March 2026

2025 Annual

EQR Technical Report

Indiana Family and Social Services

Office of Medicaid Policy and Planning

Final

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Acknowledgements, Acronyms, and Initialisms[1]

AAP .... Adults' Access to Preventive/Ambulatory Health Services
ABA .... Applied Behavior Analysis
ADA .... Americans with Disabilities Act
AHU .... Acute Hospital Utilization
AMR .... Asthma Medication Ratio
ANA .... Annual Network Adequacy
Anthem .... Blue Cross Blue Shield Anthem, Managed Care Entity
AOD .... Alcohol and Other Drug Abuse/Dependence
AON .... Area of Noncompliance
APM-E .... Metabolic Monitoring for Children and Adolescents on Anti-Psychotics
Axon .... Axon Advisors, Limited Liability Company
BPD .... Blood Pressure Control for Patients with Diabetes
BR .... Biased Rate
CA .... Compliance Assessment
CAHPS® .... Consumer Assessment of Healthcare Providers and Systems
CAP .... Corrective Action Plan
CareSource .... CareSource Indiana, Managed Care Entity
CBP .... Controlling Blood Pressure
CDF .... Screening for Depression and Follow-up
CFR .... Code of Federal Regulations
CHIP .... Children's Health Insurance Program
CHL .... Community Health Liason
CHW .... Community Health Worker
CIS-E .... Childhood and Immunization Status
CM .... Case Management
CMR .... Comprehensive Medication Review
CMS .... Centers for Medicare & Medicaid Services
CY .... Calendar Year
DME .... Durable Medical Equipment
DSF-E....... Depression Screening and Follow-up for Adolescents and Adults
DSMES .... Diabetes Self-Management Education and Support
EDU .... Emergency Department Utilization
EED .... Eye Exam for Patients with Diabetes
EHR .... Electronic Health Record
EQR .... External Quality Review
EQRO .... External Quality Review Organization
ER .... Emergency Room
ESRD .... End-Stage Renal Disease
ESRI ArcGIS® .... Environmental Systems Research Institute, Inc. ArcGIS™
FSSA .... Indiana Family and Social Services Administration
FUA Follow-Up After Emergency Department Visit for Substance Use
FUH .... Follow-Up After Hospitalization for Mental Illness
FUM.. Follow-Up After Emergency Department Visit for Mental Illness
GMI .... Glucose Management Indicator
GSD .... Glycemic Status Assessment for Patients with Diabetes
Hb .... Hemoglobin
HBD .... Hemoglobin A1c Control <8 for Patients with Diabetes
HCC .... Hoosier Care Connect
HEDIS® .... Healthcare Effectiveness Data and Information Set, a registered trademark of the NCQA
HHS .... Department of Health and Human Services
HHW .... Hoosier Healthwise

[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.*

HIE .... Health Information Exchange
HIP .... Healthy Indiana Plan
HMO .... Health Maintenance Organization
HNS .... Health Needs Screening
ID .... Identification
IDSS .... Interactive Data Submission System
IET .... Initiation and Engagement of Alcohol and Other Drug
IHCP .... Indiana Health Coverage Programs
IMA-E .... Immunizations for Adolescents
IMD .... Institutions for Mental Disease
ISCA/ISCAT .... Information Systems Capability Assessment Tool
KED .... Kidney Health Evaluation for Patients with Diabetes
LLC .... Limited Liability Company
MCE .... Managed Care Entity
MHS .... Managed Health Services, Managed Care Entity
MLTSS .... Managed Long-Term Services and Supports
MMIS .... Medicaid Management Information System
mPulse .... An UnitedHealthcare Centralized Vendor Program
MSLC .... Myers & Stauffer Limited Liability Company
MSR .... Minimum Submission Review
MTM .... Medication Therapy Management Program
MY .... Measurement Year
NA .... Not Applicable
NB .... No Benefit
NCQA .... National Committee for Quality Assurance
NQ .... Not Required
NR .... Not Reported
OB/GYN .... Obstetrician/Gynecologist
ODW .... Operations Data Warehouse
OED .... Oral Evaluation, Dental Services
OMPP .... Office of Medicaid Policy and Planning
P4O .... Payment-for-Outcomes
P&P .... Policy and Procedure
PCHM .... Patient-Centered Medical Home
PCP .... Primary Care Provider/Physician
PCR .... Plan All-Cause Readmissions
PDF .... Portable Document Format
PDSA .... Plan-Do-Study-Act
PHQ .... Patient Health Questionnaire
PIP .... Performance Improvement Project
PIRT .... Preeclampsia Interdisciplinary Review Team
PMP .... Primary Medical Provider
PMV .... Performance Measure Validation
PND-E .... Prenatal Depression Screening and Follow-Up
PPC .... Timeliness of Prenatal and Postpartum Care
PPD-E .... Postpartum Depression Screening and Follow-Up
QI .... Quality Improvement
Qsource® .... EQRO, a registered trademark
RFI .... Request for Information
Roadmap .... Record of Administration, Data Management and Processes
SAA .... Adherence to Antipsychotic Medications for Individuals with Schizophrenia
SDOH .... Social Determinants of Health
SMC .... Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia
SMD .... Diabetes Monitoring for Persons with Diabetes and Schizophrenia
SMI .... Serious Mental Illness
SMS .... Short Message Service
SQL .... Structured Query Language
SSD .... Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications
SSFB .... Start Smart for Baby
SSI .... Supplemental Security Income

SUD .... Substance Use Disorder
TBD .... To be Determined
TMR...Targeted Medication Review
UHC................................. UnitedHealthcare, a Managed Care Entity
UM..Utilization Management
VBP .... Value-Based Payment
VRI ....A ModivCare® Service
WCV .... Child and Adolescent Well-Care Visits
W30 ....Well-Child Visits in the First 30 Months of Life

Overview

In accordance with Title 42 *Code of Federal Regulations* (CFR) § 438.364, Qsource has produced this *2024 Annual External Quality Review Organization (EQRO) Technical Report* to summarize the quality, timeliness, and accessibility of care furnished to enrollees in the Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) program by the Managed Care Entities (MCEs) and their respective Indiana Health Coverage Plans (IHCPs). Indiana's MCEs include Blue Cross Blue Shield Anthem (hereafter referred to as Anthem), CareSource Indiana (hereafter referred to as CareSource), MDwise, Managed Health Services (hereafter referred to as MHS), and UnitedHealthcare (hereafter referred to as UHC).

OMPP contracted with Qsource to conduct External Quality Review (EQR) activities and ensure that the results of those activities are reviewed to perform an external, independent assessment and produce an annual report. Qsource serves as OMPP's EQRO and prepared this *2025 Annual EQRO Technical Report* to document the MCEs' IHCPs' performance in providing services to enrollees, identify areas for improvement, and recommend interventions to improve the process and outcomes of care.

This section provides a brief history of OMPP, the population(s) served by each IHCP, enrollee data for each MCE, OMPP's quality improvement initiative descriptions with calendar year (CY) 2024 results, the mandatory EQR activities conducted by Qsource in 2025 (including targeted quality objectives), guidelines provided by the Centers for Medicare & Medicaid Services (CMS) for reporting EQR activities, and the intended utilization for this report.

OMPP Background

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

- **The Healthy Indiana Plan** (HIP) was created in January 2008 under a separate Section 1115 waiver authority. The HIP 2.0 model is a health insurance program that offsets medical, vision, and dental service costs for adults between the ages of 19 and 64 who meet designated income limitations. The HIP program provides qualified adults access to comprehensive benefits without high-cost premiums or expensive copays. HIP is responsible for supplying preventive health care and services to thousands of Indiana residents while encouraging appropriate Emergency Room (ER) usage.
- **Hoosier Care Connect** (HCC) provides health coverage for individuals who require similar services but do not qualify for Medicare; these populations include those aged 65 and over, blind, disabled, and/or those receiving Supplemental Security Income (SSI). The program also provides health

coverage for many of Indiana's foster children. The program was implemented in April 2015, under a 1915(b)-waiver authority. Members enrolled in the HCC program receive all Indiana Medicaid-covered benefits in addition to individualized care coordination services based on assessed member needs. The care of Hoosier Care Connect members is managed through a contracted network of primary medical providers (PMPs), specialists, and other care providers.

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

Five MCEs are contracted with the state of Indiana:

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

Anthem and MHS service the HHW, HIP, and HCC lines of business for risk-based managed care, while CareSource and MDwise service the HHW and HIP lines of business. UHC services only the HCC line of business. As of January 1, 2026, MDwise will no longer service the HHW and HIP lines of business, after FSSA ended their contract.

Members

According to the FSSA narrative on the monthly Medicaid financial report for December 2024, published in March 2025, Medicaid enrollment across all programs and delivery systems totaled 1,969,829 individuals, as of December 2024, which was 73,068 (3.6%) below the forecasted amount. This is down 42,560 members in comparison to the December 2023 enrollment number of 2,012,389. This is, in part, due to the launch of the Managed Long-Term Services and Supports (MLTSS) program Indiana PathWays for Aging on July 1, 2024, which shifted enrollment of 116,785 individuals from Medicaid fee-for-service and Hoosier Care Connect to the new Indiana PathWays for Aging managed care program.

Table 1 presents enrollment for 2024 by month.

Table 1. Total MCE and IHCP Members by Month												
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Healthy Indiana Plan												
Anthem	338,361	334,950	332,630	328,783	325,224	322,627	325,158	324,149	323,330	321,815	316,818	316,787
CareSource	81,316	81,183	81,314	80,926	90,563	80,480	81,677	81,878	82,370	82,699	81,810	82,826
MDwise	161,205	160,187	159,569	158,434	157,019	156,131	157,073	156,571	156,166	155,377	153,254	153,736
MHS	136,705	135,924	135,586	134,754	133,625	133,023	134,455	134,158	134,091	133,865	132,330	133,015
Total	**717,587**	**712,244**	**709,099**	**702,897**	**706,431**	**692,261**	**698,363**	**696,756**	**695,957**	**693,756**	**684,212**	**686,364**
Hoosier Healthwise												
Anthem	314,359	313,062	313,191	312,729	310,755	308,654	309,136	310,458	311,516	309,683	309,029	309,623
CareSource	78,793	78,580	78,792	78,955	78,732	78,490	78,780	79,227	79,722	79,517	79,681	80,254
MDwise	206,883	205,142	204,159	202,875	200,701	198,754	198,371	198,612	198,978	197,745	197,090	197,010
MHS	180,903	179,871	179,833	179,310	177,824	175,925	175,646	176,153	176,741	175,802	175,590	176,088
Total	**780,938**	**776,655**	**775,975**	**773,869**	**768,012**	**761,823**	**761,933**	**764,450**	**766,957**	**762,747**	**761,390**	**762,975**
Hoosier Care Connect												
Anthem	56,818	56,417	56,228	56,023	55,779	55,359	44,829	45,030	45,367	45,676	45,892	46,031
MHS	32,957	32,875	32,797	32,804	32,688	32,469	27,749	27,836	28,137	28,342	28,440	28,504
UHC	6,353	6,497	6,579	6,686	6,688	6,621	5,584	5,679	5,841	5,931	5,995	6,031
Total	**96,128**	**95,789**	**95,604**	**95,513**	**95,155**	**94,449**	**78,162**	**78,545**	**79,345**	**79,949**	**80,327**	**80,566**

OMPP Quality Strategy Overview

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

In 2024, Indiana outlined specific quality initiatives for the HHW, HIP, and HCC programs for the 2024-2027 time period. The initiatives outline global aims that OMPP has identified that support the objectives for all its programs. The initiatives are at the forefront of planning and implementation of this Quality

Strategy. Ongoing monitoring will provide OMPP with quality-related data for future monitoring and planning. To this end, OMPP established the Five Pillars of Well Being, based on State health initiatives, input from external partners, the review of State and national data, and the needs of the population. These Five Pillars are aligned with the Medicaid Child and Adult Core Sets. These initiatives are listed below.

1. Behavioral Health – Improve health outcomes through preventive care and behavioral health condition management.
    a. Improve use of preventive behavioral health screenings and follow up.
    b. Improve care coordination and follow up for members with mental health and substance use disorders.
2. Maternal/Child Health – Improve the health and wellness of pregnant persons, new mothers, infants, and children.
    a. Improve access to care for infants, children, and adolescents, with a focus on preventive and developmental screenings and well child visits.
    b. Ensure early detection and follow up regarding prenatal and postpartum depression.
3. Oral Health – Improve oral health and prevent oral disease.
    a. Improve access to dental services.
    b. Increase utilization of annual dental visits to improve prevention of oral disease.
4. Chronic Conditions – Improve the health of members with chronic conditions.
    a. Reduce complications for members diagnosed with diabetes.
    b. Reduce emergency room utilization and inpatient readmission for members with chronic disease.
5. Care Coordination – Enhance care and service coordination between care settings.
    a. Deliver person-centered services and supports.
    b. Assure timely access to appropriate services and supports to enable participants to live in their setting of choice.
    c. Increase outpatient provider visits and medication reviews after inpatient admission or transitions between level of care setting.
    d. Reduce inpatient readmissions for physical and behavioral health.

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' and IHCPs' performance and unmet objectives, and opportunities for improvement identified in the external quality review.

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

Tables 2, 3, and 4 present the strategic initiatives for each MCE, with their 2023 and 2024 achievement results against the OMPP-established goals. Where the MCEs display

improvement from Measurement Year (MY) 2023 to MY 2024, the MY 2024 score is accompanied by a green arrow (↑); where the MCE's scores went down, the score is accompanied by a red arrow (↓). If an arrow does not accompany the score, the score did not change, or the comparison is not applicable due to not applicable (NA) measurement. A column indicating whether or not each MY 2024 result met the established goal is addressed under goal attainment of these tables. Please note that Goal 2 of the Five Pillars does not apply to HCC's population.

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
Goal 1: Improve Health Outcomes Through Preventive Care and Behavioral Health Condition Management							
Measure: Follow-Up After Emergency Department Visit for Substance Use (FUA) 7-Day and 30-Day Follow-Up **Domain:** Quality and Access to Care	Healthcare Effectiveness Data and Information Set (HEDIS®) measure using administrative data	Anthem	7-Day: 29.0	7-Day: 17.78	7-Day: 29.09	7-Day: 21.98 ↓	Not Met
			30-Day: 40.0	30-Day: 27.77	30-Day: 40.85	30-Day: 28.02 ↓	Not Met
		CareSource	7-Day: 29.0	7-Day: 17.78	7-Day: 24.64	7-Day: 30.30 ↑	Met
			30-Day: 40.0	30-Day: 27.77	30-Day: 34.78	30-Day: 37.88 ↑	Not Met
		MDwise	7-Day: 29.0	7-Day: 17.78	7-Day: 13.59	7-Day: 15.03 ↑	Not Met
			30-Day: 40.0	30-Day: 27.77	30-Day: 21.04	30-Day: 23.70 ↑	Not Met
		MHS	7-Day: 29.0	7-Day: 17.78	7-Day: 20.60	7-Day: 18.11 ↓	Not Met
			30-Day: 40.0	30-Day: 27.77	30-Day: 33.48	30-Day: 29.13 ↓	Not Met
Measure: Follow-Up After Hospitalization for Mental Illness (FUH) 7-Day and 30-Day Follow-Up **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	7-Day: 38.0	7-Day: 43.44	7-Day: 36.74	7-Day: 52.81 ↑	Met
			30-Day: 56.0	30-Day: 67.47	30-Day: 58.11	30-Day: 74.49 ↑	Met
		CareSource	7-Day: 38.0	7-Day: 43.44	7-Day: 46.89	7-Day: 60.92 ↑	Met
			30-Day: 56.0	30-Day: 67.47	30-Day: 73.08	30-Day: 82.53 ↑	Met
		MDwise	7-Day: 38.0	7-Day: 43.44	7-Day: 39.49	7-Day: 39.49	Met
			30-Day: 56.0	30-Day: 67.47	30-Day: 61.56	30-Day: 60.11 ↓	Met
		MHS	7-Day: 38.0	7-Day: 43.44	7-Day: 41.51	7-Day: 48.19 ↑	Met
			30-Day: 56.0	30-Day: 67.47	30-Day: 67.20	30-Day: 73.17 ↑	Met

