 2021, for OB/GYNs and PMPs providers."

A random sample of 71 providers was selected from MHS' roster of enrolled PMP and OB/GYN providers. A manual search was performed for these providers using MHS' "Find a Doctor" website. The search was able to locate 39 (55.00%) of the 71 randomly sampled providers from the data extract in the provided "Find a Doctor" website. The sample included a mix of physicians (MD), physician's assistants (PA) and nurse practitioners (NP). The percentage of physicians (MD) found was higher (61.00%) than the overall found (55.00%). It is possible that some of the variance below is related to timing differences in the period the rosters represent (October 1, 2021) and the period that the testing occurred.

Figure 49. Manual Sampling Results - MHS

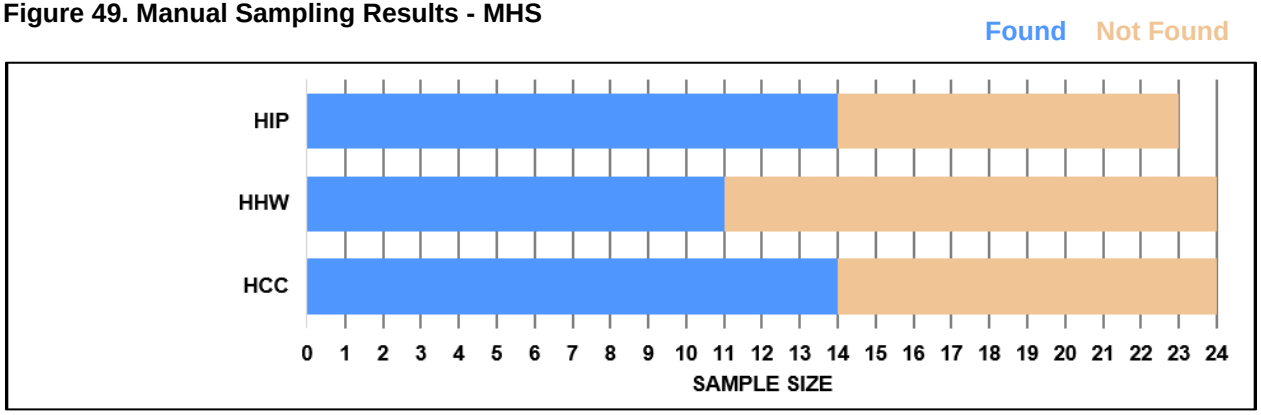
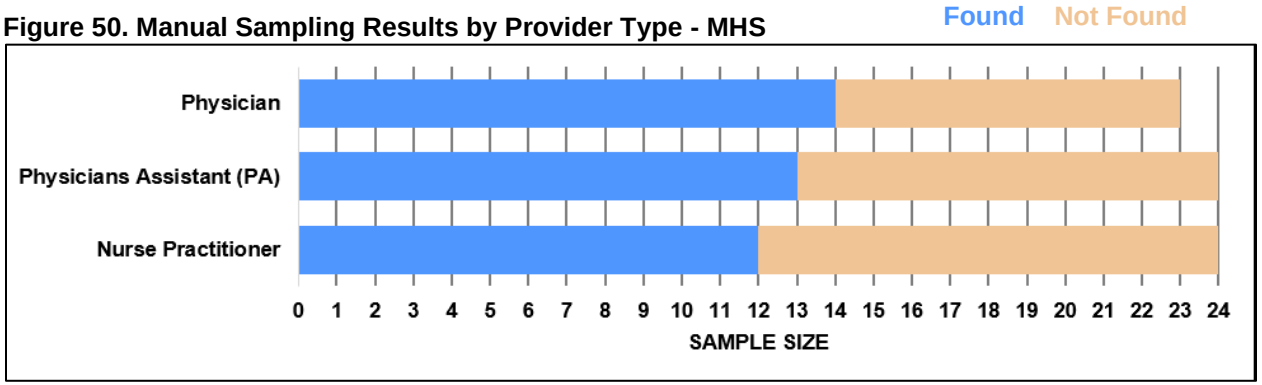


Figure 50. Manual Sampling Results by Provider Type - MHS



Strengths, Suggestions, and AONs

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

As shown in **Table 22**, all MCEs were compliant with the geographic accessibility standard.

Table 22. Strengths, Suggestions, and AONs

Anthem	**Strengths**	
	HHW, HIP, and HCC	♦ Anthem met the requirements for geographic accessibility to PMP and OB/GYN providers for 100% of their HHW, HIP and HCC members.
	Suggestions	
	HHW, HIP, and HCC	♦ Anthem may want to consider expanding their HIP provider networks to include all providers available in the HHW and HCC provider networks. ♦ Anthem may want to consider incorporating additional data quality validations into member and provider record-keeping. Refer to the tables in Appendix B comprising comparisons of the member and provider rosters submitted for this assessment to the annual Reports 0902 and 0903.

Table 22. Strengths, Suggestions, and AONs

		♦ Anthem may want to consider reviewing the provider directories issued to their members for completeness and accuracy.
	AONs	
	HHW, HIP, and HCC	♦ None noted.
CareSource	**Strengths**	
	HHW and HIP	♦ CareSource met the requirements for geographic accessibility to OB/GYN providers for 100% of their HHW and HIP members. ♦ CareSource met the requirements for geographic accessibility to PMP providers for greater than 99.9% of their HHW and HIP members.
	Suggestions	
	HHW and HIP	♦ CareSource may want to consider incorporating additional data quality validations into member and provider record-keeping. Refer to the tables in Appendix B comprising comparisons of the member and provider rosters they submitted for this assessment to their annual Reports 0902 and 0903 to the state. ♦ CareSource may want to consider reviewing the provider directories issued to their members for completeness and accuracy.
	AONs	
	HHW and HIP	♦ None noted.
MDwise	**Strengths**	
	HHW and HIP	♦ MDwise has met the requirements for geographic accessibility to PMP and OB/GYN providers for 100% of their HHW and HIP members.
	Suggestions	
	HHW and HIP	♦ MDwise may want to research potential OB/GYN service locations in Clay, Ripley, and Vermillion Counties to determine if additional provider locations in these counties could improve members' access. ♦ Additionally, MDwise may want to confirm the PMP service locations for individual practitioners, including those who provide services at an unusually high number of locations.

Table 22. Strengths, Suggestions, and AONs		
		♦ As a further data quality control, MDwise may want to consider reviewing their Report 0902 (Count of Providers) to the state against their roster of enrolled providers to ensure the PMP and OB/GYN counts are accurate.
	AONs	
	HHW and HIP	♦ None noted.
MHS	**Strengths**	
	HHW, HIP, and HCC	♦ MHS met the requirements for geographic accessibility to PMP and OB/GYN providers for 100% of their HHW, HIP and HCC members.
	Suggestions	
	HHW, HIP, and HCC	♦ MHS may want to consider reviewing their HHW PMP rosters to ensure they are complete and accurate. ♦ Additionally, as a data quality control, MHS may want to consider reviewing the Report 0902 (Count of Providers) submitted to OMPP against the provider rosters to ensure the OB/GYN counts are accurate. ♦ It is recommended that MHS have the ability to identify what providers were enrolled in each program historically, as well as currently.
	AONs	
	HHW, HIP, and HCC	♦ None noted.