Table 2. Hoosier Healthwise Quality Strategy Initiatives							
Measure and Domain	**Methodology**	**MCE**	**Goal**	**Statewide Performance Baseline**	**MY 2023 Results**	**MY 2024 Results**	**Goal Attainment**
Measure: Follow-Up After Emergency Department Visit for Mental Illness (FUM) 7-Day and 30-Day Follow-Up **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	7-Day: 40.0	7-Day: 47.14	7-Day: 40.78	7-Day: 52.61 ↑	Met
			30-Day: 54.0	30-Day: 61.58	30-Day: 53.82	30-Day: 70.21 ↑	Met
		CareSource	7-Day: 40.0	7-Day: 47.14	7-Day: 49.37	7-Day: 61.36 ↑	Met
			30-Day: 54.0	30-Day: 61.58	30-Day: 69.62	30-Day: 75.00 ↑	Met
		MDwise	7-Day: 40.0	7-Day: 47.14	7-Day: 53.23	7-Day: 51.35 ↓	Met
			30-Day: 54.0	30-Day: 61.58	30-Day: 67.99	30-Day: 69.14 ↑	Met
		MHS	7-Day: 40.0	7-Day: 47.14	7-Day: 44.87	7-Day: 51.97 ↑	Met
			30-Day: 54.0	30-Day: 61.58	30-Day: 63.84	30-Day: 70.79 ↑	Met
Measure: Initiation and Engagement of Alcohol and Other Drug (IET) **Domain:** Timely Access to Care	HEDIS® measure using administrative data	Anthem	Total: 43.0	Initiation of AOD - Alcohol Abuse or Dependence (Total) 31.18	42.39	44.54 ↑	Met
				Engagement of AOD - Alcohol Abuse or Dependence (Total) 9.63	20.49	13.45 ↓	Not Met
				Initiation of AOD - Opioid Abuse or Dependence (Total) 55.66	64.72	62.96 ↓	Met
				Engagement of AOD - Opioid Abuse or Dependence (Total) 34.60	46.85	35.80 ↓	Not Met
				Initiation of AOD - Other Drug Abuse or Dependence (Total) 43.70	34.54	49.20 ↑	Met

Table 2. Hoosier Healthwise Quality Strategy Initiatives							
Measure and Domain	**Methodology**	**MCE**	**Goal**	**Statewide Performance Baseline**	**MY 2023 Results**	**MY 2024 Results**	**Goal Attainment**
				Engagement of AOD - Other Drug Abuse or Dependence (Total) 14.21	16.38	15.63 ↓	Not Met
				Initiation of AOD - Total (Total) 41.44	41.87	49.20 ↑	Met
				Engagement of AOD - Total (Total) 14.78	22.57	16.57 ↓	Not Met
		CareSource	Total: 43.0	Initiation of AOD - Alcohol Abuse or Dependence (Total) 31.18	Not Reported	29.03	Not Met
				Engagement of AOD - Alcohol Abuse or Dependence (Total) 9.63	Not Reported	6.45	Not Met
				Initiation of AOD - Opioid Abuse or Dependence (Total) 55.66	Not Reported	100	Met
				Engagement of AOD - Opioid Abuse or Dependence (Total) 34.60	Not Reported	57.14	Met
				Initiation of AOD - Other Drug Abuse or Dependence (Total) 43.70	Not Reported	43.45	Met
				Engagement of AOD - Other Drug Abuse or Dependence (Total) 14.21	Not Reported	14.29	Not Met

Table 2. Hoosier Healthwise Quality Strategy Initiatives							
Measure and Domain	**Methodology**	**MCE**	**Goal**	**Statewide Performance Baseline**	**MY 2023 Results**	**MY 2024 Results**	**Goal Attainment**
				Initiation of AOD - Total (Total) 41.44	53.54	41.35 ↓	Not Met
				Engagement of AOD - Total (Total) 14.78	20.00	13.50 ↓	Not Met
		MDwise	Total: 43.0	Initiation of AOD - Alcohol Abuse or Dependence (Total) 31.18	35.23	35.75 ↑	Not Met
				Engagement of AOD - Alcohol Abuse or Dependence (Total) 9.63	11.08	10.88 ↓	Not Met
				Initiation of AOD - Opioid Abuse or Dependence (Total) 55.66	57.81	71.11 ↑	Met
				Engagement of AOD - Opioid Abuse or Dependence (Total) 34.60	36.72	42.22 ↑	Not Met
				Initiation of AOD - Other Drug Abuse or Dependence (Total) 43.70	45.20	43.69 ↓	Met
				Engagement of AOD - Other Drug Abuse or Dependence (Total) 14.21	14.31	14.16 ↓	Not Met
				Initiation of AOD - Total (Total) 41.44	43.97	43.33 ↓	Met
				Engagement of AOD - Total (Total) 14.78	15.43	14.93 ↓	Not Met

Table 2. Hoosier Healthwise Quality Strategy Initiatives							
Measure and Domain	**Methodology**	**MCE**	**Goal**	**Statewide Performance Baseline**	**MY 2023 Results**	**MY 2024 Results**	**Goal Attainment**
		MHS	Total: 43.0	Initiation of AOD - Alcohol Abuse or Dependence (Total) 31.18	29.43	Not Reported	Not Reported
				Engagement of AOD - Alcohol Abuse or Dependence (Total) 9.63	12.97	Not Reported	Not Reported
				Initiation of AOD - Opioid Abuse or Dependence (Total) 55.66	55.07	Not Reported	Not Reported
				Engagement of AOD - Opioid Abuse or Dependence (Total) 34.60	34.06	Not Reported	Not Reported
				Initiation of AOD - Other Drug Abuse or Dependence (Total) 43.70	36.83	Not Reported	Not Reported
				Engagement of AOD - Other Drug Abuse or Dependence (Total) 14.21	11.72	Not Reported	Not Reported
				Initiation of AOD - Total (Total) 41.44	36.96	43.74 ↑	Met
				Engagement of AOD - Total (Total) 14.78	14.30	16.71 ↑	Not Met
Measure: Adherence to Antipsychotic Medications for	HEDIS® measure using administrative	Anthem	58.82	52.90	56.67	61.54 ↑	Met
		CareSource	58.82	52.90	55.56	100 ↑	Met

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
Individuals with Schizophrenia (SAA) **Domain:** Timely Access to Care	data	MDwise	58.82	52.90	37.14	28.57 ↓	Not Met
		MHS	58.82	52.90	28.57	22.22 ↓	Not Met
Measure: Metabolic Monitoring for Children and Adolescents on Anti-Psychotics (APM-E) **Domain:** Timely Access to Care	HEDIS® measure using administrative data	Anthem	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total) 51.17	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total) 20.17	52.04	51.23 ↓	Met
			Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 33.09	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 26.81	33.09	32.50 ↓	Not Met
			Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 32.11	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 24.39	32.11	31.52 ↓	Not Met
		CareSource	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing	56.27	48.88 ↓	Not Met

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
			Testing (Total) 51.17	(Total) 20.17			
			Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 33.09	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 26.81	33.17	34.38 ↑	Met
			Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 32.11	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 24.39	32.19	33.26 ↑	Met
		MDwise	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total) 51.17	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total) 20.17	45.88	49.45 ↑	Not Met
			Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 33.09	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 26.81	28.01	31.07 ↑	Not Met

Table 2. Hoosier Healthwise Quality Strategy Initiatives							
Measure and Domain	**Methodology**	**MCE**	**Goal**	**Statewide Performance Baseline**	**MY 2023 Results**	**MY 2024 Results**	**Goal Attainment**
			Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 32.11	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 24.39	26.77	29.97 ↑	Not Met
		MHS	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total) 51.17	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total) 20.17	50.25	54.16 ↑	Met
		MHS	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 33.09	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 26.81	31.86	36.28 ↑	Met
		MHS	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 32.11	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 24.39	30.04	34.43 ↑	Met

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
Measure: Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SSD) **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	82.55	78.80	84.03	81.41 ↓	Not Met
		CareSource	82.55	78.80	74.55	87.50 ↑	Met
		MDwise	82.55	78.80	70.05	74.16 ↑	Not Met
		MHS	82.55	78.80	75.82	85.14 ↑	Met
Measure: Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia (SMC) **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	73.17	Not Reported	76.34	NA*	Not Applicable
		CareSource	73.17	Not Reported	NA	NA	Not Applicable
		MDwise	73.17	Not Reported	NA	NA	Not Applicable
		MHS	73.17	Not Reported	NA	NA	Not Applicable
Measure: Diabetes Monitoring for Persons with Diabetes and Schizophrenia (SMD) **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	70.05	62.50	74.06	100 ↑	Met
		CareSource	70.05	62.50	100	NA	Not Applicable
		MDwise	70.05	62.50	NA	100	Met
		MHS	70.05	62.50	NA	NA	Not Applicable
Goal 2: Improve the Health and Wellness of Pregnant Persons, New Mothers, Infants, and Children							
Measure: Timeliness of Prenatal Care (PPC-1)	HEDIS® measure using administrative data	Anthem	85.0	83.26	92.70	88.32 ↓	Met
		CareSource	85.0	83.26	87.59	91.24 ↑	Met
		MDwise	85.0	83.26	81.92	87.31 ↑	Met

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
Domain: Timely Access to Care		MHS	85.0	83.26	82.48	86.37 ↑	Met
Measure: Postpartum Care (PPC-2) **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	83.0	82.15	88.08	83.45 ↓	Met
		CareSource	83.0	82.15	85.40	91.48 ↑	Met
		MDwise	83.0	82.15	86.15	83.46 ↓	Met
		MHS	83.0	82.15	85.16	86.37 ↑	Met
Measure: Well-Child Visits in the First 30 Months of Life- 0-15 months and 15-30 months (W30) **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	0-15 months: 61.0	61.95	68.94	69.87 ↑	Met
			15-30 months: 69.0		71.09	72.39 ↑	Met
		CareSource	0-15 months: 61.0	61.95	61.19	64.20 ↑	Met
			15-30 months: 69.0		70.55	72.85 ↑	Met
		MDwise	0-15 months: 61.0	61.95	62.09	60.24 ↓	Not Met
			15-30 months: 69.0		66.65	68.33 ↑	Not Met
		MHS	0-15 months: 61.0	61.95	61.80	66.13 ↑	Met
			15-30 months: 69.0		71.87	72.34 ↑	Met
Measure: Child and Adolescent Well-Care Visits (WCV) **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	51.65	48.40	52.78	55.54 ↑	Met
		CareSource	51.65	48.40	52.18	55.00 ↑	Met
		MDwise	51.65	48.40	48.52	50.33 ↑	Not Met
		MHS	51.65	48.40	54.89	57.23 ↑	Met
Measure: Childhood	HEDIS®	Anthem	34.0	27.27[†]	25.30	22.93 ↓	Not Met

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
and Immunization Status – Combo 10 (CIS-E) **Domain:** Quality and Access to Care	measure using administrative data	CareSource	34.0	27.27†	21.01	26.97 ↑	Not Met
		MDwise	34.0	27.27†	21.56	21.39 ↓	Not Met
		MHS	34.0	27.27†	23.35	23.55 ↑	Not Met
Measure: Immunizations for Adolescents (IMA-E) **Domain:** Timely Access to Care	HEDIS® measure using administrative data	Anthem	35.0	34.73†	30.62	30.93 ↑	Not Met
		CareSource	35.0	34.73†	27.47	29.80 ↑	Not Met
		MDwise	35.0	34.73†	32.07	31.60 ↓	Not Met
		MHS	35.0	34.73†	29.20	33.34 ↑	Not Met
Goal 3: Improve Oral Health and Prevent Oral Disease							
Measure: Oral Evaluation, Dental Services (OED) **Domain:** Access to Care	HEDIS® measure using administrative data	Anthem	40.0	New Measure for MY 2023	43.21	46.08 ↑	Met
		CareSource	40.0	New Measure for MY 2023	39.58	41.70 ↑	Met
		MDwise	40.0	New Measure for MY 2023	46.49	47.65 ↑	Met
		MHS	40.0	New Measure for MY 2023	45.96	48.44 ↑	Met
Measure: Dentists and Oral Surgeons Network Adequacy **Domain:** Quality and Access to Care	OMPP-chosen performance measure using administrative data	Anthem	2 within 60 miles	Not Applicable	90 Counties Met	1 County Met ↓	Not Met
		CareSource	2 within 60 miles	Not Applicable	86 Counties Met	2 Counties Met ↓	Not Met
		MDwise	2 within 60 miles	Not Applicable	10 Counties Met	2 Counties Met ↓	Not Met
		MHS	2 within 60 miles	Not Applicable	86 Counties Met	1 County Met ↓	Not Met

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
Goal 4: Improve the Health of Members with Chronic Conditions							
Measure: Glycemic Status Assessment for Patients with Diabetes (GSD) **Domain:** Timely Access to Health	HEDIS® measure using administrative data	Anthem	<8.0%: 55.0	New Measure in MY 2024	Not Applicable	<8.0%: 50.62	Not Met
			>9.0%: To be Determined (TBD)[‡]		Not Applicable	>9.0%: 40.66	Not Applicable
		CareSource	<8.0%: 55.0	New Measure in MY 2024	Not Applicable	<8.0%: 47.73	Not Met
			>9.0%: TBD[‡]		Not Applicable	>9.0%: 45.45	Not Applicable
		MDwise	<8.0%: 55.0	New Measure in MY 2024	Not Applicable	<8.0%: 45.12	Not Met
			>9.0%: TBD[‡]		Not Applicable	>9.0%: 49.39	Not Applicable
		MHS	<8.0%: 55.0	New Measure in MY 2024	Not Applicable	<8.0%: 29.69	Not Met
			>9.0%: TBD[‡]		Not Applicable	>9.0%: 69.53	Not Applicable
Measure: Blood Pressure Control for Patients with Diabetes (BPD) **Domain:** Quality and Timely Access to Care	HEDIS® measure using administrative data	Anthem	72.99	59.06	78.59	80.50 ↑	Met
		CareSource	72.99	59.06	73.77	81.82 ↑	Met
		MDwise	72.99	59.06	70.08	73.17 ↑	Met
		MHS	72.99	59.06	70.18	82.03 ↑	Met
Measure: Eye Exam for Patients with Diabetes (EED) **Domain:** Quality and Timely Access to Care	HEDIS® measure using administrative data	Anthem	52.0	33.46	56.69	50.21 ↓	Not Met
		CareSource	52.0	33.46	50.82	52.27 ↑	Met
		MDwise	52.0	33.46	50.94	56.10 ↑	Met
		MHS	52.0	33.46	52.63	53.13 ↑	Met
Measure: Kidney	HEDIS®	Anthem	36.0	35.49[†]	35.70	19.59 ↓	Not Met

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
Health Evaluation for Patients with Diabetes (KED) **Domain:** Quality and Timely Access to Care	measure using administrative data	CareSource	36.0	35.49†	28.33	27.91 ↓	Not Met
		MDwise	36.0	35.49†	22.99	20.36 ↓	Not Met
		MHS	36.0	35.49†	25.86	18.75 ↓	Not Met
Measure: Controlling Blood Pressure (CBP) **Domain:** Quality and Timely Access to Care	HEDIS® measure using administrative data	Anthem	63.38	62.61†	70.07	73.02 ↑	Met
		CareSource	63.38	62.61†	46.94	72.73 ↑	Met
		MDwise	63.38	62.61†	60.18	51.69 ↓	Not Met
		MHS	63.38	62.61†	58.90	62.32 ↑	Not Met
Measure: Adults' Access to Preventive/Ambulatory Health Services (AAP) **Domain:** Quality and Timely Access to Care	HEDIS® measure using administrative data	Anthem	TBD‡	New Measure in MY 2023	76.28	84.70 ↑	TBD
		CareSource	TBD‡	New Measure in MY 2023	67.10	86.70 ↑	TBD
		MDwise	TBD‡	New Measure in MY 2023	63.94	78.51 ↑	TBD
		MHS	TBD‡	New Measure in MY 2023	69.03	84.55 ↑	TBD
Measure: Acute Hospital Utilization (AHU) **Domain:** Quality and Timely Access to Care	HEDIS® measure using administrative data	Anthem	TBD‡	New Measure in MY 2024	Not Applicable	Not Reported	TBD
		CareSource	TBD‡	New Measure in MY 2024	Not Applicable	Not Reported	TBD
		MDwise	TBD‡	New Measure in MY 2024	Not Applicable	Not Reported	TBD
		MHS	TBD‡	New Measure in MY 2024	Not Applicable	Not Reported	TBD
Measure: Emergency Department Utilization	HEDIS® measure using	Anthem	TBD‡	New Measure in MY 2024	Not Applicable	Not Reported	TBD

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
(EDU) **Domain:** Timely Access to Care	administrative data	CareSource	TBD‡	New Measure in MY 2024	Not Applicable	Not Reported	TBD
		MDwise	TBD‡	New Measure in MY 2024	Not Applicable	Not Reported	TBD
		MHS	TBD‡	New Measure in MY 2024	Not Applicable	Not Reported	TBD
Goal 5: Improve Care Coordination Across the Entire Service Continuum							
Measure: Plan All-Cause Readmissions (PCR) **Domain:** Timely Access to Care	HEDIS® measure using administrative data	Anthem	.9124	.9393	0.9506	0.9531 ↓	Not Met
		CareSource	.9124	.9393	Not Reported	1.1633	Not Met
		MDwise	.9124	.9393	0.9050	0.5595 ↑	Met
		MHS	.9124	.9393	1.1503	1.1849 ↓	Not Met
Measure: Completion of Initial Health Needs Screening Within 30 Days or 90 Days of MCE Enrollment Based on Care Program **Domain:** Timely Access to Care	OMPP-chosen performance measure using administrative data	Anthem	=>80%	52.30	70.23	99.2 ↑	Met
		CareSource	=>80%	52.30	100.00	104.3§ ↑	Met
		MDwise	=>80%	52.30	98.20	98.8 ↓	Met
		MHS	=>80%	52.30	52.77	52.96 ↑	Not Met

**NA=Not Applicable. The MCE followed the specifications, but the denominator was too small (<30) to report a valid rate; thus, results are not presented.*

†Most Statewide Baselines are based on CY 2022 reporting; however, this baseline is based on CY 2023 reporting.