Conclusions and Recommendations

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

Recommendations

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

2022 EQR Conclusions and Recommendations

Qsource conducted mandatory EQR activities for the OMPP program for CY 2021. Each of CMS's EQR Protocols is a learning opportunity for the MCEs and OMPP. Qsource used a collaborative approach to assist the State and MCEs with developing best practices for future reviews and ensuring enrollee quality of care was paramount. Qsource is available to collaborate with OMPP and directly assist the MCEs in accomplishing the following recommendations for improvement.

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

QIP Validation

Goal 1 of OMPP's Quality Strategy is to continuously monitor quality improvement measures and strive to maintain high standards to improve the health of enrollees. OMPP contractually requires the MCEs to complete QIPs yearly and 2021 was the second measurement year for Qsource to evaluate the required QIPS. Analysis of each QIP revealed that the MCEs demonstrated an understanding of the improvement process by providing descriptions of the intervention, barriers, and likelihood to create a change, as well as future considerations for the interventions implemented. At the same time, weaknesses were noted in a majority of the QIPs regarding missing or incomplete information, which compromised the ability of Qsource to evaluate and make conclusions about the results and the validity of the study. Prior to 2021, the MCEs were allowed to report QIP results and evaluation on MCE developed templates and reporting schedules. For the 2021 EQR evaluation, Qsource developed a QIP Summary Form (with accompanying QIP Summary Form Completion Instructions)

and a QIP Validation Tool to standardize the process by which each MCE delivers QIP information to OMPP and how the information was assessed. With this requirement, Qsource found improvement in the QIP information submitted for evaluation compared to previous years. Although improvements are still needed in the submission of QIP data and progress measurement, the MCEs have shown moderate improvement; Qsource views the results as a learning opportunity for the MCEs and will assist in education of the MCEs to achieve better results next measurement year. OMPP should continue to monitor the MCEs QIPs as part of its Quality Strategy to ensure quality, timeliness, and access to care for its enrollees.

PMV

PMV is designed to assess the accuracy of reported performance measures and determine the extent to which the reported rates follow the measure specifications and reporting requirements. To assess MCE performance over time, Qsource validated three measures for Translation and Interpretation Services: total contacts to language line during the reporting period, total requests for interpreter services during the reporting period, and total requests for interpretation services requested and fulfilled during the reporting period. Qsource defined the scope of the validation to include the OMPP required metrics. This validation included data source, reporting frequency, and format of those measures. In addition to document review, Qsource audit included system demonstrations, review of data output files, observation of data processing, and review of data reports.

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

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

All MCEs met all specifications for the designated measures. In addition, the data integration, control, and performance measure documentation review indicated an overall high confidence in the MCE's ability to provide quality and timely care for its enrollees. No deficiencies were noted in the MCE's processes for data collection and performance measure reporting.

ANA

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

the quality improvement efforts of OMPP and is embedded into the expectations of the contracted health plans.

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

Overall, the results of the 2022 EQR activities demonstrated that the MCEs were well-qualified and committed to facilitating timely, accessible, and high-quality healthcare for all enrollees.

Appendix A | PMV Measure Rates

Qsource validated the set of three performance measures identified by OMPP, Translation and Interpretation Services. Qsource accepted the MCE's data submissions from OMPP for each reported measure. The data consisted of MCE-reported totals for each quarter. Revisions were made to the Reporting Manual in quarter two of 2021, which included instructions for reporting 0511: Translation and Interpretation Services. The modifications made to each measure item impacted all MCEs at the same point in quarter two of 2021. Based on the instructions for reporting Translation and Interpretation Services, data were measured differently for quarter one of 2021 and were therefore excluded from 2021 yearly analysis. Qsource used the remaining quarterly totals to complete this report (April 2021 – December 2021).

Table A-1. Quarter 2 Translation and Interpretation Services

Measure Name	Item	Anthem			CareSource		MDwise		MHS		
		HHW	HIP	HCC	HHW	HIP	HHW	HIP	HHW	HIP	HCC
Count of Members	Total contacts to language line during the reporting period	546	3,536	312	335	139	629	382	756	723	111
Count of Requests	Total requests for interpreter services during the reporting period	99	292	8	5	2	0	0	116	11	26
	Total requests for interpretation services requested and fulfilled during the reporting period	95	283	7	5	2	0	0	93	9	19
Percentage of Completed Requests	Percent of interpretation requests completed during the reporting period	95.96%	96.92%	87.50%	100%	100%	N/A	N/A	80.17%	81.82%	73.08%

Table A-2. Quarter 3 Translation and Interpretation Services

Measure Name	Item	Anthem			CareSource		MDwise		MHS		
		HHW	HIP	HCC	HHW	HIP	HHW	HIP	HHW	HIP	HCC
Count of Members	Total contacts to language line during the reporting period	421	2,618	177	194	109	353	322	712	647	101
Count of Requests	Total requests for interpreter services during the reporting period	111	315	17	14	0	1	2	88	10	28
	Total requests for interpretation services requested and fulfilled during the reporting period	100	295	14	13	0	1	1	74	3	26
Percentage of Completed Requests	Percent of interpretation requests completed during the reporting period	90.09%	93.65%	82.35%	92.86%	N/A	100%	50.00%	84.09%	30.00%	92.86%

Table A-3. Quarter 4 Translation and Interpretation Services

Measure Name	Item	Anthem			CareSource		MDwise		MHS		
		HHW	HIP	HCC	HHW	HIP	HHW	HIP	HHW	HIP	HCC
Counts of Members	Total Days of all members with SUD-related conditions in IMDs in the Reporting Period	429	2,206	164	352	146	337	232	869	827	119
Count of Requests	Total requests for interpreter services during the reporting period	80	276	8	11	5	0	2	87	25	23

Table A-3. Quarter 4 Translation and Interpretation Services

Measure Name	Item	Anthem			CareSource		MDwise		MHS		
		HHW	HIP	HCC	HHW	HIP	HHW	HIP	HHW	HIP	HCC
	Total requests for interpretation services that were requested and fulfilled during the reporting period	70	258	5	10	5	0	1	69	18	21
Percentage of Completed Requests	Percentage of interpretation requests completed during the reporting period	87.50%	93.48%	62.50%	90.91%	100.00%	N/A	50.00%	79.31%	72.00%	91.30%

Table A-4. Quarters 2, 3 and 4 Totals for Translation and Interpretation Services

Measure Name	Item	Anthem			CareSource		MDwise		MHS		
		HHW	HIP	HCC	HHW	HIP	HHW	HIP	HHW	HIP	HCC
Counts of Members	Total contacts to language line during the reporting period	1,396	8,360	653	881	394	1,319	936	2,337	2,197	331
Count of Requests	Total requests for interpreter services during the reporting period	290	883	33	30	7	1	4	291	46	77
	Total requests for interpretation services that were requested and fulfilled during the reporting period	265	836	26	28	7	1	2	236	30	66
Percentage of Completed Requests	Percent of interpretation requests completed during the reporting period	91.38%	94.68%	78.79%	93.33%	100%	100%	50.00%	81.10%	65.22%	85.71%

Appendix B | ANA Excluded Source Data

Excluded Source Data Records: Anthem

Table B-1 summarizes Anthem's member and provider records that were excluded from analysis. From the member records submitted by Anthem, most of the records excluded from analysis were invalid addresses, except for the HIP program, where most of its excluded records were members not Medicaid eligible on the snapshot date, October 1, 2021. The resulting count of members included in the analysis by program were:

- HHW – 297,134 members
- HIP – 324,157 members
- HCC – 59,955 members

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

- HHW – 12,853 provider service locations
- HIP – 12,332 provider service locations
- HCC – 12,853 provider service locations

Table B-1. Source Records Excluded from Analysis

Data Source	Health Programs			
Member Records	**HHW**	**HIP**	**HCC**	**All Programs**
Total Records Submitted	297,956	326,628	60,131	684,715
Total Records Excluded from Analysis	822 (0.30%)	2,471 (0.80%)	176 (0.30%)	3,469 (0.50%)
Invalid address	799	828	170	1,797
Not Medicaid eligible*	5	1,640	6	1,651
Duplicate record	18	0	0	18
Out-of-state residence	0	3	0	3
Provider Records	**HHW**	**HIP**	**HCC**	**All Programs**
Total Records Submitted	14,124	13,390	14,124	41,638

Table B-1. Source Records Excluded from Analysis				
Data Source	**Health Programs**			
Total Records Excluded from Analysis	1,271 (9.00%)	1,058 (8.00%)	1,271 (9.00%)	3600 (1.50%)
Duplicate provider service location	1,110	902	1,110	3,122
Not Medicaid eligible*	102	104	102	308
Located more than 60 miles outside of Indiana	58	51	58	167
National Provider Identifier (NPI) deactivated by CMS	1	1	1	3

** "Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against state records. The records were flagged as "Not Medicaid eligible" if the MMIS ID was not found, or if the member/provider was not actively enrolled on the snapshot date (October 1, 2021).*

Excluded Source Data Records: CareSource

Table B-2 summarizes CareSource's member and provider records that were excluded from analysis. From the member records submitted by CareSource, most of the records excluded from analysis were members who were not Medicaid eligible on the snapshot date (October 1, 2021.) The resulting count of members included in the analysis by program were:

- HHW – 71,440 members
- HIP – 65,305 members

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

- HHW – 6,201 provider service locations
- HIP – 6,193 provider service locations

Table B-2. Source Records Excluded from Analysis			
Data Source	**Health Programs**		
Member Records	**HHW**	**HIP**	**All Programs**
Total Records Submitted	76,281	72,535	148,816
Total Records Excluded from Analysis	4,841 (6.30%)	7,230 (10.00%)	12,071 (8.10%)

Table B-2. Source Records Excluded from Analysis			
Data Source	**Health Programs**		
Not Medicaid eligible*	4,621	7,017	11,638
Invalid address	220	211	431
Out-of-state residence	0	2	2
Provider Records	**HHW**	**HIP**	**All Programs**
Total Records Submitted	6,663	7,223	13,886
Total Records Excluded from Analysis	462 (6.90%)	1,030 (14.30%)	1,492 (10.70%)
Duplicate provider service location	462	1,029	1,491
Not Medicaid eligible*	0	1	1

** "Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against state records. The records were flagged as "Not Medicaid eligible" if the MMIS ID was not found, or if the member/provider was not actively enrolled on the snapshot date (October 1, 2021).*

Excluded Source Data Records: MDwise

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

- HHW – 226,728 members
- HIP – 162,384 members

From the provider records submitted by MDwise, most of the records we excluded from analysis were not Medicaid eligible on the snapshot date (October 1, 2021.) The resulting count of providers included in the analysis by program were:

- HHW – 36,410 provider service locations
- HIP – 37,209 provider service locations

Table B-3. Source Records Excluded from Analysis			
Data Source	**Health Programs**		
Member Records	**HHW**	**HIP**	**All Programs**
Total Records Submitted	227,629	163,204	390,863
Total Records Excluded From Analysis	901 (0.40%)	850 (0.50%)	1,751 (0.40%)
Out-of-state residence	421	433	854
Invalid address	467	404	871
Not Medicaid eligible*	13	13	26
Provider Records	**HHW**	**HIP**	**All Programs**
Total Records Submitted	41,045	41,986	83,031
Total Records Excluded From Analysis	4,635 (11.30%)	4,777 (11.40%)	9,412 (11.30%)
Duplicate provider service location	4,414	4,542	8,956
Located more than 60 miles outside of Indiana	203	218	421
Not Medicaid eligible*	18	17	35

"Not Medicaid eligible" was determined by validating the MMIS ID against state records. The record was tagged as "Not Medicaid eligible" if the MMIS ID was not found, or if the member/provider was not actively enrolled on the snapshot date (October 1, 2021.)

Excluded Source Data Records: MHS

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

- HHW – 178,345 members
- HIP – 122,150 members
- HCC – 35,351 members

From the provider records submitted by MHS, most of the records excluded from analysis were not Medicaid eligible on the snapshot date (October 1, 2021.) The resulting count of providers included in the analysis by program were:

- HHW – 5,002 provider service locations
- HIP – 4,767 provider service locations
- HCC – 5,095 provider service locations

Table B-4. Source Records Excluded from Analysis

Data Source	Health Programs			
Member Records	**HHW**	**HIP**	**HCC**	**All Programs**
Total Records Submitted	179,274	123,004	35,823	338,101
Total Records Excluded from Analysis	929 (0.50%)	854 (0.70%)	472 (1.30%)	2,225 (0.70%)
Out-of-state residence	440	414	305	1,159
Invalid address	471	353	121	945
Not Medicaid eligible*	18	87	46	151
Provider Records	**HHW**	**HIP**	**HCC**	**All Programs**
Total Records Submitted	5,078	4,837	5,180	15,095
Total Records Excluded from Analysis	76 (1.50%)	70 (1.40%)	85 (1.60%)	231 (1.50%)
Not Medicaid eligible*	70	64	79	213
Located more than 60 miles outside of Indiana	3	3	4	10
Duplicate provider service location	3	3	2	8

** "Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against state records. The records were tagged as Not Medicaid eligible" if the MMIS ID was not found, or if the member/provider was not actively enrolled on the snapshot date (October 1, 2021).*

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

Provider-to-member ratios are a method for assessing the average patient load of healthcare providers within a network. Large patient loads may result in excessive wait periods for patients between the request for an appointment and the scheduled appointment date. The method for assessing provider-to-member ratios counts each provider once regardless of how many service locations the provider has. Hence, the assessment of provider-to-member ratio at a county level may yield different results than for the state overall.