‡This is a new HEDIS® measure presented by the National Committee for Quality Assurance (NCQA) for MY 2024. MY 2024 is considered the Baseline Measurement Year for the measure.

§The calculation of the performance measure target rates displayed both an inflated numerator of members screened as well as a deflated denominator of eligible new members, despite the MCE calculating the reporting for this measure in accordance with the 2024 OMPP Managed Care Entity Reporting Manual Instructions. These variances resulted in erroneously high reporting rates of members screened within the compliant timeframe during each reporting period. Considerations for the state's MCE reporting structure for this measure will be provided to OMPP.

Table 3. Healthy Indiana Plan Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
Goal 1: Improve Health Outcomes Through Preventive Care and Behavioral Health Condition Management							
Measure: Follow-Up After Emergency Department Visit for Substance Use (FUA) 7-Day and 30-Day Follow-Up **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	7-Day: 29.0	7-Day: 17.78	7-Day: 28.97	7-Day: 30.34 ↑	Met
			30-Day: 40.0	30-Day: 27.77	30-Day: 40.73	30-Day: 41.55 ↑	Met
		CareSource	7-Day: 29.0	7-Day: 17.78	7-Day: 25.81	7-Day: 32.78 ↑	Met
			30-Day: 40.0	30-Day: 27.77	30-Day: 38.03	30-Day: 44.54 ↑	Met
		MDwise	7-Day: 29.0	7-Day: 17.78	7-Day: 22.63	7-Day: 26.16 ↑	Not Met
			30-Day: 40.0	30-Day: 27.77	30-Day: 33.59	30-Day: 36.02 ↑	Not Met
		MHS	7-Day: 29.0	7-Day: 17.78	7-Day: 25.32	7-Day: 29.24 ↑	Met
			30-Day: 40.0	30-Day: 27.77	30-Day: 34.94	30-Day: 38.26 ↑	Not Met
Measure: Follow-Up After Hospitalization for Mental Illness (FUH) 7-Day and 30-Day Follow-Up **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	7-Day: 38.0	7-Day: 43.44	7-Day: 30.95	7-Day: 32.51 ↑	Not Met
			30-Day: 56.0	30-Day: 67.47	30-Day: 51.42	30-Day: 51.99 ↑	Not Met
		CareSource	7-Day: 38.0	7-Day: 43.44	7-Day: 34.09	7-Day: 38.50 ↑	Met
			30-Day: 56.0	30-Day: 67.47	30-Day: 53.99	30-Day: 59.59 ↑	Met
		MDwise	7-Day: 38.0	7-Day: 43.44	7-Day: 23.44	7-Day: 24.19 ↑	Not Met
			30-Day: 56.0	30-Day: 67.47	30-Day: 41.12	30-Day: 41.77 ↑	Not Met
		MHS	7-Day: 38.0	7-Day: 43.44	7-Day: 28.81	7-Day: 31.36 ↑	Not Met
			30-Day: 56.0	30-Day: 67.47	30-Day: 48.74	30-Day: 52.85 ↑	Not Met
Measure: Follow-Up After Emergency Department Visit for Mental Illness (FUM) 7-Day and 30-Day Follow-Up	HEDIS® measure using administrative data	Anthem	7-Day: 40.0	7-Day: 47.14	7-Day: 35.87	7-Day: 35.42 ↓	Not Met
			30-Day: 54.0	30-Day: 61.58	30-Day: 47.53	30-Day: 47.30 ↓	Not Met
		CareSource	7-Day: 40.0	7-Day: 47.14	7-Day: 31.12	7-Day: 49.86 ↑	Met
			30-Day: 54.0	30-Day: 61.58	30-Day: 41.07	30-Day: 56.66 ↑	Met

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
Domain: Quality and Access to Care		MDwise	7-Day: 40.0	7-Day: 47.14	7-Day: 32.11	7-Day: 35.67 ↑	Not Met
			30-Day: 54.0	30-Day: 61.58	30-Day: 42.81	30-Day: 45.91 ↑	Not Met
		MHS	7-Day: 40.0	7-Day: 47.14	7-Day: 32.21	7-Day: 36.31 ↑	Not Met
			30-Day: 54.0	30-Day: 61.58	30-Day: 44.58	30-Day: 47.53 ↑	Not Met
Measure: Initiation and Engagement of Alcohol and Other Drug (IET) **Domain:** Timely Access to Care	HEDIS® measure using administrative data	Anthem	Total: 43.0	Initiation of AOD - Alcohol Abuse or Dependence (Total) 31.18	42.58	47.07 ↑	Met
				Engagement of AOD - Alcohol Abuse or Dependence (Total) 9.63	21.24	23.12 ↑	Not Met
				Initiation of AOD - Opioid Abuse or Dependence (Total) 55.66	66.71	72.96 ↑	Met
				Engagement of AOD - Opioid Abuse or Dependence (Total) 34.60	48.79	53.61 ↑	Met
				Initiation of AOD - Other Drug Abuse or Dependence (Total) 43.70	33.77	40.38 ↑	Not Met
				Engagement of AOD - Other Drug Abuse or Dependence (Total) 14.21	16.74	20.29 ↑	Not Met
				Initiation of AOD - Total (Total) 41.44	42.05	48.19 ↑	Met

Table 3. Healthy Indiana Plan Quality Strategy Initiatives

Table 3. Healthy Indiana Plan Quality Strategy Initiatives							
Measure and Domain	**Methodology**	**MCE**	**Goal**	**Statewide Performance Baseline**	**MY 2023 Results**	**MY 2024 Results**	**Goal Attainment**
				Engagement of AOD - Total (Total) 14.78	23.48	26.96 ↑	Not Met
		CareSource	Total: 43.0	Initiation of AOD - Alcohol Abuse or Dependence (Total) 31.18	Not Reported	42.92	Not Met
				Engagement of AOD - Alcohol Abuse or Dependence (Total) 9.63	Not Reported	20.51	Not Met
				Initiation of AOD - Opioid Abuse or Dependence (Total) 55.66	Not Reported	73.24	Met
				Engagement of AOD - Opioid Abuse or Dependence (Total) 34.60	Not Reported	56.81	Met
				Initiation of AOD - Other Drug Abuse or Dependence (Total) 43.70	Not Reported	36.35	Not Met
				Engagement of AOD - Other Drug Abuse or Dependence (Total) 14.21	Not Reported	21.48	Not Met
				Initiation of AOD - Total (Total) 41.44	42.86	44.94 ↑	Met
				Engagement of AOD - Total (Total) 14.78	27.54	27.56 ↑	Not Met
		MDwise	Total: 43.0	Initiation of AOD - Alcohol Abuse or	41.80	38.78 ↓	Not Met

Table 3. Healthy Indiana Plan Quality Strategy Initiatives							
Measure and Domain	**Methodology**	**MCE**	**Goal**	**Statewide Performance Baseline**	**MY 2023 Results**	**MY 2024 Results**	**Goal Attainment**
				Dependence (Total) 31.18			
				Engagement of AOD - Alcohol Abuse or Dependence (Total) 9.63	19.40	18.68 ↓	Not Met
				Initiation of AOD - Opioid Abuse or Dependence (Total) 55.66	72.45	65.86 ↓	Met
				Engagement of AOD - Opioid Abuse or Dependence (Total) 34.60	53.66	47.39 ↓	Met
				Initiation of AOD - Other Drug Abuse or Dependence (Total) 43.70	31.36	35.39 ↑	Not Met
				Engagement of AOD - Other Drug Abuse or Dependence (Total) 14.21	15.56	18.35 ↑	Not Met
				Initiation of AOD - Total (Total) 41.44	40.29	41.05 ↑	Not Met
				Engagement of AOD - Total (Total) 14.78	22.01	22.84 ↑	Not Met
		MHS	Total: 43.0	Initiation of AOD - Alcohol Abuse or Dependence (Total) 31.18	40.42	Not Reported	Not Reported
				Engagement of AOD - Alcohol Abuse or	17.54	Not Reported	Not Reported

Table 3. Healthy Indiana Plan Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
				Dependence (Total) 9.63			
				Initiation of AOD - Opioid Abuse or Dependence (Total) 55.66	71.01	Not Reported	Not Reported
				Engagement of AOD - Opioid Abuse or Dependence (Total) 34.60	53.71	Not Reported	Not Reported
				Initiation of AOD - Other Drug Abuse or Dependence (Total) 43.70	33.10	Not Reported	Not Reported
				Engagement of AOD - Other Drug Abuse or Dependence (Total) 14.21	16.21	Not Reported	Not Reported
				Initiation of AOD - Total (Total) 41.44	40.97	43.40 ↑	Met
				Engagement of AOD - Total (Total) 14.78	22.12	24.18 ↑	Not Met
Measure: Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) **Domain:** Timely Access to Care	HEDIS® measure using administrative data	Anthem	58.82	52.90	48.45	50.89 ↓	Not Met
		CareSource	58.82	52.90	40.99	47.57 ↑	Not Met
		MDwise	58.82	52.90	44.97	45.78 ↑	Not Met
		MHS	58.82	52.90	44.27	55.83 ↑	Not Met

Table 3. Healthy Indiana Plan Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
Measure: Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SSD) **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	82.55	78.80	84.03	83.68 ↓	Met
		CareSource	82.55	78.80	83.58	83.52 ↓	Met
		MDwise	82.55	78.80	80.27	80.94 ↑	Not Met
		MHS	82.55	78.80	82.04	83.38 ↑	Met
Measure: Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia (SMC) **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	73.42	Not Reported	81.48	85.29 ↑	Met
		CareSource	73.42	Not Reported	NA*	60.00	Not Met
		MDwise	73.42	Not Reported	80.00	66.67 ↓	Not Met
		MHS	73.42	Not Reported	66.67	0.00 ↓	Not Met
Measure: Diabetes Monitoring for Persons with Diabetes and Schizophrenia (SMD) **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	64.87	62.50	72.29	76.29 ↑	Met
		CareSource	64.87	62.50	82.35	72.73 ↓	Met
		MDwise	64.87	62.50	67.33	68.00 ↑	Met
		MHS	64.87	62.50	77.48	65.00 ↓	Met
Goal 2: Improve the Health and Wellness of Pregnant Persons, New Mothers, Infants, and Children							
Measure:	HEDIS®	Anthem	85.0	83.26	91.97	91.73 ↓	Met

Table 3. Healthy Indiana Plan Quality Strategy Initiatives							
Measure and Domain	**Methodology**	**MCE**	**Goal**	**Statewide Performance Baseline**	**MY 2023 Results**	**MY 2024 Results**	**Goal Attainment**
Timeliness of Prenatal Care (PPC-1) **Domain:** Timely Access to Care	measure using administrative data	CareSource	85.0	83.26	82.24	86.86 ↑	Met
		MDwise	85.0	83.26	82.29	89.61 ↑	Met
		MHS	85.0	83.26	79.81	86.37 ↑	Met
Measure: Postpartum Care (PPC-2) **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	83.0	82.15	87.10	88.32 ↑	Met
		CareSource	83.0	82.15	81.51	86.13 ↑	Met
		MDwise	83.0	82.15	79.86	81.00 ↑	Not Met
		MHS	83.0	82.15	79.32	82.97 ↑	Not Met
Goal 3: Improve Oral Health and Prevent Oral Disease							
Measure: Oral Evaluation, Dental Services (OED) **Domain:** Access to Care	HEDIS® measure using administrative data	Anthem	40.0	New Measure for MY 2023	25.04	26.00 ↑	Not Met
		CareSource	40.0	New Measure for MY 2023	21.74	19.91 ↓	Not Met
		MDwise	40.0	New Measure for MY 2023	26.40	26.37 ↓	Not Met
		MHS	40.0	New Measure for MY 2023	25.93	27.24 ↑	Not Met
Measure: Dentists and Oral Surgeons Network Adequacy **Domain:** Quality and Access to Care	OMPP-chosen performance measure using administrative data	Anthem	2 within 60 miles	Not Applicable	91 Counties Met	0 Counties Met ↓	Not Met
		CareSource	2 within 60 miles	Not Applicable	86 Counties Met	6 Counties Met ↓	Not Met
		MDwise	2 within 60 miles	Not Applicable	9 Counties Met	2 Counties Met ↓	Not Met
		MHS	2 within 60 miles	Not Applicable	87 Counties Met	1 County Met ↓	Not Met

Table 3. Healthy Indiana Plan Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
Goal 4: Improve the Health of Members with Chronic Conditions							
Measure: Glycemic Status Assessment for Patients with Diabetes (GSD) **Domain:** Timely Access to Health	HEDIS® measure using administrative data	Anthem	<8.0%: 55.0	New Measure for MY 2024	Not Applicable	<8.0%: 67.15	Met
			>9.0%: TBD‡		Not Applicable	>9.0%: 24.82	Not Applicable
		CareSource	<8.0%: 55.0	New Measure for MY 2024	Not Applicable	<8.0%: 59.61	Met
			>9.0%: TBD‡		Not Applicable	>9.0%: 31.14	Not Applicable
		MDwise	<8.0%: 55.0	New Measure for MY 2024	Not Applicable	<8.0%: 56.45	Met
			>9.0%: TBD‡		Not Applicable	>9.0%: 33.82	Not Applicable
		MHS	<8.0%: 55.0	New Measure for MY 2024	Not Applicable	<8.0%: 63.75	Met
			>9.0%: TBD‡		Not Applicable	>9.0%: 26.52	Not Applicable
Measure: Blood Pressure Control for Patients with Diabetes (BPD) **Domain:** Quality and Timely Access to Care	HEDIS® measure using administrative data	Anthem	72.99	59.06	75.91	74.21 ↓	Met
		CareSource	72.99	59.06	71.78	70.07 ↓	Not Met
		MDwise	72.99	59.06	59.37	70.32 ↑	Not Met
		MHS	72.99	59.06	70.80	76.64 ↑	Met
Measure: Eye Exam for Patients with Diabetes (EED) **Domain:** Quality and Timely Access to Care	HEDIS® measure using administrative data	Anthem	52.0	33.46	54.26	59.61 ↑	Met
		CareSource	52.0	33.46	47.45	55.96 ↑	Met
		MDwise	52.0	33.46	49.39	54.01 ↑	Met
		MHS	52.0	33.46	55.72	59.12 ↑	Met
Measure: Kidney Health Evaluation for	HEDIS® measure using	Anthem	36.0	35.49†	35.77	37.34 ↑	Met

Table 3. Healthy Indiana Plan Quality Strategy Initiatives							
Measure and Domain	**Methodology**	**MCE**	**Goal**	**Statewide Performance Baseline**	**MY 2023 Results**	**MY 2024 Results**	**Goal Attainment**
Patients with Diabetes (KED) **Domain:** Quality and Timely Access to Care	administrative data	CareSource	36.0	35.49†	35.89	41.64 ↑	Met
		MDwise	36.0	35.49†	29.39	33.38 ↑	Not Met
		MHS	36.0	35.49†	35.55	38.04 ↑	Met
Measure: Controlling Blood Pressure (CBP) **Domain:** Quality and Timely Access to Care	HEDIS® measure using administrative data	Anthem	63.38	62.61†	68.13	70.80 ↑	Met
		CareSource	63.38	62.61†	67.15	66.42 ↓	Met
		MDwise	63.38	62.61†	54.01	61.61 ↑	Not Met
		MHS	63.38	62.61†	62.77	69.59 ↑	Met
Measure: Adults' Access to Preventive/ Ambulatory Health Services (AAP) **Domain:** Quality and Timely Access to Care	HEDIS® measure using administrative data	Anthem	TBD‡	New Measure for MY 2023	75.89	75.00 ↓	Not Applicable
		CareSource	TBD‡	New Measure for MY 2023	69.86	69.96 ↑	Not Applicable
		MDwise	TBD‡	New Measure for MY 2023	71.01	70.31 ↓	Not Applicable
		MHS	TBD‡	New Measure for MY 2023	73.69	73.32 ↓	Not Applicable
Measure: Acute Hospital Utilization (AHU) **Domain:** Quality and Timely Access to Care	HEDIS® measure using administrative data	Anthem	TBD‡	New Measure for MY 2024	Not Reported	Not Reported	Not Applicable
		CareSource	TBD‡	New Measure for MY 2024	Not Reported	Not Reported	Not Applicable
		MDwise	TBD‡	New Measure for MY 2024	Not Reported	Not Reported	Not Applicable
		MHS	TBD‡	New Measure for MY 2024	Not Reported	Not Reported	Not Applicable
Measure:	HEDIS®	Anthem	TBD‡	New Measure for MY	Not Reported	Not Reported	Not