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

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

The methodology for assigning individual providers to exactly one report column (provider network category, i.e., PMP or OB/GYN) and one county when assessing Report 0902 was as follows:

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

Appendix C | Detailed Analysis of Provider Network Access

Overall Provider Network Accessibility

Table C-123. Anthem PMP Provider Network Adequacy by Program

	HHW	HIP	HCC	All Programs*
Count of Providers**	3,938	3,844	3,938	4,356
Count of Members	297,134	324,157	59,955	681,246
Provider-to-Member Ratio	1:75	1:84	1:15	1:156
Count of Provider Service Locations	9,787	9,295	9,787	10,863
Count of Members within 30 miles of a Provider	297,134	324,157	59,955	681,246
Percentage of Members within 30 miles of a Provider Service Location	100%	100%	100%	100%

** Individual providers enrolled in multiple health programs are counted a single time in the "All Programs" provider count.*
*** Includes out-of-state providers.*

Table C-2. Anthem OB/GYN Provider Network Adequacy by Program

Measure	HHW	HIP	HCC	All Programs*
Count of Providers**	855	847	855	858
Count of Members	149,926	194,587	8,817	373,330
Provider-to-Member Ratio	1:175	1:230	1:34	1:435
Count of Provider Service Locations	2,734	2,716	2,734	2,757
Count of Members within 60 miles of 2 OB/GYNs	149,926	194,587	8,817	373,330
Percentage of Members within 60 miles of 2 OB/GYNs	100%	100%	100%	100%

** Individual providers enrolled in multiple health programs are counted a single time in the "All Programs" provider count.*
*** Includes out-of-state providers.*

Table C-3. CareSource PMP Provider Network Adequacy by Program

	HHW	HIP	All Programs*
Count of Providers**	1,604	1,607	1,617
Count of Members	71,440	65,305	136,745
Provider-to-Member Ratio	1:45	1:41	1:85
Count of Provider Service Locations	5,040	5,027	5,061
Count of Members within 30 miles of a Provider	71,437	65,303	136,740
Percentage of Members within 30 miles of a Provider Service Location	99.90%	99.90%	99.90%

** Individual providers enrolled in multiple health programs are counted a single time in the "All Programs" provider count.*
*** Includes out-of-state providers.*

Table C-4. CareSource OB/GYN Provider Network Adequacy by Program

Measure	HHW	HIP	All Programs*
Count of Providers**	325	325	325
Count of Members	36,765	35,771	72,536
Provider-to-Member Ratio	1:113	1:110	1:223
Count of Provider Service Locations	1,161	1,162	1,174
Count of Members within 60 miles of 2 OB/GYNs	36,765	35,771	72,536
Percentage of Members within 60 miles of 2 OB/GYNs	100%	100%	100%

** Individual providers enrolled in multiple health programs are counted a single time in the "All Programs" provider count.*
*** Includes out-of-state providers.*

Table C-5. MDwise PMP Provider Network Adequacy by Program

	HHW	HIP	All Programs*
Count of Providers**	11,020	11,003	11,413
Count of Members	226,728	162,384	389,112
Provider-to-Member Ratio	1:21	1:15	1: 34
Count of Provider Service Locations	34,032	34,749	35,531
Count of Members within 30 miles of a Provider	226,728	162,384	389,112
Percentage of Members within 30 miles of a Provider Service Location	100%	100%	100%

** Individual providers enrolled in multiple health programs are counted a single time in the "All Programs" provider count.*
*** Includes out-of-state providers.*

Table C-6. MDwise OB/GYN Provider Network Adequacy by Program

	HHW	HIP	All Programs*
Count of Providers**	869	883	893
Count of Members	114,117	103,176	217,293
Provider-to-Member Ratio	1:131	1:117	1:243
Count of Provider Service Locations	2,376	2,460	2,512
Count of Members within 60 miles of 2 OB/GYNs	114,117	103,176	217,293
Percentage of Members within 60 miles of 2 OB/GYNs	100%	100%	100%

** Individual providers enrolled in multiple health programs are counted a single time in the "All Programs" provider count.*
*** Includes out-of-state providers.*

Table C-7. MHS PMP Provider Network Adequacy by Program

	HHW	HIP	HCC	All Programs*
Count of Providers**	3,614	3,418	3,736	3,971
Count of Members	178,345	122,150	35,351	335,846
Provider-to-Member Ratio	1:49	1:36	1:9	1:85
Count of Provider Service Locations	3,899	3,679	4,048	4,355
Count of Members within 30 miles of a Provider	178,345	122,150	35,351	335,846
Percentage of Members within 30 miles of a Provider Service Location	100%	100%	100%	100%

** Individual providers enrolled in multiple health programs are counted a single time in the "All Programs" provider count.*
*** Includes out-of-state providers.*

Table C-8. MHS OB/GYN Provider Network Adequacy by Program

Measure	HHW	HIP	HCC	All Programs*
Count of Providers**	689	678	656	715
Count of Members	90,247	76,476	16,464	183,187
Provider-to-Member Ratio	1:131	1:113	1:25	1:256
Count of Provider Service Locations	1,102	1,087	1,046	1,189
Count of Members within 60 miles of 2 OB/GYNs	90,247	76,476	16,464	183,187
Percentage of Members within 60 miles of 2 OB/GYNs	100%	100%	100%	100%

** Individual providers enrolled in multiple health programs are counted a single time in the "All Programs" provider count.*
*** Includes out-of-state providers.*

Provider Network Accessibility by County

Population density influences provider network accessibility. **Table C-9** and **Table C-10** are an assessment of the MCE's reporting of its provider network, specifically PMP and OB/GYN providers. MCEs are contractually required to annually submit to the state a **Report 0902 Count of Enrolled Providers** for each program they manage. The MCE's 0902 reports were compared to the detailed provider listings submitted for the provider network adequacy assessment. The assessment comprises two tables, one for each program managed by each MCE. Counts of providers are presented by county.

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

Table C-9. Anthem HHW - Count of Providers by Provider Network Category and County

County	PMP			OB/GYN			Total		
	MCE Report 0902	MSLC Calculated	Over (Under) Reported	MCE Report 0902	MSLC Calculated	Over (Under) Reported	MCE Report 0902	MSLC Calculated	Over (Under) Reported
All Counties	5,029	3,938	1,091	1,014	855	159	6,043	4,793	1,250
Adams	21	19	2	1	1	-	22	20	2
Allen	222	190	32	62	41	21	284	231	53
Bartholomew	59	44	15	10	7	3	69	51	18
Benton	-	-	-	-	-	-	-	-	-
Blackford	7	10	(3)	-	-	-	7	10	(3)
Boone	43	39	4	6	1	5	49	40	9
Brown	3	1	2	-	-	-	3	1	2
Carroll	20	8	12	1	-	1	21	8	13
Cass	39	22	17	1	1	-	40	23	17

Table C-9. Anthem HHW - Count of Providers by Provider Network Category and County

County	PMP			OB/GYN			Total		
	MCE Report 0902	MSLC Calculated	Over (Under) Reported	MCE Report 0902	MSLC Calculated	Over (Under) Reported	MCE Report 0902	MSLC Calculated	Over (Under) Reported
Clark	123	59	64	9	4	5	132	63	69
Clay	20	16	4	1	-	1	21	16	5
Clinton	8	6	2	4	1	3	12	7	5
Crawford	12	7	5	-	-	-	12	7	5
Daviess	22	17	5	3	1	2	25	18	7
Dearborn	43	30	13	4	8	(4)	47	38	9
Decatur	21	25	(4)	4	4	-	25	29	(4)
Dekalb	14	9	5	3	1	2	17	10	7
Delaware	86	69	17	11	8	3	97	77	20
Dubois	21	13	8	6	6	-	27	19	8
Elkhart	52	62	(10)	23	21	2	75	83	(8)
Fayette	14	5	9	-	2	(2)	14	7	7
Floyd	45	33	12	7	1	6	52	34	18
Fountain	8	7	1	-	-	-	8	7	1
Franklin	18	6	12	4	3	1	22	9	13
Fulton	14	11	3	6	5	1	20	16	4
Gibson	26	21	5	2	2	-	28	23	5
Grant	35	35	-	5	7	(2)	40	42	(2)
Greene	26	24	2	3	3	-	29	27	2
Hamilton	237	148	89	82	66	16	319	214	105

Table C-9. Anthem HHW - Count of Providers by Provider Network Category and County

County	PMP			OB/GYN			Total		
	MCE Report 0902	MSLC Calculated	Over (Under) Reported	MCE Report 0902	MSLC Calculated	Over (Under) Reported	MCE Report 0902	MSLC Calculated	Over (Under) Reported
Hancock	56	31	25	6	7	(1)	62	38	24
Harrison	34	22	12	1	-	1	35	22	13
Hendricks	114	57	57	33	12	21	147	69	78
Henry	50	46	4	8	-	8	58	46	12
Howard	64	60	4	10	11	(1)	74	71	3
Huntington	12	16	(4)	2	2	-	14	18	(4)
Jackson	23	27	(4)	6	6	-	29	33	(4)
Jasper	14	14	-	-	4	(4)	14	18	(4)
Jay	15	14	1	1	2	(1)	16	16	-
Jefferson	31	24	7	4	5	(1)	35	29	6
Jennings	15	16	(1)	-	2	(2)	15	18	(3)
Johnson	131	87	44	14	15	(1)	145	102	43
Knox	33	30	3	5	8	(3)	38	38	-
Kosciusko	27	20	7	6	4	2	33	24	9
Lagrange	8	3	5	2	2	-	10	5	5
Lake	369	287	82	68	55	13	437	342	95
LaPorte	79	70	9	7	9	(2)	86	79	7
Lawrence	45	27	18	2	2	-	47	29	18
Madison	92	88	4	18	17	1	110	105	5
Marion	677	500	177	160	151	9	837	651	186

Table C-9. Anthem HHW - Count of Providers by Provider Network Category and County

County	PMP			OB/GYN			Total		
	MCE Report 0902	MSLC Calculated	Over (Under) Reported	MCE Report 0902	MSLC Calculated	Over (Under) Reported	MCE Report 0902	MSLC Calculated	Over (Under) Reported
Marshall	30	31	(1)	4	4	-	34	35	(1)
Martin	2	4	(2)	-	-	-	2	4	(2)
Miami	13	21	(8)	3	4	(1)	16	25	(9)
Monroe	71	88	(17)	17	12	5	88	100	(12)
Montgomery	64	25	39	8	6	2	72	31	41
Morgan	30	24	6	6	13	(7)	36	37	(1)
Newton	5	6	(1)	-	-	-	5	6	(1)
Noble	12	9	3	2	2	-	14	11	3
Ohio	3	3	-	-	-	-	3	3	-
Orange	19	13	6	8	8	-	27	21	6
Owen	11	9	2	-	1	(1)	11	10	1
Parke	15	31	(16)	-	-	-	15	31	(16)
Perry	18	11	7	1	1	-	19	12	7
Pike	9	9	-	-	-	-	9	9	-
Porter	86	60	26	9	5	4	95	65	30
Posey	7	7	-	-	-	-	7	7	-
Pulaski	10	11	(1)	-	-	-	10	11	(1)
Putnam	36	31	5	-	2	(2)	36	33	3
Randolph	16	18	(2)	1	2	(1)	17	20	(3)
Ripley	21	31	(10)	-	1	(1)	21	32	(11)

Table C-9. Anthem HHW - Count of Providers by Provider Network Category and County

County	PMP			OB/GYN			Total		
	MCE Report 0902	MSLC Calculated	Over (Under) Reported	MCE Report 0902	MSLC Calculated	Over (Under) Reported	MCE Report 0902	MSLC Calculated	Over (Under) Reported
Rush	17	19	(2)	-	1	(1)	17	20	(3)
St. Joseph	127	17	110	37	3	34	164	20	144
Scott	15	7	8	1	2	(1)	16	9	7
Shelby	45	10	35	2	-	2	47	10	37
Spencer	11	111	(100)	-	35	(35)	11	146	(135)
Starke	14	10	4	-	-	-	14	10	4
Steuben	16	14	2	3	3	-	19	17	2
Sullivan	8	5	3	1	2	(1)	9	7	2
Switzerland	2	1	1	-	-	-	2	1	1
Tippecanoe	67	58	9	13	19	(6)	80	77	3
Tipton	5	5	-	-	-	-	5	5	-
Union	2	3	(1)	-	-	-	2	3	(1)
Vanderburgh	154	121	33	18	16	2	172	137	35
Vermillion	5	12	(7)	-	-	-	5	12	(7)
Vigo	85	74	11	13	18	(5)	98	92	6
Wabash	16	17	(1)	3	3	-	19	20	(1)
Warren	1	1	-	-	-	-	1	1	-
Warrick	61	58	3	32	15	17	93	73	20
Washington	19	22	(3)	1	2	(1)	20	24	(4)
Wayne	52	43	9	5	1	4	57	44	13