Table 3. Healthy Indiana Plan Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
Emergency Department Utilization (EDU) **Domain:** Timely Access to Care	measure using administrative data			2024			Applicable
		CareSource	TBD‡	New Measure for MY 2024	Not Reported	Not Reported	Not Applicable
		MDwise	TBD‡	New Measure for MY 2024	Not Reported	Not Reported	Not Applicable
		MHS	TBD‡	New Measure for MY 2024	Not Reported	Not Reported	Not Applicable
Goal 5: Improve Care Coordination Across the Entire Service Continuum							
Measure: Plan All-Cause Readmissions (PCR) **Domain:** Timely Access to Care	HEDIS® measure using administrative data	Anthem	.9124	.9393	0.9282	1.0155 ↓	Not Met
		CareSource	.9124	.9393	Not Reported	1.1459	Not Met
		MDwise	.9124	.9393	0.9299	1.0481 ↓	Not Met
		MHS	.9124	.9393	1.0009	1.1373 ↓	Not Met
Measure: Completion of Initial Health Needs Screening Within 30 Days or 90 Days of MCE Enrollment Based on Care Program **Domain:** Timely Access to Care	OMPP-chosen performance measure using administrative data	Anthem	=>80%	52.30	99.78	99.2 ↓	Met
		CareSource	=>80%	52.30	100	115.1§ ↑	Met
		MDwise	=>80%	52.30	96.20	97.2↑	Met
		MHS	=>80%	52.30	63.57	70.77↑	Not Met

**NA=Not Applicable. The MCE followed the specifications, but the denominator was too small (<30) to report a valid rate; thus, results are not presented.*

†Most Statewide Baselines are based on CY 2022 reporting; however, this baseline is based on CY 2023 reporting.

‡This is a new HEDIS measure presented by the National Committee for Quality Assurance (NCQA) for MY 2024. MY 2024 is considered the Baseline Measurement Year for the measure.

§The calculation of the performance measure target rates displayed both an inflated numerator of members screened as well as a deflated denominator of eligible new members, despite the MCE calculating the reporting for this measure in accordance with the 2024 OMPP Managed Care Entity Reporting Manual Instructions. These variances resulted in

erroneously high reporting rates of members screened within the compliant timeframe during each reporting period. Considerations for the state's MCE reporting structure for this measure will be provided to OMPP.

Table 4. Hoosier Care Connect Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
Goal 1: Improve Health Outcomes Through Preventive Care and Behavioral Health Condition Management							
Measure: Follow-Up After Emergency Department Visit for Substance Use (FUA) 7-Day and 30-Day Follow-Up **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	7-Day: 29.0	7-Day: 17.78	7-Day: 32.37	7-Day: 32.12 ↓	Met
			30-Day: 40.0	30-Day: 27.77	30-Day: 46.33	30-Day: 43.98 ↓	Met
		MHS	7-Day: 29.0	7-Day: 17.78	7-Day: 21.17	7-Day: 23.31 ↑	Not Met
			30-Day: 40.0	30-Day: 27.77	30-Day: 32.12	30-Day: 40.20 ↑	Met
		UHC	7-Day: 29.0	7-Day: 17.78	7-Day: 28.57	7-Day: 27.40 ↓	Not Met
			30-Day: 40.0	30-Day: 27.77	30-Day: 51.85	30-Day: 36.99 ↓	Not Met
Measure: Follow-Up After Hospitalization for Mental Illness (FUH) 7-Day and 30-Day Follow-Up **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	7-Day: 38.0	7-Day: 43.44	7-Day: 40.53	7-Day: 43.93 ↑	Met
			30-Day: 56.0	30 Day: 67.47	30-Day: 61.74	30-Day: 62.98 ↑	Met
		MHS	7-Day: 38.0	7-Day: 43.44	7-Day: 29.65	7-Day: 36.29 ↑	Not Met
			30-Day: 56.0	30 Day: 67.47	30-Day: 54.49	30-Day: 59.90 ↑	Met
		UHC	7-Day: 38.0	7-Day: 43.44	7-Day: 39.78	7-Day: 43.90 ↑	Met
			30-Day: 56.0	30-Day: 67.47	30-Day: 55.91	30-Day: 60.49 ↑	Met
Measure: Follow-Up After Emergency Department Visit for Mental Illness (FUM) 7-Day and 30-Day Follow-Up **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	7-Day: 40.0	7-Day: 47.14	7-Day: 43.31	7-Day: 48.60 ↑	Met
			30-Day: 54.0	30-Day: 61.58	30-Day: 57.70	30-Day: 62.98 ↑	Met
		MHS	7-Day: 40.0	7-Day: 47.14	7-Day: 43.78	7-Day: 42.51 ↑	Met
			30-Day: 54.0	30-Day: 61.58	30-Day: 58.96	30-Day: 59.58 ↑	Met
		UHC	7-Day: 40.0	7-Day: 47.14	7-Day: 38.60	7-Day: 51.22 ↑	Met
			30-Day: 54.0	30-Day: 61.58	30-Day: 50.88	30-Day: 65.85 ↑	Met

Table 4. Hoosier Care Connect Quality Strategy Initiatives							
Measure and Domain	**Methodology**	**MCE**	**Goal**	**Statewide Performance Baseline**	**MY 2023 Results**	**MY 2024 Results**	**Goal Attainment**
Measure: Initiation and Engagement of Alcohol and Other Drug (IET) **Domain:** Timely Access to Care	HEDIS® measure using administrative data	Anthem	Total: 43.0	Initiation of AOD - Alcohol Abuse or Dependence (Total) 31.78	42.73	46.16 ↑	Met
				Engagement of AOD - Alcohol Abuse or Dependence (Total) 9.63	16.63	19.05 ↑	Not Met
				Initiation of AOD - Opioid Abuse or Dependence (Total) 55.66	50.12	51.60 ↑	Met
				Engagement of AOD - Opioid Abuse or Dependence (Total) 34.60	31.79	27.49 ↓	Not Met
				Initiation of AOD - Other Drug Abuse or Dependence (Total) 43.70	36.15	40.95 ↑	Not Met
				Engagement of AOD - Other Drug Abuse or Dependence (Total) 14.21	15.30	15.56 ↑	Not Met
				Initiation of AOD - Total (Total) 41.44	40.21	44.16 ↑	Met
				Engagement of AOD - Total (Total) 14.78	18.13	18.40 ↑	Not Met
		MHS	Total: 43.0	Initiation of AOD - Alcohol Abuse or Dependence (Total) 31.78	37.93	Not Reported	Not Reported

Table 4. Hoosier Care Connect Quality Strategy Initiatives							
Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
				Engagement of AOD - Alcohol Abuse or Dependence (Total) 9.63	10.34	Not Reported	Not Reported
				Initiation of AOD - Opioid Abuse or Dependence (Total) 55.66	56.12	Not Reported	Not Reported
				Engagement of AOD - Opioid Abuse or Dependence (Total) 34.60	31.22	Not Reported	Not Reported
				Initiation of AOD - Other Drug Abuse or Dependence (Total) 43.70	34.89	Not Reported	Not Reported
				Engagement of AOD - Other Drug Abuse or Dependence (Total) 14.21	11.23	Not Reported	Not Reported
				Initiation of AOD - Total (Total) 41.44	38.27	40.35 ↑	Not Met
				Engagement of AOD - Total (Total) 14.78	13.11	16.74 ↑	Not Met
		UHC	Total: 43.0	Initiation of AOD - Alcohol Abuse or Dependence (Total) 31.78	49.35	34.82 ↓	Not Met
				Engagement of AOD - Alcohol Abuse or Dependence (Total) 9.63	16.88	7.14 ↓	Not Met

Table 4. Hoosier Care Connect Quality Strategy Initiatives							
Measure and Domain	**Methodology**	**MCE**	**Goal**	**Statewide Performance Baseline**	**MY 2023 Results**	**MY 2024 Results**	**Goal Attainment**
				Initiation of AOD - Opioid Abuse or Dependence (Total) 55.66	62.07	56.76 ↓	Met
				Engagement of AOD - Opioid Abuse or Dependence (Total) 34.60	24.14	27.03 ↑	Not Met
				Initiation of AOD - Other Drug Abuse or Dependence (Total) 43.70	43.03	39.29 ↓	Not Met
				Engagement of AOD - Other Drug Abuse or Dependence (Total) 14.21	9.09	12.50 ↑	Not Met
				Initiation of AOD - Total (Total) 41.44	46.86	39.85 ↓	Not Met
				Engagement of AOD - Total (Total) 14.78	12.92	12.26 ↓	Not Met
Measure: Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) **Domain:** Timely Access to Care	HEDIS® measure using administrative data	Anthem	58.82	52.90	65.87	69.15 ↑	Met
		MHS	58.82	52.90	65.25	73.08 ↑	Met
		UHC	58.82	52.90	58.82	58.82	Met
Measure: Metabolic Monitoring for Children and Adolescents on Anti-Psychotics (APM-	HEDIS® measure using administrative data	Anthem	Metabolic Monitoring for Children and Adolescents on Antipsychotics -	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing	54.68	52.37 ↓	Met

Table 4. Hoosier Care Connect Quality Strategy Initiatives							
Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
E) **Domain:** Timely Access to Care			Blood Glucose Testing (Total) 51.17	(Total) 20.17			
			Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 33.09	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 26.81	38.35	35.92 ↓	Met
			Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 32.11	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 24.39	37.45	34.89 ↓	Met
		MHS	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total) 51.17	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total) 20.17	52.58	55.26 ↑	Met
			Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 33.09	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 26.81	37.88	39.21 ↑	Met

Table 4. Hoosier Care Connect Quality Strategy Initiatives							
Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
			Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 32.11	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 24.39	36.48	37.83 ↑	Met
		UHC	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total) 51.17	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total) 20.17	54.46	56.69 ↑	Met
		UHC	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 33.09	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total) 26.81	43.56	39.37 ↓	Met
		UHC	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 32.11	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) 24.39	42.57	39.37 ↓	Met

Table 4. Hoosier Care Connect Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
Measure: Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SSD) **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	82.55	78.80	84.99	83.17 ↓	Met
		MHS	82.55	78.80	82.28	81.85 ↓	Not Met
		UHC	82.55	78.80	84.21	82.39 ↓	Not Met
Measure: Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia (SMC) **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	73.17	Not Reported	74.63	81.40 ↑	Met
		MHS	73.17	Not Reported	80.00	76.00 ↓	Met
		UHC	73.17	Not Reported	100	0.00 ↓	Not Met
Measure: Diabetes Monitoring for Persons with Diabetes and Schizophrenia (SMD) **Domain:** Quality and Access to Care	HEDIS® measure using administrative data	Anthem	70.05	62.50	75.92	78.59 ↑	Met
		MHS	70.05	62.50	72.41	76.59 ↑	Met
		UHC	70.05	62.50	59.09	56.00 ↓	Not Met
Goal 3: Improve Oral Health and Prevent Oral Disease							
Measure: Oral Evaluation, Dental Services (OED) **Domain:** Access to Care	HEDIS® measure using administrative data	Anthem	40.0	New Measure for MY 2023	48.18	50.47 ↑	Met
		MHS	40.0	New Measure for MY 2023	50.17	51.96 ↑	Met
		UHC	40.0	New Measure for MY 2023	44.91	43.93 ↓	Met

Table 4. Hoosier Care Connect Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
Measure: Dentists and Oral Surgeons Network Adequacy **Domain:** Quality and Access to Care	OMPP-chosen performance measure using administrative data	Anthem	2 within 60 miles	Not Applicable	92 Counties Met	0 Counties Met ↓	Not Met
		MHS	2 within 60 miles	Not Applicable	89 Counties Met	1 County Met ↓	Not Met
		UHC	2 within 60 miles	Not Applicable	84 Counties Met	9 Counties Met ↓	Not Met
Goal 4: Improve the Health of Members with Chronic Conditions							
Measure: Glycemic Status Assessment for Patients with Diabetes (GSD) **Domain:** Timely Access to Health	HEDIS® measure using administrative data	Anthem	<8.0%: 55.0	New Measure for MY 2024	Not Applicable	<8.0%: 63.75	Met
			>9.0%: TBD‡		Not Applicable	>9.0%: 27.01	Not Applicable
		MHS	<8.0%: 55.0	New Measure for MY 2024	Not Applicable	<8.0%: 58.64	Met
			>9.0%: TBD‡		Not Applicable	>9.0%: 30.41	Not Applicable
		UHC	<8.0%: 55.0	New Measure for MY 2024	Not Applicable	<8.0%: 51.24	Not Met
			>9.0%: TBD‡		Not Applicable	>9.0%: 42.24	Not Applicable
Measure: Blood Pressure Control for Patients with Diabetes (BPD) **Domain:** Quality and Timely Access to Care	HEDIS® measure using administrative data	Anthem	72.99	59.06	73.97	73.48 ↓	Met
		MHS	72.99	59.06	72.26	71.05 ↓	Not Met
		UHC	72.99	59.06	62.19	61.80 ↓	Not Met

Table 4. Hoosier Care Connect Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
Measure: Eye Exam for Patients with Diabetes (EED) **Domain:** Quality and Timely Access to Care	HEDIS® measure using administrative data	Anthem	52.0	33.46	61.31	58.39 ↓	Met
		MHS	52.0	33.46	60.83	57.42 ↓	Met
		UHC	52.0	33.46	45.27	47.20 ↑	Not Met
Measure: Kidney Health Evaluation for Patients with Diabetes (KED) **Domain:** Quality and Timely Access to Care	HEDIS® measure using administrative data	Anthem	36.0	35.49†	36.05	35.51 ↓	Not Met
		MHS	36.0	35.49†	36.64	35.55 ↓	Not Met
		UHC	36.0	35.49†	30.05	29.97 ↓	Not Met
Measure: Controlling Blood Pressure (CBP) **Domain:** Quality and Timely Access to Care	HEDIS® measure using administrative data	Anthem	63.38	62.61†	73.24	70.56 ↓	Met
		MHS	63.38	62.61†	66.18	70.32 ↑	Met
		UHC	63.38	62.61†	63.50	62.29 ↓	Not Met
Measure: Adults' Access to Preventive/Ambulatory Health Services (AAP) **Domain:** Quality and Timely Access to Care	HEDIS® measure using administrative data	Anthem	TBD‡	New Measure for MY 2023	81.73	81.64 ↓	Not Applicable
		MHS	TBD‡	New Measure for MY 2023	78.36	77.65 ↓	Not Applicable
		UHC	TBD‡	New Measure for MY 2023	74.19	76.97 ↑	Not Applicable
Measure: Acute Hospital Utilization (AHU) **Domain:** Quality and Timely Access to Care	HEDIS® measure using administrative data	Anthem	TBD‡	New Measure for MY 2024	Not Reported	Not Reported	Not Applicable
		MHS	TBD‡	New Measure for MY 2024	Not Reported	Not Reported	Not Applicable
		UHC	TBD‡	New Measure for MY 2024	Not Reported	Not Reported	Not Applicable

Table 4. Hoosier Care Connect Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Statewide Performance Baseline	MY 2023 Results	MY 2024 Results	Goal Attainment
Measure: Emergency Department Utilization (EDU) **Domain:** Timely Access to Care	HEDIS® measure using administrative data	Anthem	TBD‡	New Measure for MY 2024	Not Reported	Not Reported	Not Applicable
		MHS	TBD‡	New Measure for MY 2024	Not Reported	Not Reported	Not Applicable
		UHC	TBD‡	New Measure for MY 2024	Not Reported	Not Reported	Not Applicable
Goal 5: Improve Care Coordination Across the Entire Service Continuum							
Measure: Plan All-Cause Readmissions (PCR) **Domain:** Timely Access to Care	HEDIS® measure using administrative data	Anthem	.9124	.9393	1.0404	1.1338 ↓	Not Met
		MHS	.9124	.9393	1.0410	1.2365 ↓	Not Met
		UHC	.9124	.9393	1.1005	1.5265 ↓	Not Met
Measure: Completion of Initial Health Needs Screening Within 30 Days or 90 Days of MCE Enrollment Based on Care Program **Domain:** Timely Access to Care	OMPP-chosen performance measure using administrative data	Anthem	=>80%	52.30	99.75	99.5 ↓	Met
		MHS	=>80%	52.30	64.17	70.28 ↑	Not Met
		UHC	=>80%	52.30	67.10	61.80 ↓	Not Met

**NA=Not Applicable. The MCE followed the specifications, but the denominator was too small (<30) to report a valid rate; thus, results are not presented.*
†Most Statewide Baselines are based on CY 2022 reporting; however, this baseline is based on CY 2023 reporting.
‡This is a new HEDIS measure presented by the National Committee for Quality Assurance (NCQA) for MY 2024. MY 2024 is considered the Baseline Measurement Year for the measure.

Quality Strategy Evaluation and Conclusions

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

EQR Activities

As outlined in Title 42 CFR, 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 2025, following the CMS *External Quality Review Protocols* (updated in 2023).

EQR Mandatory Activities

Following the CMS Protocols published in February 2023, Qsource conducted the EQR activities shown in [Table 5](#).

Table 5. EQR Activities Conducted in 2025

Protocol #	Activity Name	Mandatory or Optional	Measurement Period
1	***Validation of Performance Improvement Projects***	Mandatory	January 2024 – December 2024
2	***Validation of Performance Measures***	Mandatory	January 2024 – December 2024
3	***Review of Compliance with Medicaid and CHIP Managed Care Regulations***	Mandatory	January 2023 – December 2023
4	***Validation of Network Adequacy***	Mandatory	Varied (See Below)
	Geographic Network Adequacy Analysis and Validation		As of October 2024
	Member-to Provider Ratio Analysis		As of October 2024
	Secret Shopper Survey		January 2024 – December 2024
9	***Focus Studies on Quality of Care***	Optional	January 2024 – December 2024

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 had previously chosen to review all applicable standards every three years. Protocol 3 was performed in 2024 (MY 2023), assessing all relevant standards.

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

CMS National Quality Strategy

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

Quality of Care

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

Timeliness of Care

For quality care to be effective, it must be delivered promptly. Thus, various standards for timely care were monitored through MCE compliance with federal and state regulations. Several PIPs validated by Qsource addressed the timeliness of care for enrollees: Timeliness of Postpartum Care and Diabetes Management. Qsource's validation of performance measures evaluated timeliness measures determined by OMPP.

Access to Care

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

Technical Report Guidelines

Qsource is responsible for creating and producing this *2025 Annual EQRO Technical Report*, which compiles the results of these EQR activities. To assist both EQROs and state agencies, CMS supplemented the requirements of 42 CFR § 438.364, as incorporated by 42 CFR § 457.1250, and provided guidelines in the 2023 EQR Protocols for producing annual technical reports.

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

- Protocol 1. Validation of Performance Improvement Projects (PIPs)
- Protocol 2. Validation of Performance Measures (PMV)
- Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations (CA)
- Protocol 4. Validation of Network Adequacy (ANA)
- Protocol 9: Focus Studies on Quality Care

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

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

The *2025 Annual EQRO Technical Report* provides OMPP with substantive, unbiased data on the MCEs and recommendations for action toward far-reaching performance improvement. This report is based on detailed findings that can be reviewed in the individual EQR activity reports provided to OMPP.

The appendices provide additional EQR activity information:

- Appendix A | Detailed PIP Validation Findings
- Appendix B | ANA Analysis Methodology and Ratios
- Appendix C | Detailed Analysis of Provider Network Access

EQRO Team

The review team included the following staff:

- Jazzmin Kennedy, Qsource, Indiana EQR Program Manager
- Jill Edmondson, Qsource, EQR Program Manager
- Christa Thompson, Qsource, Quality Improvement (QI) Advisor
- Frances Richardson, Qsource, Clinical QI Advisor
- Albert Kennedy, Qsource, Technical Writer
- Courtney Hall, Qsource, Technical Writer
- Fidencio Caballero, Qsource, Healthcare Data Analyst

- Kathy Haley, Myers and Stauffer
- Catherine Snider, Myers and Stauffer
- Emily Brammer, Axon Advisors, Limited Liability Company (LLC)

Protocol 1: Performance Improvement Project (PIP) Validation

Objectives

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

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

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

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

Technical Methods of Data Collection and Analysis

Qsource developed a PIP Summary Form (with accompanying PIP Summary Form Completion Instructions) and PIP Validation Tool to standardize the process by which each MCE delivered PIP information to OMPP and how that information is assessed. Qsource reviewed each PIP's design and implementation using the PIP Summary Form submitted by the MCE and determined the PIP's validation rating based on the MCE's percentage of compliance with the recently revised and published CMS's EQR Protocol 1: *Validation of Performance Improvement Projects (2023)*.

Each MCE was contractually required to submit PIP studies annually to OMPP as requested. PIPs should include the necessary documentation for submitted data collection, data

analysis plans, and an interpretation of all results. MCEs should also address threats to validity regarding data analysis and include an interpretation of study results. The guidance and methods for each of these steps were included in the PIP Summary Form and Summary Form Completion Instructions.

Per the Protocol, Qsource assessed the overall validity and reliability of the PIP methods and findings to determine whether or not it had confidence in the results. Qsource assigned two validation ratings based on its assessment of whether the PIP (1) adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and (2) produced evidence of improvement. The ratings were scored on a scale of high, moderate, low, or no confidence. For the first validation rating, Qsource's scoring methodology was based on the percentage of elements met out of all elements assessed. Each PIP involves nine required steps, and each step consists of elements essential to the successful completion of a PIP. The elements within each step were scored as Met, Not Met, or NA. To assign the second validation rating, Qsource reviewed its assessments of the nine steps required from the protocol and assessed the relative strengths and weaknesses of the PIP and the extent to which they affected the confidence in the generalizability and usefulness of the PIP's findings.

Table 6 lists the nine PIP steps used for assessing the PIP methodology.

Table 6. PIP Steps

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

Table 7 presents the rating criteria used for PIP validation based on the CMS EQR Protocol's suggested rating scale.

Table 7. PIP Validation Rating Criteria

Rating	Criteria
Rating 1	
High Confidence	Of all elements assessed, 90–100% were met across all activities.
Moderate Confidence	Of all elements assessed, 80–<90% were met across all activities.
Low Confidence	Of all elements assessed, 70–<80% were met across all activities.
No Confidence	Less than 70% of all elements were met.
Rating 2	
High Confidence	The PIP achieved statistically significant

Table 7. PIP Validation Rating Criteria	
Rating	**Criteria**
	improvement for all performance measures and interventions resulted in demonstrated improvement.
Moderate Confidence	The PIP achieved statistically or non-statistically significant improvement for at least one measure.
Low Confidence	The PIP did not demonstrate statistically or non-statistically significant improvement or none of the interventions resulted in demonstrated improvement.
No Confidence	The PIP did not follow approved methodology or processes through the end date.

As part of the validation process, Qsource noted strengths, suggestions, and areas of noncompliance (AONs) for each MCE.

Strengths were noted when an MCE demonstrated particular proficiency in a given step and can be identified regardless of validation rating. Achieving "met" on elements in each step was the expected result. A strength was noted if the MCE went above and beyond the expected outcome of simply "meeting" an element. Suggestions were given when documentation for an evaluation element included the basic components to meet requirements, but enhanced documentation could demonstrate a stronger understanding of CMS protocols. Qsource determined AONs (Weaknesses) for those evaluation elements assessed as Not Met and, therefore, not in full compliance with CMS protocols. When any element of a PIP step received an AON, Qsource provided technical assistance to help the MCE follow CMS protocol and revise the PIP as needed to improve performance and, thereby, the efficacy of the PIP.

Description of Data Obtained

The MCEs are required to produce PIPs for any Indiana programs administered. This report includes three programs – Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect. Qsource received the MCEs' PIP Summary Forms on July 14, 2025, and assessed them for the following PIP topics, as found in **Table 8**.

The MCEs had two mandatory PIPs, one clinical and one nonclinical, that must be conducted across all programs; however, each MCE was allowed to include additional PIP topics that pinpointed specific needs of their enrollees. Anthem submitted two PIP topics across their three programs, CareSource and MDwise submitted three PIP topics across their two programs, MHS submitted three PIP topics across their three programs, and UHC submitted two PIP topics for their one program. Qsource received and assessed PIP Summary Forms for the following PIP topics:

Table 8. PIP Topics by MCE and IHCP											
PIP Topic	Anthem			CareSource		MDwise		MHS			UHC
	HIP	HHW	HCC	HIP	HHW	HIP	HHW	HIP	HHW	HCC	HCC
Improving Diabetes Management (Clinical)	X	X	X	X	X	X	X	X	X	X	X
Improving Member Satisfaction (Nonclinical)				X	X	X	X	X	X	X	X
Improve Birth Outcomes and Postpartum Care (Clinical)				X	X	X	X	X	X	X	
Improving Asthma, Hypertension, and Cardio Health through Social Determinants of Health (SDOH) (Nonclinical)	X	X	X								

Table 9 displays the PIP names, as chosen by the MCEs, the PIPs' EQR validation status, and what MY the PIP is in.

Table 9. PIP Validation Status and Measurement Year			
MCE	PIP Title	Validation Status	Measurement Year
Anthem (HHW/HIP/HCC)	*Improving Diabetes Management*	Validated	Baseline Year
	Triple Care Triumph: Harnessing SDOH Driven Wellness in Diabetes, Asthma, and Cardio Health	Validated	Baseline Year
CareSource (HHW/HIP)	*Improve Access to Annual Kidney Health Evaluation for Members Diagnosed with Diabetes*	Validated	Baseline Year
	Improve Birth Outcomes for Pregnant Members at Risk for Preeclampsia	Validated	Baseline Year
	Improve Member Satisfaction and Reported Perception of the Health Plan	Validated	Baseline Year
MDwise (HHW/HIP)	*Disease Management: Diabetes Care*	Validated	Baseline Year
	Post-Partum Care	Validated	Baseline Year

Table 9. PIP Validation Status and Measurement Year			
MCE	**PIP Title**	**Validation Status**	**Measurement Year**
	Member Satisfaction	Validated	Baseline Year
MHS (HHW/HIP/HCC)	*Improving Diabetes Management*	Validated	Baseline Year
	Reduction in Maternal and Infant Mortality	Validated	Baseline Year
	Member Experience	Validated	Baseline Year
UHC (HCC)	*Improving Glycemic Status Assessment Rates for Patients with Diabetes (GSD)*	Validated	Baseline Year
	Improving Member Satisfaction with the Health Plan's Member Services	Validated	Baseline Year

Each MCE tailored their chosen PIP topics to focus on their specific member populations with tailored aim statements. **Table 10** displays the population and aim statements for each of the MCEs' PIP topics.

Table 10. PIP Aim Statements and Populations			
MCE	**PIP Name**	**Aim Statement**	**PIP Population**
Anthem (HIP/HHW/ HCC)	*Improving Diabetes Management*	Will a comprehensive engagement strategy—encompassing provider collaboration with incentives, ER use interventions, personalized member interactions, and tailored approaches for specific populations—enhance diabetes management among Anthem Indiana Medicaid HCC, HIP, and HHW Health Plan members aged 18-75 with type 1 or type 2 diabetes included in the NCQA HEDIS® Glycemic Status Assessment Administrative measure achieve a 44.25% rate for Diabetes Glycemic Status Assessment <8 control and reduce hospital inpatient admissions due to diabetes short-term complications by 5% during measurement period from 1/1/2023 to 12/31/2026?	All members aged 18-75 covered under Anthem Medicaid HIP, HCC, and HHW, diagnosed with Type 1 or Type 2 diabetes, and included in the HEDIS® Glycemic Status Assessment measure per applicable HEDIS Technical Specifications.
	Triple Care Triumph: Harnessing	Will a robust engagement strategy—encompassing quality improvement collaboration with providers, incentive programs, comprehensive care management, and enhanced SDOH assessments	All members aged 5-85 covered under Anthem Medicaid HIP, HCC, and HHW, diagnosed with

Table 10. PIP Aim Statements and Populations			
MCE	**PIP Name**	**Aim Statement**	**PIP Population**
	SDOH Driven Wellness in Diabetes, Asthma, and Cardio Health	and referrals—improve NCQA HEDIS® rates among IN Medicaid HCC, HHW, and HIP Plan members with asthma, cardiovascular disease, and diabetes from 1/1/2023 to 12/31/2026, by achieving the target percentiles of the NCQA HEDIS® Quality Compass All Health Maintenance Organization (HMO) Benchmarks for the following measures? ♦ Asthma Medication Ratio (AMR): Improve adherence to asthma controllers for ages 5-64 to achieve the 66th Quality Compass percentile. ♦ Controlling High Blood Pressure (CBP): Improve blood pressure compliance for ages 18-85 to achieve the 90th Quality Compass percentile. ♦ Glycemic Status Assessment (GSD): Improve diabetes control <8 for ages 18-75 to achieve the 10th Quality Compass percentile.	asthma, diabetes, or cardiovascular disease, and included in the HEDIS® Asthma Medication Ratio (AMR), Controlling High Blood Pressure (CBP), and/or Hemoglobin A1c Control <8 for Patients with Diabetes (HBD)/Glycemic Status Assessment (GSD) measures.
CareSource (HIP/HHW)	*Improve Access to Annual Kidney Health Evaluation for Members Diagnosed with Diabetes*	Will targeted provider education on the HEDIS® Kidney Health Evaluation (KED) standards of care and decision support tools improve the compliance rate for annual kidney health evaluation for HIP members ages 18-85 years diagnosed with type 1 or type 2 diabetes by 5.09 percentage points to reach 33rd percentile benchmark over the annual review period. Will targeted provider education on the HEDIS® KED standards of care and decision support tools improve the compliance rate for annual kidney health evaluation for HHW members ages 18-85 years diagnosed with type 1 or type 2 diabetes by 5.09 percentage points to reach 33rd percentile benchmark over the annual review period.	The entire population enrolled in HHW or HIP, and all members (entire population) assigned to the MCE during the enrollment period (January 1 to December 31 of the MY) ages 18-85 years with a diagnosis of type 1 or 2 diabetes during the MY or the year prior to the MY and identified as needing annual kidney health evaluation.
	Improve Birth Outcomes for Pregnant Members at Risk for Preeclampsia	Will implementation of a proactive preeclampsia interdisciplinary surveillance hub facilitate a reduction in the rate of preterm births for pregnant members at-risk for preeclampsia by 2% from baseline during the first annual remeasurement period (Measurement Year [MY] 2025)?	The entire population of pregnant members with live births occurring within the MY identified with one or more of the following risk factors associated with preeclampsia: diagnosis of Hypertension, Diabetes, Obesity,

Table 10. PIP Aim Statements and Populations

MCE	PIP Name	Aim Statement	PIP Population
			Renal Disease, maternal age 35 or greater, and member reported race as Black or African American
	Improve Member Satisfaction and Reported Perception of the Health Plan	Will strategies to increase engagement in enhanced benefits and incentive rewards drive improved satisfaction rates Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Rating of Health Plan for members enrolled in HHW program by 2.96 percentage points from 33rd to 66.67th percentile (1-year goal) and Dissatisfaction with Health Plan Grievances by 3% (1-year goal) from 0.79 to 0.76 by the annual review period? Will strategies to increase engagement in enhanced benefits and incentive rewards drive improved satisfaction rates CAHPS® Rating of Health Plan for members enrolled in the HIP program by 2.55 percentage points from 33rd to 66.67th percentile (1-year goal) and Dissatisfaction with Plan Grievances by 3% (1-year goal) from 3.07 to 2.98 by the annual review period?	The entire population enrolled in HHW or HIP.
MDwise (HIP/HHW)	*Disease Management: Diabetes Care*	Will engagement with care managers and member programs like InControl increase the number of diabetic members that receive an annual hemoglobin (Hb) A1c test, with results that are <8.0 indicating normal or good range, for the period beginning January 1, 2024, and ending December 31, 2024?	MDwise members aged 18-64, with continuous enrollment of at least 180 days, with no gaps in enrollment of more than 45 days, who have an identified diagnosis of diabetes (type 1 or type 2).
	Post-Partum Care	Can MDwise improve the number of postpartum visits within 7-84 days of giving birth, by 5% for all eligible HHW and HIP members in Indiana, utilizing targeted care management engagement to increase the timeliness of care visit, each re-measurement year by December 31, 2025?	All MDwise members who have delivered a baby, in any setting, from October 8th the year prior, to October 7th of the current year with continuous enrollment from 45 days pre-birth to 60 days post-birth.
	Member Satisfaction	Can MDwise improve CAHPS® ratings of the health plan rating (8,9,10), e.g. member satisfaction with the health plan, by 3% and decrease member grievances by 5% for the period beginning on January 1, 2024, and ending on December 31, 2025, for members in	MDwise members, of any age, with continuous enrollment in the plan of at least 180 days with no gaps in enrollment of more than

Table 10. PIP Aim Statements and Populations			
MCE	**PIP Name**	**Aim Statement**	**PIP Population**
		Indiana by increasing member engagement with phone, mail, and text interventions?	45 days, with any diagnosis or procedures given in the MY.
MHS (HIP/HHW/ HCC)	*Improving Diabetes Management*	Will targeted member interventions improve the percentage rate of MHS Medicaid adult members (ages 18–75) with type 1 or type 2 diabetes who receive a retinal eye exam and maintain blood pressure control during each remeasurement year?	All adult members between 18-64 years of age with a diagnosis of diabetes (types 1 or 2) that are continuously enrolled with no more than one gap in enrollment of up to 45 days in the MY, require a retinal eye exam, and have adequately controlled blood pressure readings (<140/90 mm HG).
	Reduction in Maternal and Infant Mortality	Will targeted outreach by the MHS Start Smart for Baby (SSFB) Care Management team—through phone calls, emails, and text messages—following the identification of OB members lead to increased enrollment of pregnant members in the SSFB program and a reduction in hospital admissions among high-risk obstetrics (OB) members during each remeasurement year?	All pregnant members enrolled during the MY.
	Member Experience	Will targeted interventions increase the CAHPS summary rating by two (2) percentage points for Medicaid HIP, HHW, and HCC adult members, and parents/guardians of HHW and HCC child members, who respond with a rating of 8,9, or 10 for the CAHPS survey question “Rating of Health Plan” during each remeasurement period?	A random sample of members continuously enrolled in the MCE for at least five of the last six months of the MY who completed the “Rating of Health Plan” question in the annual CAHPS® surveys.
UHC (HCC)	*Improving Glycemic Status Assessment Rates for Patients with Diabetes (GSD)*	Will targeted member interventions improve compliance rates for those HCC members 18-75 years of age with diabetes who fall into the GSD HEDIS® measure, Glycemic Status <8.0% and Glycemic Status >9.0%, year over year?	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (HbA1c or glucose management indicator [GMI]) was at the following levels during the MY: Glycemic Status <8.0%, or Glycemic Status >9.0%.