Table C-9. Anthem HHW - Count of Providers by Provider Network Category and County

County	PMP			OB/GYN			Total		
	MCE Report 0902	MSLC Calculated	Over (Under) Reported	MCE Report 0902	MSLC Calculated	Over (Under) Reported	MCE Report 0902	MSLC Calculated	Over (Under) Reported
Wells	16	13	3	2	2	-	18	15	3
White	6	18	(12)	2	-	2	8	18	(10)
Whitley	15	7	8	2	1	1	17	8	9
Out of State	644	475	169	209	163	46	853	638	215

Table C-10. Anthem Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of Anthem Members	Anthem Provider-to-Member Ratio
Region 1 – North		**129,376**	**1:80**
DeKalb	Rural	2,600	1:68
Elkhart	Urban	10,057	1:54
Fulton	Rural	1,650	1:55
Jasper	Rural	2,505	1:76
Kosciusko	Rural	3,901	1:87
LaGrange	Rural	1,174	1:69
Lake	Urban	50,964	1:78
LaPorte	Urban	10,933	1:75
Marshall	Rural	3,446	1:35
Newton	Rural	1,046	1:52

Table C-10. Anthem Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of Anthem Members	Anthem Provider-to-Member Ratio
Noble	Rural	2,098	1:57
Porter	Urban	12,842	1:54
Pulaski	Rural	914	1:42
St. Joseph	Urban	19,901	1:52
Starke	Rural	2,393	1:53
Steuben	Rural	1,632	1:78
Whitley	Urban	1,320	1:29
Region 2 – North Central		**101,514**	**1:85**
Adams	Rural	1,514	1:61
Allen	Urban	30,997	1:111
Benton	Rural	442	There are no Anthem PMPs in this county
Blackford	Rural	954	1:64
Carroll	Rural	923	1:31
Cass	Rural	2,389	1:50
Clinton	Rural	1,676	1:168
Delaware	Urban	7,887	1:55
Fountain	Rural	946	1:95
Grant	Rural	6,563	1:104
Howard	Urban	6,217	1:67
Huntington	Rural	1,926	1:36
Jay	Rural	1,553	1:52

Table C-10. Anthem Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of Anthem Members	Anthem Provider-to-Member Ratio
Madison	Urban	16,078	1:102
Miami	Rural	2,399	1:55
Montgomery	Rural	2,665	1:27
Randolph	Rural	1,501	1:42
Tippecanoe	Urban	9,180	1:103
Tipton	Rural	866	1:96
Wabash	Rural	1,733	1:40
Warren	Rural	375	1:25
Wells	Rural	1,642	1:39
White	Rural	1,088	1:32
Region 3 – Central		**149,346**	**1:94**
Boone	Urban	2,236	1:25
Hamilton	Urban	10,201	1:28
Hendricks	Urban	7,131	1:35
Johnson	Urban	13,501	1:47
Marion	Urban	110,325	1:112
Morgan	Urban	5,952	1:49
Region 4 – Southwest		**76,980**	**1:67**
Clay	Urban	2,079	1:55
Crawford	Rural	1,033	1:43
Daviess	Rural	2,821	1:36
Dubois	Rural	1,650	1:43

Table C-10. Anthem Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of Anthem Members	Anthem Provider-to-Member Ratio
Gibson	Rural	3,123	1:65
Greene	Rural	3,628	1:71
Knox	Rural	2,929	1:73
Lawrence	Rural	4,584	1:52
Martin	Rural	837	1:64
Orange	Rural	1,322	1:25
Owen	Rural	2,217	1:148
Parke	Rural	975	1:13
Perry	Rural	1,900	1:76
Pike	Rural	1,197	1:100
Posey	Urban	1,868	1:267
Putnam	Rural	2,584	1:42
Spencer	Rural	1,484	1:93
Sullivan	Rural	1,721	1:75
Vanderburgh	Urban	24,291	1:93
Vermillion	Rural	1,073	1:14
Vigo	Urban	8,362	1:55
Warrick	Urban	5,302	1:40
Region 5 – Southeast		**77,362**	**1:68**
Bartholomew	Urban	3,662	1:43
Brown	Rural	1,057	1:211
Clark	Urban	8,664	1:54

Table C-10. Anthem Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of Anthem Members	Anthem Provider-to-Member Ratio
Dearborn	Urban	2,145	1:47
Decatur	Rural	1,785	1:41
Fayette	Rural	2,594	1:96
Floyd	Urban	5,855	1:76
Franklin	Rural	1,466	1:42
Hancock	Urban	5,974	1:60
Harrison	Urban	4,030	1:72
Henry	Rural	4,189	1:48
Jackson	Rural	3,670	1:53
Jefferson	Rural	2,299	1:77
Jennings	Rural	2,138	1:102
Monroe	Urban	9,681	1:79
Ohio	Rural	244	1:81
Ripley	Rural	1,995	1:46
Rush	Rural	1,744	1:44
Scott	Rural	2,606	1:70
Shelby	Urban	3,372	1:42
Switzerland	Rural	669	1:335
Union	Rural	436	1:26
Washington	Rural	2,791	1:48
Wayne	Rural	4,296	1:44
All Regions		**534,578**	**1:75**

** Regions are Indiana Health Coverage Program's Provider Relations Regions. https://www.in.gov/medicaid/providers/contact-information/provider-relations-consultants/*
*** Includes metropolitan counties designated as eligible for Rural Health funding by the FORHP.*

Table C-11. CareSource Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of CareSource Members	CareSource Provider-to-Member Ratio
Region 1 – North		**22,024**	**1:49**
DeKalb	Rural	626	1:5
Elkhart	Urban	1,761	1:220
Fulton	Rural	199	1:33
Jasper	Rural	460	1:29
Kosciusko	Rural	1,250	1:38
LaGrange	Rural	340	1:24
Lake	Urban	8,064	1:58
LaPorte	Urban	1,771	1:48
Marshall	Rural	465	1:93
Newton	Rural	232	1:116
Noble	Rural	698	1:6
Porter	Urban	1,808	1:48
Pulaski	Rural	200	1:50
St. Joseph	Urban	2,774	1:121
Starke	Rural	393	1:39
Steuben	Rural	580	1:53
Whitley	Urban	403	1:3
Region 2 – North Central		**26,592**	**1:35**
Adams	Rural	474	1:53
Allen	Urban	7,718	1:27