Table 10. PIP Aim Statements and Populations			
MCE	PIP Name	Aim Statement	PIP Population
	Improving Member Satisfaction with the Health Plan's Member Services	Do targeted interventions in the Member Services department increase the percentage of adult HCC members who respond to the CAHPS® Adult Survey Questions: In the past six months how often did your health plan's customer service give you the information or help you needed (question 24), and Customer service treated me with courtesy and respect (question 25), with an answer of "Usually" or "Always" year over year?	All UHC HCC members ages 18 and over who completed the Adult Medicaid Satisfaction CAHPS® Survey in the MY.

Interventions

Table 11 presents the MCE-reported PIP interventions, as outlined by the MCE in the PIP Summary Form. The focus of the intervention was determined by Qsource and designated as either provider, enrollee, or MCE-focused. The table contains direct quotes from the MCEs.

Table 11. MY 2024 PIP Interventions			
MCE	PIP Title	Interventions	Domain of Care
Anthem (HIP/HHW/ HCC)	*Improving Diabetes Management*	**Provider-focused:** Value-based Provider (VBP) Incentive – Strengthens collaborative quality efforts between the Anthem Providers Success Team and Primary Care Providers (PCPs) in value-based incentive agreements. With 53% of Anthem's Medicaid members in these provider groups, this strategy adopts a holistic, patient-centered approach. It emphasizes advanced data analytics to identify gaps, benchmark performance, and develop improvement strategies. The focus is on quality planning, continuous monitoring, and regular impact assessments, quickly resolving provider obstacles with health plan support. Additionally, it promotes clear, consistent communication among all stakeholders to ensure active engagement of the entire care team, including members and patients.	Access to Care
		Member-focused: High Emergency Department Utilizer Program – Identifying members having ER overutilization and implementing appropriate interventions to connect members with appropriate outpatient providers and services to decrease unnecessary ER utilization is the goal of the ER High Utilizer Program. The program aims to provide care coordination support	Access to Care

Table 11. MY 2024 PIP Interventions			
MCE	**PIP Title**	**Interventions**	**Domain of Care**
		to these members to help members receive the most appropriate care in the right setting and at the right time.	
		Member-focused: High Touch Member Outreach Program – This strategy involves prioritizing face-to-face visits for members in critical situations: urgent referrals, unmet needs due to SDOH, unreachable cases in care coordination, upcoming loss of eligibility, and excessive emergency room visits without recent wellness checks. Anthem's Community Health Workers (CHWs) play a key role by educating members, reviewing HEDIS® care gaps, assessing SDOH needs, and facilitating community resource referrals. CHWs also assist with appointment scheduling and connect members to primary care providers and case management, helping them navigate the health plan and system effectively.	Access to Care
	Triple Care Triumph: Harnessing SDOH Driven Wellness in Diabetes, Asthma, and Cardio Health	**Provider-focused:** SDOH Provider Incentive Program – Educate and engage providers to perform SDOH assessments on patients and refer patients to appropriate Community Resources for SDOH needs identified for food, housing, or transportation.	Access to Care
		MCE-focused: VRI® Remote Condition Monitoring Program – The VRI remote condition monitoring program is designed to empower members in managing asthma, hypertension, or diabetes by supporting their health management in a comfortable and private setting. Members are equipped with devices that allow them to self-monitor their health from the convenience of their homes. Each day, members take their readings or utilize devices which track rescue and controller inhaler medication use, which are automatically transmitted to VRI's secure monitoring platform. If any readings fall outside the typical range, VRI proactively reaches out to the member. Any confirmed concerns related to these readings are communicated to the member's physician or a higher level of care as needed. VRI follows up with members within 24-36 hours to ensure their condition is stable and addresses any new or worsening symptoms. Additionally, VRI forwards any further needs through Anthem Case Management (CM) to ensure comprehensive support.	Quality of Care and Timeliness of Care
		Provider-focused: Provider Quality Collaboration & Support – Anthem's quality collaboration with contracted providers is driven by a comprehensive approach that combines patient-centered care and robust data analytics. This provider engagement strategy leverages sophisticated analytics to identify care gaps, benchmark performance, and develop effective improvement plans. It emphasizes quality planning, continuous monitoring, and impact assessment, while promptly addressing obstacles with health plan support. Additionally, it fosters clear communication among all stakeholders, ensuring active involvement of the entire care team, including patients, in their healthcare journey.	Quality of Care and Access to Care

Table 11. MY 2024 PIP Interventions			
MCE	**PIP Title**	**Interventions**	**Domain of Care**
CareSource (HIP/HHW)	*Improve Access to Annual Kidney Health Evaluation for Members Diagnosed with Diabetes*	**Provider-focused:** CareSource will deliver a targeted provider education campaign to improve the rate of provider adoption and member access to the recommended annual kidney health evaluation. Targeted education will include a review of the clinical standards and recommendations and address common barriers among providers and members. One-on-one provider meetings will be conducted by and the shared responsibility of the Quality improvement Specialist and Community Health Liaisons (CHL). Providers will receive a minimum of two annual one-on-one meetings highlighting the clinical standards accompanied with a member gap list and provider specific rates. Providers unwilling or unable to complete the two recommended annual one-on-one meetings will receive educational materials and upon confirmation of a secure platform will receive a member gap roster for review.	Quality of Care and Access to Care
	Improve Birth Outcomes for Pregnant Members at Risk for Preeclampsia	**MCE-focused:** CareSource will form a Preeclampsia Interdisciplinary Review Team (PIRT) to act as a surveillance hub driving evidence-based care for pregnant members at-risk for preeclampsia through systematic case review. The purpose of the systematic case review is to facilitate evidence-based clinical decision-making to improve birth outcomes, and the quality of care delivered. Through this systematic approach, CareSource will enhance surveillance and interdisciplinary collaboration and coordinated care to pregnant members with a diagnosis of hypertension, diabetes, obesity, renal disease, maternal age less than 19 years and greater than 35 years, and members with a reported race as Black or African American.	Quality of Care and Access to Care
	Improve Member Satisfaction and Reported Perception of the Health Plan	**Provider-focused:** Standardized Staff Training on Enhanced Benefits and Rewards – CareSource will implement a standardized staff training tool to facilitate member awareness and engagement in enhanced benefits during inbound and outbound member calls.	Quality of Care
MDwise (HIP/HHW)	*Disease Management: Diabetes Care*	**Member-focused:** Increase member enrollment in MDwise's care management chronic disease management program INcontrol.	Access to Care
		Member-focused: Engage diabetic members via educational Short Message Service (SMS) text campaign.	Quality of Care
	Post-Partum Care	**Member-focused:** Increase case management outreach to members who are identified as pregnant.	Access to Care

Table 11. MY 2024 PIP Interventions

MCE	PIP Title	Interventions	Domain of Care
	Member Satisfaction	**Member-focused:** Utilize MDwise Quality Outreach Representatives to engage members with MDwise via telephone.	Access to Care
		Member-focused: Utilize mailers and postcards to engage members with MDwise.	Access to Care
		Member-focused: Utilize text message campaigns to engage members with MDwise.	Access to Care
MHS (HIP/HHW/ HCC)	*Improving Diabetes Management*	**Provider-focused:** Expand provider education strategy focusing on the BPD and the EED measures targeting outreach with providers, who have MHS Medicaid members with diabetes and the members who do not have controlled blood pressure reading or a retinal eye exam. Expansion of provider education will include communication delivered in various modes and topics related to the measures, such as but not limited to: ♦ Provider emails; ♦ Provider blogs; ♦ Provider office visits; and ♦ Campaign to promote how to help a member obtain a blood pressure monitor.	Quality of Care
	Reduction in Maternal and Infant Mortality	**Member-focused:** MHS Care Coordinators outreach to all members with a pregnancy diagnosis and offer enrollment into the SSFB program. If members are unreachable or refuse program, then outreach to the member continues and education is sent to the member until delivery.	Timeliness of Care and Access to Care
	Member Experience	**Member-focused:** To monitor real-time member satisfaction with the MHS call center and identify barriers hindering member satisfaction, the plan will implement a post-call survey. A random sample of members will receive an SMS text-based customer service survey within one day of their call to MHS Member Services, unless they have received the survey within the past 30 days. Members who do not have a mobile phone number on file with the plan will not receive the survey.	Quality of Care
UHC (HCC)	*Improving Glycemic Status Assessment Rates for*	**Member-focused:** Optum Rx Medication Therapy Management Program (MTM) – Data, interventions and monitoring focused on optimizing drug therapy, improving adherence, reducing risk for interactions and closing gaps in care. Key services comprising the MTM Program are annual Comprehensive Medication Reviews (CMR) and daily Targeted Medication Reviews (TMR). This intervention consists of calls to members identified including	Access to Care and Quality of Care

Table 11. MY 2024 PIP Interventions			
MCE	**PIP Title**	**Interventions**	**Domain of Care**
	Patients with Diabetes (GSD)	for diabetes with applicable disease states – eight or more chronic meds and over three or more disease states (members can opt out). Recommendations go to the provider regardless of member engagement (based on conversations with the member). This includes a medication action plan.	
		Member-focused: Centralized Vendor Program (mPulse) – mPulse is a UHC Community and State National Program. For UHC Community Plan Indiana, diabetes is a focus measure. The focus is on IN members with an identified care gap closure by outreaching to members based on their communication preference. Three methods of outreach: text, Interactive Voice Response, and email.	Access to Care
		Member-focused: Livongo is an evidence-based platform for remote monitoring and chronic condition management. The platform includes live (telephonic) coaching and 24/7 monitoring as well as AI/App engagement and outreach. UHC will engage in diabetes and hypertension management. Goals include managing healthy activities, diet, medication adherence, regular testing (e.g., blood glucose, blood pressure) and reminders about important doctor visits such as A1C testing, diabetic retinal eye exams, kidney testing and wound management. This program will be piloted for certain diabetic members with hypertension in our population who are not being care managed.	Access to Care and Timeliness of Care
		Member-focused: Community Partnerships – Community partnerships are utilized to leverage member and provider education regarding diabetes best practices and member self-care.	Access to Care and Quality of Care
	Improving Member Satisfaction with the Health Plan's Member Services	**MCE-focused:** Interventions currently in place will be reviewed for continuance, enhancement, modification, and/or termination.	Quality of Care
		Provider-focused: Member services call center audits are conducted by the Member Services supervisory staff on a frequent and ongoing basis. Results of the audits are reviewed with the respective call center staff and any action steps are taken with the identified staff member where needed improvement is identified. Further detailed information related to the history of the member call center audits can be found in Improvement Strategy 1 above. As of Quarter 2 for Remeasurement 1, the local member services supervisory staff are no longer conducting the call center audits. These audits have been transferred to the national member services team. Despite the transfer, the process has not changed. Audit results are funneled down to the local health plan member services supervisory staff who conduct any needed action steps	Quality of Care

Table 11. MY 2024 PIP Interventions			
MCE	**PIP Title**	**Interventions**	**Domain of Care**
		with identified local member services call center staff.	
		Member-focused: Member escalation refers to the process of guiding team members on how to escalate the incident management process. It is a written procedure that outlines the upward flow of alerts and responsibility within an organization and ensures the necessary parties are brought on board at the appropriate time in an incident's lifecycle. Escalation management is also used to handle customer issues that can't be resolved during a customer's initial interaction with a support team member. It involves advancing a customer's concern to higher levels of expertise or authority until the issue has been resolved.	Access to Care and Quality of Care

Performance Measures and Measurement Scores

Table 12 presents the MCE-chosen performance measures for each PIP as well as the goals, benchmarks, MY rates, and statistical significance in year-over-year score comparisons. Because this is the Baseline Measurement Year for all of the PIPs, there will be no year-over-year score comparisons or statistical significance listed. These analyses will be included in next year's report. Additionally, scores presented in the table are presented in the manner that they were submitted by the MCE.

Table 12. PIP Validation Status and Performance Scores							
MCE	**PIP Name**	**Performance Measure**	**IHCP**	**MY 2024 Goal**	**Benchmark**	**MY 2024 Rate**	**Statistical Significance**
Anthem	*Improving Diabetes Management*	Glycemic Status Assessment < 8%	HIP	44.25%	44.25% HBD <8	39.59%	NA*
			HHW	44.25%	44.25% HBD <8	36.10%	NA
			HCC	44.25%	44.25% HBD <8	37.63%	NA
		Inpatient Admissions for Diabetes Short-term	HIP	11.20	5% Reduction	11.24	NA

Table 12. PIP Validation Status and Performance Scores							
MCE	**PIP Name**	**Performance Measure**	**IHCP**	**MY 2024 Goal**	**Benchmark**	**MY 2024 Rate**	**Statistical Significance**
		Complications per 1000			from Baseline		
			HHW	11.20	5% Reduction from Baseline	25.00	NA
			HCC	11.20	5% Reduction from Baseline	12.09	NA
	Triple Care Triumph: Harnessing SDOH Driven Wellness in Diabetes, Asthma, and Cardio Health	Asthma Medication Ratio (AMR)	HIP	70.56%	70.56%	60.61%	NA
			HHW	70.56%	70.56%	71.64%	NA
			HCC	70.56%	70.56%	63.38%	NA
		Glycemic Status Assessment (GSD)	HIP	44.25%	44.25%	39.59%	NA
			HHW	44.25%	44.25%	36.10%	NA
			HCC	44.25%	44.25%	37.63%	NA
		Controlling High Blood Pressure (CBP)	HIP	72.75%	72.75%	70.80%	NA
			HHW	72.75%	72.75%	73.02%	NA
			HCC	72.75%	72.75%	70.56%	NA
CareSource	*Improve Access to Annual Kidney Health Evaluation for Members Diagnosed with Diabetes*	HEDIS® KED for Patients with Diabetes	HIP	45.11%	NA	41.64%	NA
			HHW	33.00%	NA	27.91%	NA
	Improve Birth Outcomes for Pregnant Members	Preterm Birth Rate for Members At-Risk for Preeclampsia	HIP	2% reduction to baseline	NA	27.72%	NA

Table 12. PIP Validation Status and Performance Scores							
MCE	**PIP Name**	**Performance Measure**	**IHCP**	**MY 2024 Goal**	**Benchmark**	**MY 2024 Rate**	**Statistical Significance**
	at Risk for Preeclampsia		HHW	2% reduction to baseline	NA	22.89%	NA
	Improve Member Satisfaction and Reported Perception of the Health Plan	CAHPS® General Survey Rating of Health Plan – HIP Adult/HHW Child	HIP	64.05%	64.71%	61.50%	NA
			HHW	73.76%	64.71%	70.88%	NA
		Rate Dissatisfaction with Plan Grievances per 1,000 Members	HIP	2.96	NA	3.07	NA
			HHW	0.76	NA	0.79	NA
MDwise	*Disease Management: Diabetes Care*	Glycemic Status Assessment for Patients with Diabetes (GSD)	HIP	44.25%	44.25%	56.45%	NA
			HHW	44.25%	44.25%	45.12%	NA
	Post-Partum Care	Prenatal and Postpartum Care – Postpartum Visits	HIP	83.33%	82.00%	81.00%	NA
			HHW	83.33%	82.00%	83.46%	NA
	Member Satisfaction	Performance Measure 1: Number of Member Grievances	HIP	2.45 per 1,000 members	2.46 per 1,000 members	2.72 per 1,000 members	NA
			HHW	2.45 per 1,000 members	2.46 per 1,000 members	2.72 per 1,000 members	NA
		Performance Measure 2: CAHPS® – HIP Adult/HHW Child	HIP	69.48%	80.5%	71.7%	NA
			HHW	88.9%	91.18%	91.4%	NA
MHS	*Improving Diabetes Management*	Blood Pressure Control for Patients with Diabetes (BPD)	HIP	Not listed	NA	40.71%	NA
			HHW	Not listed	NA	40.71%	NA
			HCC	Not listed	NA	40.71%	NA
		Eye Exam for Patients with	HIP	Not listed	NA	48.65%	NA

Table 12. PIP Validation Status and Performance Scores

MCE	PIP Name	Performance Measure	IHCP	MY 2024 Goal	Benchmark	MY 2024 Rate	Statistical Significance
		Diabetes (EED)	HHW	Not listed	NA	48.65%	NA
			HCC	Not listed	NA	48.65%	NA
	Reduction in Maternal and Infant Mortality	Pregnant Members enrolled in SSFB program	HIP	20.00%	NA	27.8%	NA
			HHW	20.00%	NA	27.8%	NA
			HCC	20.00%	NA	27.8%	NA
		Reduce hospital admissions for high-risk OB members	HIP	12.6%	NA	15.9%	NA
			HHW	12.6%	NA	15.9%	NA
			HCC	12.6%	NA	15.9%	NA
	Member Experience	Performance Measure 1: HEDIS® CAHPS® Measure Rating of Health Plans – Adult	HIP	82.9%	80.9%	79.3%	NA
			HHW	82.9%	80.9%	71.4%	NA
			HCC	82.9%	80.9%	77.6%	NA
		Performance Measure 2: HEDIS® CAHPS® Measure Rating of Health Plans – Child	HIP	91.3%	89.3%	NR[‡]	NA
			HHW	91.3%	89.3%	87.9%	NA
			HCC	91.3%	89.3%	84.7%	NA
UHC	*Improving Glycemic Status Assessment Rates for Patients with Diabetes (GSD)*	Glycemic Status <8.0% and Glycemic Status >9.0%	HCC	TBD[†]	TBD	<8%: 51.24% >9%: 42.24%	NA
	Improving Member Satisfaction with the Health Plan's Member Services	Maintained or improved scores for question numbers 24 and 25 of the CAHPS® Survey	HCC	#24: 86.27% #25: 95.73%	#24: 85.89% #25: 95.33%	NR[#]	NA

Not Applicable
[†]*To be determined: the MCE stated that these rates will be determined after the baseline year has been completed.*
[‡]*Not Reported. There is no data for Performance Measure 2 for HIP in the Member Experience PIP because the age group measured does not apply to HIP.*
[#]*Not reported: The MCE reported that rates had not yet been published by NCQA at the time of this PIP submission.*

Validation Results MY 2024 PIPs

Table 13 presents each PIP's name, the elements met and applicable, the overall score, and validation ratings. The MCEs were required to submit at least one clinical and one non-clinical PIP. The overall score represents the percentage of elements met, Validation Rating 1 indicates if the overall PIP met requirements, and Validation Rating 2 indicates if significant and sustained improvement occurred.

For the PIP review, 4 of the 13 PIPs received a High Confidence validation rating for Validation Rating 1, 3 of the 13 PIPs received a Moderate Confidence for Validation Rating 1, and 6 of the 13 PIPs received a No Confidence Rating for Validation Rating 1. All 13 PIPs received a NA rating for Validation Rating 2, as this was the first year the PIPs were administered. Appendix A contains additional details about each PIP study.

Table 13. PIP Validation Status and Performance Scores

MCE	PIP Name	Elements		Overall Score	Validation Rating 1	Validation Rating 2
		Met	Applicable			
Anthem	*Improving Diabetes Management*	35	39	89.74%	Moderate Confidence	NA*
	Triple Care Triumph: Harnessing SDOH Driven Wellness in Diabetes, Asthma, and Cardio Health	39	42	92.86%	High Confidence	NA
CareSource	*Improve Access to Annual Kidney Health Evaluation for Members Diagnosed with Diabetes*	39	41	95.12%	High Confidence	NA
	Improve Birth Outcomes for Pregnant Members at Risk for Preeclampsia	40	43	93.02%	High Confidence	NA
	Improve Member Satisfaction and Reported Perception of the Health Plan	37	42	88.10%	Moderate Confidence	NA
MDwise	*Disease Management: Diabetes Care*	40	44	90.91%	High Confidence	NA
	Post-Partum Care	30	43	69.77%	No Confidence	NA
	Member Satisfaction	38	46	82.61%	Moderate Confidence	NA

Table 13. PIP Validation Status and Performance Scores

MCE	PIP Name	Elements		Overall Score	Validation Rating 1	Validation Rating 2
		Met	Applicable			
MHS	*Improving Diabetes Management*	23	41	56.10%	No Confidence	NA
	Reduction in Maternal and Infant Mortality	12	41	29.27%	No Confidence	NA
	Member Experience	22	40	55.00%	No Confidence	NA
UHC	*Improving Glycemic Status Assessment Rates for Patients with Diabetes (GSD)*	19	41	46.34%	No Confidence	NA
	Improving Member Satisfaction with the Health Plan's Member Services	12	41	29.27%	No Confidence	NA

**Not Applicable*

Anthem's *Improving Diabetes Management* PIP was validated by the EQRO during its Baseline Year and received a Validation Rating 1 of Moderate Confidence based on the PIP's adherence to acceptable methodology in each phase of the PIP. The PIP's Design Methodology received a score of 12/13 elements (92.31%), the Data Collection methodology received a score of 12/15 elements (80.00%), and the Data Analysis and Interpretation Methodology received a score of 11/11 elements (100%) for an overall score of 89.74%. Similarly, Anthem's *Triple Care Triumph: Harnessing SDOH Driven Wellness in Diabetes, Asthma, and Cardio Health* PIP was also validated during its Baseline Year and received a Validation Rating 1 of High Confidence based on the PIP's adherence to acceptable methodology in each phase of the PIP. The PIP's Design Methodology received a score of 11/13 elements (84.62%), the Data Collection methodology received a score of 17/18 elements (94.44%), and the Data Analysis and Interpretation Methodology received a score of 11/11 elements (100%) for an overall score of 92.86%. Both of Anthem's PIPs received a Validation Rating 2 of NA due to the PIPs being in their Baseline Year.

CareSource's *Improve Access to Annual Kidney Health Evaluation for Members Diagnosed with Diabetes* PIP was validated by the EQRO during its Baseline Year and received a Validation Rating 1 of High Confidence based on the PIP's adherence to acceptable methodology in each phase of the PIP. The PIP's Design Methodology received a score of 13/14 elements (92.86%), the Data Collection methodology received a

score of 14/15 elements (93.33%), and the Data Analysis and Interpretation Methodology received a score of 12/12 elements (100%) for an overall score of 95.12%. Similarly, CareSource's *Improve Birth Outcomes for Pregnant Members at Risk for Preeclampsia* PIP was also validated during its Baseline Year and received a Validation Rating 1 of High Confidence based on the PIP's adherence to acceptable methodology in each phase of the PIP. The PIP's Design Methodology received a score of 13/14 elements (92.86%), the Data Collection methodology received a score of 15/17 elements (88.24%), and the Data Analysis and Interpretation Methodology received a score of 12/12 elements (100%) for an overall score of 93.02%. Additionally, CareSource's *Improve Member Satisfaction and Reported Perception of the Health Plan* PIP was validated during its Baseline Year and received a Validation Rating 1 of Moderate Confidence based on the PIP's adherence to acceptable methodology in each phase of the PIP. The PIP's Design Methodology received a score of 10/13 elements (76.92%), the Data Collection methodology received a score of 16/17 elements (94.12%), and the Data Analysis and Interpretation Methodology received a score of 11/12 elements (91.67%) for an overall score of 88.10%. All three of CareSource's PIPs received a Validation Rating 2 of NA due to the PIPs being in their Baseline Year.

MDwise's *Disease Management: Diabetes Care* PIP was validated by the EQRO during its Baseline Year and received a Validation Rating 1 of High Confidence based on the PIP's adherence to acceptable methodology in each phase of the PIP. The PIP's Design Methodology received a score of 10/13 elements (76.92%), the Data Collection methodology received a score of 19/20 elements (95.00%), and the Data Analysis and Interpretation Methodology received a score of 11/11 elements (100%) for an overall score of 90.91%. While MDwise's *Post-Partum Care* PIP was also validated during its Baseline Year, this PIP received a Validation Rating 1 of No Confidence based on the PIP's lack of adherence to acceptable methodology in each phase of the PIP. The PIP's Design Methodology received a score of 9/13 elements (69.23%), the Data Collection methodology received a score of 11/18 elements (61.11%), and the Data Analysis and Interpretation Methodology received a score of 10/12 elements (83.33%) for an overall score of 69.77%. MDwise's *Member Satisfaction,* the third PIP, was validated during its Baseline Year and received a Validation Rating 1 of Moderate Confidence based on the PIP's adherence to acceptable methodology in each phase of the PIP. The PIP's Design Methodology received a score of 11/14 elements (78.58%), the Data Collection methodology received a score of 20/21 elements (95.24%), and the Data Analysis and Interpretation Methodology received a score of 7/11 elements (63.64%) for an overall score of 82.61%. All three of MDwise's PIPs received a Validation Rating 2 of NA due to the PIPs being in their Baseline Year.

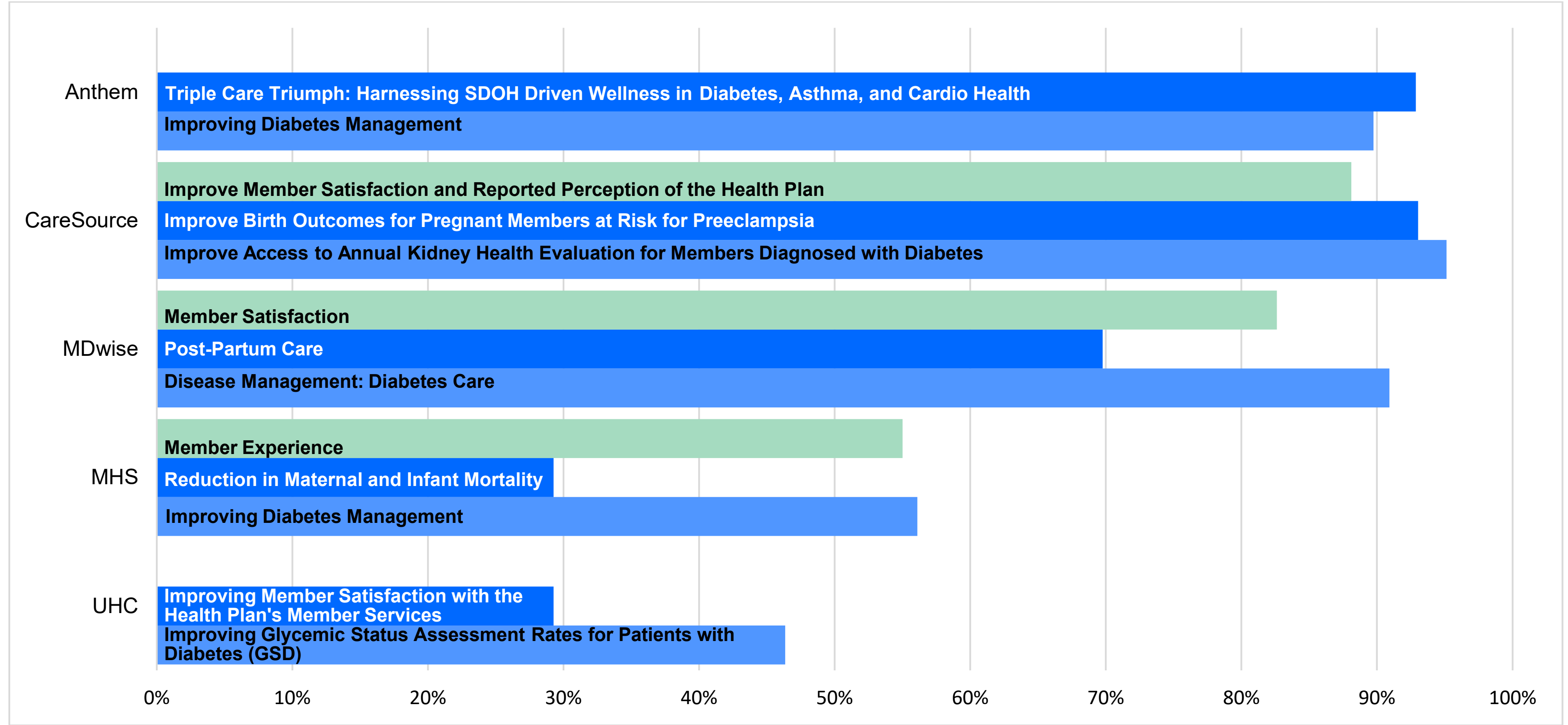
MHS's *Improving Diabetes Management* PIP was validated by the EQRO during its Baseline Year and received a Validation

Rating 1 of No Confidence based on the PIP's lack of adherence to acceptable methodology in each phase of the PIP. The PIP's Design Methodology received a score of 7/13 elements (53.85%), the Data Collection methodology received a score of 9/18 elements (50.00%), and the Data Analysis and Interpretation Methodology received a score of 7/10 elements (70.00%) for an overall score of 56.10%. Similarly, MHS's *Reduction in Maternal and Infant Mortality* PIP was also validated during its Baseline Year and received a Validation Rating 1 of No Confidence based on the PIP's lack of adherence to acceptable methodology in each phase of the PIP. The PIP's Design Methodology received a score of 6/13 elements (46.15%), the Data Collection methodology received a score of 3/16 elements (18.75%), and the Data Analysis and Interpretation Methodology received a score of 3/12 elements (25.00%) for an overall score of 29.27%. MHS's *Member Satisfaction,* the third PIP, was validated during its Baseline Year and also received a Validation Rating 1 of No Confidence based on the PIP's lack of adherence to acceptable methodology in each phase of the PIP. The PIP's Design Methodology received a score of 8/13 elements (61.54%), the Data Collection methodology received a score of 6/15 elements (40.00%), and the Data Analysis and Interpretation Methodology received a score of 8/12 elements (66.67%) for an overall score of 55.00%. All three of MHS's PIPs received a Validation Rating 2 of NA due to the PIPs being in their Baseline Year.

UHC's *Improving Glycemic Status Assessment Rates for Patients with Diabetes (GSD)* PIP was validated by the EQRO during its Baseline Year and received a Validation Rating 1 of No Confidence based on the PIP's lack of adherence to acceptable methodology in each phase of the PIP. The PIP's Design Methodology received a score of 8/13 elements (61.54%), the Data Collection methodology received a score of 8/18 elements (44.44%), and the Data Analysis and Interpretation Methodology received a score of 3/10 elements (30.00%) for an overall score of 46.34%. Similarly, UHC's *Improving Member Satisfaction with the Health Plan's Member Services* PIP was also validated during its Baseline Year and received a Validation Rating 1 of No Confidence based on the PIP's lack of adherence to acceptable methodology in each phase of the PIP. The PIP's Design Methodology received a score of 7/13 elements (53.85%), the Data Collection methodology received a score of 3/17 elements (17.65%), and the Data Analysis and Interpretation Methodology received a score of 2/11 elements (18.18%) for an overall score of 29.27%. Both of UHC's PIPs received a Validation Rating 2 of NA due to the PIPs being in their Baseline Year.

Figure 1 presents a comparison of the PIP Validation Scores.