Table C-11. CareSource Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of CareSource Members	CareSource Provider-to-Member Ratio
Benton	Rural	167	1:14
Blackford	Rural	225	1:38
Carroll	Rural	367	1:33
Cass	Rural	737	1:67
Clinton	Rural	721	1:28
Delaware	Urban	1,862	1:29
Fountain	Rural	302	CareSource has no providers enrolled in this county
Grant	Rural	1,346	1:96
Howard	Urban	1,734	1:28
Huntington	Rural	725	1:5
Jay	Rural	399	1:36
Madison	Urban	2,861	1:18
Miami	Rural	755	1:38
Montgomery	Rural	661	1:18
Randolph	Rural	584	1:83
Tippecanoe	Urban	3,137	1:41
Tipton	Rural	190	1:38
Wabash	Rural	569	1:14
Warren	Rural	113	1:13
Wells	Rural	461	1:38
White	Rural	484	1:17

Table C-11. CareSource Provider-to-Member Ratio by County

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

Table C-11. CareSource Provider-to-Member Ratio by County

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

Table C-11. CareSource Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of CareSource Members	CareSource Provider-to-Member Ratio
Jackson	Rural	784	1:30
Jefferson	Rural	368	1:184
Jennings	Rural	481	1:48
Monroe	Urban	1,880	1:38
Ohio	Rural	79	1:79
Ripley	Rural	437	1:24
Rush	Rural	319	1:53
Scott	Rural	526	1:40
Shelby	Urban	968	1:121
Switzerland	Rural	151	1:151
Union	Rural	158	1:158
Washington	Rural	581	1:53
Wayne	Rural	1,955	1:58
All Regions		**111,858**	**1:40**

** Regions are Indiana Health Coverage Program's Provider Relations Regions. https://www.in.gov/medicaid/providers/contact-information/provider-relations-consultants/*
*** Includes metropolitan counties designated as eligible for Rural Health funding by the FORHP.*

Table C-12. MDwise Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of MDwise Members	MDwise Provider-to-Member Ratio
Region 1 – North		**78,915**	**1:23**
DeKalb	Rural	2,456	1:12

Table C-12. MDwise Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of MDwise Members	MDwise Provider-to-Member Ratio
Elkhart	Urban	3,501	1:10
Fulton	Rural	1,210	1:23
Jasper	Rural	1,830	1:10
Kosciusko	Rural	3,608	1:13
LaGrange	Rural	1,252	1:13
Lake	Urban	30,973	1:27
LaPorte	Urban	8,281	1:21
Marshall	Rural	1,745	1:17
Newton	Rural	789	1:72
Noble	Rural	3,406	1:16
Porter	Urban	5,227	1:11
Pulaski	Rural	658	1:20
St. Joseph	Urban	8,661	1:9
Starke	Rural	1,625	1:11
Steuben	Rural	1,787	1:11
Whitley	Urban	1,906	1:8
Region 2 – North Central		**93,867**	**1:21**
Adams	Rural	1,113	1:14
Allen	Urban	28,836	1:14
Benton	Rural	827	1:17
Blackford	Rural	1,159	1:11
Carroll	Rural	1,267	1:19

Table C-12. MDwise Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of MDwise Members	MDwise Provider-to-Member Ratio
Cass	Rural	4,110	1:38
Clinton	Rural	3,945	1:17
Delaware	Urban	9,427	1:14
Fountain	Rural	1,280	1:67
Grant	Rural	2,817	1:16
Howard	Urban	6,680	1:20
Huntington	Rural	2,700	1:10
Jay	Rural	1,253	1:10
Madison	Urban	4,887	1:6
Miami	Rural	3,050	1:33
Montgomery	Rural	1,623	1:9
Randolph	Rural	2,425	1:36
Tippecanoe	Urban	9,984	1:14
Tipton	Rural	520	1:3
Wabash	Rural	2,206	1:10
Warren	Rural	592	1:8
Wells	Rural	1,439	1:11
White	Rural	1,727	1:9
Region 3 – Central		**120,389**	**1:21**
Boone	Urban	1,696	1:6
Hamilton	Urban	7,444	1:3
Hendricks	Urban	5,623	1:4

Table C-12. MDwise Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of MDwise Members	MDwise Provider-to-Member Ratio
Johnson	Urban	5,013	1:6
Marion	Urban	97,672	1:21
Morgan	Urban	2,941	1:9
Region 4 – Southwest		**40,000**	**1:17**
Clay	Urban	2,854	1:44
Crawford	Rural	262	1:12
Daviess	Rural	1,682	1:13
Dubois	Rural	684	1:4
Gibson	Rural	926	1:14
Greene	Rural	1,590	1:32
Knox	Rural	997	1:4
Lawrence	Rural	2,148	1:8
Martin	Rural	324	1:41
Orange	Rural	613	1:5
Owen	Rural	957	1:46
Parke	Rural	1,495	1:29
Perry	Rural	473	1:12
Pike	Rural	273	1:23
Posey	Urban	722	1:11
Putnam	Rural	1,122	1:10
Spencer	Rural	374	1:8
Sullivan	Rural	1,834	1:56

Table C-12. MDwise Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of MDwise Members	MDwise Provider-to-Member Ratio
Vanderburgh	Urban	4,437	1:5
Vermillion	Rural	1,857	1:12
Vigo	Urban	13,528	1:21
Warrick	Urban	848	1:2
Region 5 – Southeast		**53,199**	**1:17**
Bartholomew	Urban	4,147	1:8
Brown	Rural	545	1:68
Clark	Urban	4,787	1:14
Dearborn	Urban	3,749	1:24
Decatur	Rural	1,951	1:10
Fayette	Rural	2,448	1:24
Floyd	Urban	2,972	1:7
Franklin	Rural	1,323	1:22
Hancock	Urban	1,656	1:7
Harrison	Urban	1,018	1:9
Henry	Rural	4,221	1:21
Jackson	Rural	1,922	1:10
Jefferson	Rural	1,151	1:13
Jennings	Rural	2,121	1:23
Monroe	Urban	3,578	1:4
Ohio	Rural	472	1:118
Ripley	Rural	1,709	1:14

Table C-12. MDwise Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of MDwise Members	MDwise Provider-to-Member Ratio
Rush	Rural	782	1:9
Scott	Rural	1,711	1:20
Shelby	Urban	1,595	1:6
Switzerland	Rural	675	1:16
Union	Rural	418	1:38
Washington	Rural	1,240	1:14
Wayne	Rural	7,008	1:13
All Regions		**386,370**	**1:22**

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

Table C-13. MHS Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of MHS Members	MHS Provider-to-Member Ratio
Region 1 – North		**96,985**	**1:112**
DeKalb	Rural	1,461	1:70
Elkhart	Urban	24,259	1:240
Fulton	Rural	1,303	1:130
Jasper	Rural	1,389	1:99
Kosciusko	Rural	4,075	1:120
LaGrange	Rural	917	1:71
Lake	Urban	22,939	1:88

Table C-13. MHS Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of MHS Members	MHS Provider-to-Member Ratio
LaPorte	Urban	3,884	1:60
Marshall	Rural	2,097	1:70
Newton	Rural	661	1:110
Noble	Rural	1,707	1:122
Porter	Urban	4,480	1:54
Pulaski	Rural	744	1:74
St. Joseph	Urban	23,641	1:129
Starke	Rural	1,170	1:98
Steuben	Rural	1,693	1:113
Whitley	Urban	565	1:31
Region 2 – North Central		**59,244**	**1:76**
Adams	Rural	1,181	1:91
Allen	Urban	13,811	1:75
Benton	Rural	387	1:194
Blackford	Rural	535	1:67
Carroll	Rural	591	1:54
Cass	Rural	1,423	1:55
Clinton	Rural	1,081	1:98
Delaware	Urban	5,721	1:66
Fountain	Rural	480	1:160
Grant	Rural	5,907	1:174
Howard	Urban	4,202	1:63

Table C-13. MHS Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of MHS Members	MHS Provider-to-Member Ratio
Huntington	Rural	1,256	1:90
Jay	Rural	844	1:77
Madison	Urban	7,292	1:74
Miami	Rural	1,568	1:92
Montgomery	Rural	1,871	1:67
Randolph	Rural	1,034	1:80
Tippecanoe	Urban	6,035	1:57
Tipton	Rural	567	1:63
Wabash	Rural	1,216	1:68
Warren	Rural	226	1:45
Wells	Rural	749	1:50
White	Rural	1,267	1:75
Region 3 – Central		**64,112**	**1:54**
Boone	Urban	1,787	1:27
Hamilton	Urban	6,520	1:30
Hendricks	Urban	4,669	1:50
Johnson	Urban	5,117	1:39
Marion	Urban	43,657	1:65
Morgan	Urban	2,362	1:62
Region 4 – Southwest		**26,749**	**1:56**
Clay	Urban	675	1:68
Crawford	Rural	725	1:363

Table C-13. MHS Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of MHS Members	MHS Provider-to-Member Ratio
Daviess	Rural	985	1:58
Dubois	Rural	1,993	1:100
Gibson	Rural	568	1:32
Greene	Rural	855	1:39
Knox	Rural	3,327	1:145
Lawrence	Rural	1,662	1:57
Martin	Rural	496	1:124
Orange	Rural	2,367	1:169
Owen	Rural	951	1:86
Parke	Rural	399	1:44
Perry	Rural	447	1:37
Pike	Rural	435	1:87
Posey	Urban	528	1:59
Putnam	Rural	1,574	1:63
Spencer	Rural	649	1:46
Sullivan	Rural	373	1:47
Vanderburgh	Urban	4,047	1:41
Vermillion	Rural	320	1:32
Vigo	Urban	2,224	1:28
Warrick	Urban	879	1:22
Region 5 – Southeast		**42,081**	**1:77**
Bartholomew	Urban	4,733	1:89

Table C-13. MHS Provider-to-Member Ratio by County

Region* / County	Rural** / Urban	Count of MHS Members	MHS Provider-to-Member Ratio
Brown	Rural	666	1:333
Clark	Urban	6,218	1:60
Dearborn	Urban	762	1:32
Decatur	Rural	759	1:69
Fayette	Rural	951	1:56
Floyd	Urban	2,296	1:64
Franklin	Rural	434	1:87
Hancock	Urban	1,085	1:49
Harrison	Urban	999	1:45
Henry	Rural	1,321	1:55
Jackson	Rural	2,279	1:253
Jefferson	Rural	2,890	1:126
Jennings	Rural	1,593	1:145
Monroe	Urban	3,301	1:51
Ohio	Rural	15	1:29
Ripley	Rural	746	1:41
Rush	Rural	622	1:62
Scott	Rural	1,383	1:99
Shelby	Urban	3,300	1:165
Switzerland	Rural	604	1:302
Union	Rural	179	1:179
Washington	Rural	1,103	1:79

Table C-13. MHS Provider-to-Member Ratio by County			
Region* / County	**Rural** / Urban**	**Count of MHS Members**	**MHS Provider-to-Member Ratio**
Wayne	Rural	3,742	1:94
All Regions		**288,901**	**1:71**

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

PMP Access by Member Demographics

Table C-14. Anthem Member Demographics				
Demographics			**Count of Members**	
Age	**Gender**	**Rural* /Urban**	**With Access**	**Without Access**
Pediatric (18 years and younger)	Male	Rural	29,229	0
Adult (19–64 years)	Male	Rural	26,793	0
65+ years	Male	Rural	287	0
Pediatric (18 years and younger)	Female	Rural	27,455	0
Adult (19–64 years)	Female	Rural	39,368	0
65+ years	Female	Rural	439	0
Pediatric (18 years and younger)	Male	Urban	101,948	0
Adult (19–64 years)	Male	Urban	82,340	0
65+ years	Male	Urban	1,267	0
Pediatric (18 years and younger)	Female	Urban	96,442	0
Adult (19–64 years)	Female	Urban	126,795	0
65+ years	Female	Urban	2,215	0

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

Table C-15. CareSource Member Demographics

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

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

Table C-16. MDwise Member Demographics

Demographics			Count of Members	
Age	Gender	Rural*/Urban	With Access	Without Access
Pediatric (18 years and younger)	Male	Rural	28,205	0
Adult (19–64 years)	Male	Rural	16,770	0
65+ years	Male	Rural	57	0
Pediatric (18 years and younger)	Female	Rural	27,315	0
Adult (19–64 years)	Female	Rural	29,306	0

Table C-16. MDwise Member Demographics

Demographics			Count of Members	
Age	Gender	Rural*/Urban	With Access	Without Access
65+ years	Female	Rural	73	0
Unknown	Unknown	Rural	1	0
Pediatric (18 years and younger)	Male	Urban	81,240	0
Adult (19–64 years)	Male	Urban	44,264	0
65+ years	Male	Urban	98	0
Pediatric (18 years and younger)	Female	Urban	80,153	0
Adult (19–64 years)	Female	Urban	78,726	0
65+ years	Female	Urban	159	0
Unknown	Unknown	Rural	3	0

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

Table C-17. MHS Member Demographics

Demographics			Count of Members	
Age	Gender	Rural*/Urban	With Access	Without Access
Pediatric (18 years and younger)	Male	Rural	22,175	0
Adult (19–64 years)	Male	Rural	12,642	0
65+ years	Male	Rural	187	0
Pediatric (18 years and younger)	Female	Rural	20,642	0
Adult (19–64 years)	Female	Rural	21,001	0
65+ years	Female	Rural	266	0
Pediatric (18 years and younger)	Male	Urban	61,580	0
Adult (19–64 years)	Male	Urban	33,452	0
65+ years	Male	Urban	730	0

Table C-17. MHS Member Demographics

Demographics			Count of Members	
Age	Gender	Rural*/Urban	With Access	Without Access
Pediatric (18 years and younger)	Female	Urban	58,768	0
Adult (19–64 years)	Female	Urban	56,197	0
65+ years	Female	Urban	1,261	0

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