Figure 1. PIP Validation Score Comparison



Strengths, Weaknesses, and Recommendations

The following two tables, Table 14 and Table 15 present strengths and weaknesses identified for each MCE during the PIP validation, respectively. Strengths for the PIP validation indicate that the MCEs demonstrated proficiency in a given activity and can be recognized regardless of validation rating. The lack of an identified strength should not be interpreted as a shortcoming of an MCE. Areas of noncompliance (AONs), or weaknesses, arise from evaluation elements that receive a Not Met score, indicating that those elements were not fully compliant with CMS EQR Protocols. This information helps

determine whether to continue or retire an intervention. Qsource also identified suggestions when documentation for an evaluation element included the essential components to meet requirements, but enhanced documentation could demonstrate a stronger understanding of CMS EQR Protocols. The MCEs were not held accountable to address suggestions; therefore, this report did not monitor or include suggestions.

Table 14. PIP Strengths

PIP	PIP Type	PIP Step	Strengths	Domain of Care
Anthem				
Improving Diabetes Management	Clinical	No strengths were identified.		
Triple Care Triumph: Harnessing SDOH Driven Wellness in Diabetes, Asthma, and Cardio Health	Nonclinical	No strengths were identified.		
CareSource				
Improve Access to Annual Kidney Health Evaluation for Members Diagnosed with Diabetes	Clinical	Step 8: Assess the Improvement Strategies	CareSource provided a detailed barrier analysis by using a Fishbone diagram and the 5 Whys methodology and prepared a Key Driver Diagram that included primary drivers, secondary drivers, and interventions.	Quality of Care
Improve Birth Outcomes for Pregnant Members at Risk for Preeclampsia	Clinical	Step 8: Assess the Improvement Strategies	CareSource detailed the improvement strategies and Plan-Do-Study-Act (PDSA) cycles with clear documentation of the findings via charts, tables and a workflow.	Quality of Care
Improve Member Satisfaction and Reported Perception of the Health Plan	Nonclinical	No strengths were identified.		
MDwise				
Disease Management: Diabetes Care	Clinical	No strengths were identified.		
Post-Partum Care	Clinical	No strengths were identified.		
Member Satisfaction	Nonclinical	No strengths were identified.		

Table 14. PIP Strengths				
PIP	**PIP Type**	**PIP Step**	**Strengths**	**Domain of Care**
MHS				
Improving Diabetes Management	Clinical	No strengths were identified.		
Reduction in Maternal and Infant Mortality	Clinical	No strengths were identified.		
Member Satisfaction	Nonclinical	No strengths were identified.		
UHC				
Improving Glycemic Status Assessment Rates for Patients with Diabetes (GSD)	Clinical	No strengths were identified.		
Improving Member Satisfaction with the Health Plan's Member Services	Nonclinical	No strengths were identified.		

Table 15. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
Anthem				
Improving Diabetes Management	Clinical	Step 2: Review the PIP Aim Statement	Element 3: Anthem should clearly specify the current PIP time period as it relates to this 2024 baseline year submission.	Quality of Care
Improving Diabetes Management	Clinical	Step 5: Review the Selected PIP Variables and Performance Measures	Element 1a: Anthem should fully describe the variable for clarity.	Access to Care
			Element 5: Anthem should discuss the comparison of data with benchmarks and how those will inform improvement strategies.	
			Element 10: Anthem should show strong evidence that the process being measured is meaningfully associated with outcomes.	

Table 15. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
Triple Care Triumph: Harnessing SDOH Driven Wellness in Diabetes, Asthma, and Cardio Health	Nonclinical	Step 2: Review the PIP Aim Statement	Element 3: Anthem should clearly specify the current PIP time period as it relates to this 2024 baseline year submission.	Quality of Care
			Element 5: Anthem should have a defined percentage rate not a percentile as their goal.	
Triple Care Triumph: Harnessing SDOH Driven Wellness in Diabetes, Asthma, and Cardio Health	Nonclinical	Step 5: Review the Selected PIP Variables and Performance Measures	Element 10: Anthem should show strong evidence that the process being measured is meaningfully associated with outcomes.	Access to Care
CareSource				
Improve Access to Annual Kidney Health Evaluation for Members Diagnosed with Diabetes	Clinical	Step 2: Review the PIP Aim Statement	Element 3: CareSource should include an aim statement that indicates the specific time period relative to the PIP submission's performance period.	Quality of Care
Improve Access to Annual Kidney Health Evaluation for Members Diagnosed with Diabetes	Clinical	Step 5: Review the Selected PIP Variables and Performance Measures	Element 5: CareSource should include a discussion to address performance measures that includes, at a minimum, performance measure tracking, a comparison of performance to an identified benchmark rate, and how performance measure data tracking was used to evaluate quality improvement strategies.	Access to Care
Improve Birth Outcomes for Pregnant Members at Risk for Preeclampsia	Clinical	Step 2: Review the PIP Aim Statement	Element 3: The MCE should include an aim statement that indicates the specific time period relative to the PIP submission's performance period.	Quality of Care

Table 15. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
Improve Birth Outcomes for Pregnant Members at Risk for Preeclampsia	Clinical	Step 5: Review the Selected PIP Variables and Performance Measures	Element 5: CareSource should clearly demonstrate how the performance measure is available to track performance at a point in time, compare performance measures to benchmarks; and inform the selection and evaluation of quality improvement strategies.	Access to Care
			Element 10: CareSource should address whether the performance measure is a process measure and based on strong evidence that the process being measured is meaningfully associated with outcomes.	
Improve Member Satisfaction and Reported Perception of the Health Plan	Nonclinical	Step 2: Review the PIP Aim Statement	Element 1: CareSource should ensure the PIP aim statement clearly specifies the PIP improvement strategy.	Quality of Care
			Element 3: CareSource should include an aim statement that indicates the specific time period relative to the PIP submission's performance period.	
Improve Member Satisfaction and Reported Perception of the Health Plan	Nonclinical	Step 3: Review the Identified PIP Population	Element 1: CareSource should clearly define the PIP population such as demographics, characteristics, and enrollment requirements.	Access to Care
Improve Member Satisfaction and Reported Perception of the Health Plan	Nonclinical	Step 5: Review the Selected PIP Variables and Performance Measures	Element 5: CareSource should state how performance measures are tracked for progress and discuss the outcome of tracking that includes a comparison to benchmark rates rather than percentiles and how the resulting comparison was used to select and evaluate quality improvement strategies.	Access to Care
Improve Member Satisfaction and Reported Perception of the Health Plan	Nonclinical	Step 8: Assess the Improvement Strategies	Element 2: CareSource should demonstrate how selected improvement strategies are related to root causes and barriers and display the data analysis and/or quality improvement process data utilized to reach the determination.	Quality of Care
MDWise				
Disease Management:	Clinical	Step 2: Review the PIP Aim Statement	Element 2: MDwise should clearly define the PIP population within the framework of the aim statement.	Quality of Care

Table 15. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
Diabetes Care			Element 4: MDwise should write the PIP statement formatted as a single question.	
			Element 5: MDwise should include an answerable aim statement that includes a realistic and unambiguous goal.	
Disease Management: Diabetes Care	Clinical	Step 5: Review the Selected PIP Variables and Performance	Element 10: MDwise should present strong evidence that the process being measured is meaningfully associated with outcomes.	Access to Care
Post-Partum Care	Clinical	Step 2: Review the PIP Aim Statement	Element 2: MDwise should ensure that the PIP aim statement clearly specifies the PIP's target population.	Quality of Care
			Element 3: MDwise should ensure that the PIP aim statement clearly specifies the current PIP time period.	
			Element 4: MDwise should ensure that the aim statement is consistent with the documentation found in all other steps of the PIP Summary Form.	
Post-Partum Care	Clinical	Step 3: Review the Identified PIP Population	Element 1: MDwise should ensure that the PIP population is clearly defined in terms of the PIP aim statement with consistent criteria reflected in both.	Access to Care
Post-Partum Care	Clinical	Step 5: Review the Selected PIP Variables and Performance Measures	Element 1b: MDwise should include distinct variables as characteristics of the performance measure (such as an event or status that contributes to the performance measure) that detail how the variable is available to measure and track performance over time.	Quality of Care
			Element 3: MDwise should describe how data and resources are available specifically to track and produce the performance measure.	
			Element 5: MDwise should include a clear and consistent discussion to address performance measure data at a point in time that acknowledges a comparison to benchmarks and how said data was used to inform and evaluate improvement strategies.	

Table 15. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
			Element 9: MDwise should, for performance measures that include manual data collection, describe the process used to determine inter-rater reliability.	
			Element 10: MDwise should acknowledge that the performance measure is process-based and reference how the evidence links said process with health outcomes.	
Post-Partum Care	Clinical	Step 6: Review the Data Collection Procedures	Element 5: MDwise should ensure that the data collection plan appropriately identifies a data collection type that is connected with the data analysis plan.	Timeliness of Care and Quality of Care
			Element 10: MDwise should specifically detail the intra- and inter-rater reliability processes utilized for the PIP's data collection procedure.	
Post-Partum Care	Clinical	Step 7: Review the Data Analysis and Interpretation of PIP Results	Element 1: MDwise should ensure that data analysis discussions are consistent with the data analysis plan as well as the data collection plan.	Timeliness of Care and Quality of Care
			Element 8: MDwise should specifically state within this step whether there were lessons learned about less-than-optimal performance.	
Member Satisfaction	Nonclinical	Step 2: Review the PIP Aim Statement	Element 4: MDwise should provide all information to ensure the aim statement is clear and concise.	Quality of Care
			Element 5: MDwise should include an aim statement that is answerable and includes a realistic and unambiguous goal.	
Member Satisfaction	Nonclinical	Step 3: Review the Identified PIP Population	Element 1: MDwise should clearly define the PIP population, including demographics and characteristics, that is consistently applied throughout the PIP documentation.	Access to Care
Member Satisfaction	Nonclinical	Step 5: Review the Selected PIP Variables and Performance Measures	Element 2: MDwise should provide evidence that the performance measure assesses an important aspect of care that will make a difference to members' health or functional status.	Quality of Care

Table 15. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
Member Satisfaction	Nonclinical	Step 7: Review the Data Analysis and Interpretation of PIP Results	Element 1: MDwise should ensure analysis and interpretation are conducted in accordance with the data analysis plan.	Timeliness of Care and Quality of Care
			Element 6: MDwise should compare results across all available entities.	
			Element 7: MDwise should ensure that all findings are communicated in a precise and easily understood manner, without conflicting information.	
Member Satisfaction	Nonclinical	Step 8: Assess the Improvement Strategies	Element 2: MDwise should demonstrate how selected improvement strategies are related to root causes and barriers and display the data analysis and/or quality improvement process data utilized to reach the determination.	Timeliness of Care and Quality of Care
MHS				
Improving Diabetes Management	Clinical	Step 2: Review the PIP Aim Statement	Element 1: MHS should ensure that the PIP aim statement clearly specifies the improvement strategy as it is indicated throughout the PIP.	Quality of Care
			Element 3: MHS should ensure the PIP aim statement is concise.	
			Element 4: MHS should clearly specify the PIP time period, as it relates to the performance period of the PIP submission.	
			Element 5: MHS should ensure the PIP aim statement is answerable and includes a realistic and unambiguous goal.	
			Element 6: MHS should ensure that the PIP aim statement is measurable, such as including unit of change for the established goal.	
Improving Diabetes Management	Clinical	Step 3: Review the Identified PIP Population	Element 1: MHS should clearly define the PIP population in terms of, and consistent with, the PIP aim statement.	Access to Care

Table 15. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
Improving Diabetes Management	Clinical	Step 5: Review the Selected PIP Variables and Performance Measures	Element 1a: MHS should include variables that are objective, clearly defined, and time specific.	Quality of Care
			Element 1b: MHS should describe how the selected variables are available to measure performance and track improvement over time.	
			Element 3: MHS should include a discussion of how the performance measures are appropriate based on the availability of data and resources to collect the data.	
			Element 4: MHS should provide evidence that supports that the performance measures are based on current clinical knowledge or health services research.	
			Element 5: MHS should discuss and demonstrate how the performance measures address and track performance at a point in time, compare performance measures to benchmarks; and inform the selection and evaluation of quality improvement strategies.	
			Element 10: MHS should address how process measures are meaningfully associated with outcomes.	
Improving Diabetes Management	Clinical	Step 6: Review the Data Collection Procedures	Element 5: MHS should confirm that the data collection plan connects to the data analysis plan to ensure appropriate data are available.	Timeliness of Care and Quality of Care
			Element 9: MHS should ensure that the data collection plan describes intra-rater reliability processes.	
			Element 11: MHS should ensure the guidelines established for staff responsible for abstracting data are included in the data collection plan and provide the actual data collection tool.	
Improving Diabetes Management	Clinical	Step 7: Review the Data Analysis and Interpretation of PIP	Element 1: MHS should ensure the analysis and interpretation of data are conducted in accordance with the data analysis plan.	Timeliness of Care and Quality of Care

Table 15. PIP Weaknesses (AONs)

PIP	PIP Type	PIP Step	Weaknesses	Domain of Care
		Results	Element 6: MHS should ensure data for each program are evaluated independently rather than combined to allow comparative analysis between programs.	
Improving Diabetes Management	Clinical	Step 8: Assess the Improvement Strategies	Element 1: MHS should address evidence that suggests that the test of change would likely lead to the desired improvement.	Timeliness of Care and Quality of Care
Reduction in Maternal and Infant Mortality	Clinical	Step 1: Review the Selected PIP Topic	Element 2: MHS should address the consideration of CMS Child or Adult Core Set Measures even if the measure itself is not utilized for the PIP.	Timeliness of Care and Quality of Care
			Element 4: MHS should specify, and include a discussion of, how the PIP topic addresses the care of a special population and/or high priority services.	
Reduction in Maternal and Infant Mortality	Clinical	Step 2: Review the PIP Aim Statement	Element 2: MHS should include one specific PIP population within the aim statement.	Timeliness of Care and Quality of Care
			Element 3: MHS should include a specific PIP time period that is indicative of the current PIP cycle.	
			Element 4: MHS should include a PIP aim statement that concisely indicates each aim statement requirement.	
			Element 6: MHS should ensure that the PIP aim statement includes a measurable unit of change for the goal.	
Reduction in Maternal and Infant Mortality	Clinical	Step 3: Review the Identified PIP Population	Element 1: MHS should include all demographic aspects, characteristics, and enrollment criteria that are included and excluded of the PIP population as it relates to the PIP aim statement.	Access to Care
Reduction in Maternal and Infant Mortality	Clinical	Step 5: Review the Selected PIP Variables and Performance Measures	Element 1a: MHS should include variables for performance measures that are objective, clearly defined, and time specific.	Quality of Care
			Element 1b: MHS should discuss how the selected variable(s) are available to measure and track performance improvement over time.	

Table 15. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
			Element 2: MHS should include documented evidence that the performance measure aims to assess an important aspect of care that will make a difference to member's health or functional status.	
			Element 4: MHS should include actual evidence that performance measures are based on clinical knowledge or health services research.	
			Element 5: MHS should display and discuss performance for the PIP including a benchmark comparison, tracking display of data over time, and evidence that the displayed data was used to inform and evaluate the selection of improvement strategies.	
			Element 6: MHS should discuss consideration of existing measures even if an existing measure is not ultimately selected.	
			Element 7: MHS should include clearly defined criteria, such as time period, services, and important characteristics for internally developed performance measures.	
			Element 10: MHS should include process measure evidence that indicates a meaningful association with member outcomes.	
Reduction in Maternal and Infant Mortality	Clinical	Step 6: Review the Data Collection Procedures	Element 1: MHS should include a systematic method to collect valid and reliable data that reflects consideration for adequate data analysis.	Timeliness of Care and Quality of Care
			Element 2: MHS should specify a frequency of data collection that is consistent with the methodology cited for other steps within the PIP.	
			Element 3: MHS should clearly specify the source of data elements collected that is consistent with the PIP's data analysis plan.	

Table 15. PIP Weaknesses (AONs)

PIP	PIP Type	PIP Step	Weaknesses	Domain of Care
			Element 4: MHS should clearly specify the data elements collected to evaluate the effectiveness of the change for the PIP.	
			Element 5: MHS should include a logical data analysis plan that indicates how collected data are assessed and evaluated to ensure appropriate data are available and captured.	
Reduction in Maternal and Infant Mortality	Clinical	Step 7: Review the Data Analysis and Interpretation of PIP Results	Element 1: MHS should ensure that consistent information is included in the data collection and data analysis plan, relative to the PIP objective.	Timeliness of Care and Quality of Care
			Element 6: MHS should include an analysis comparing results across multiple entities (i.e., member subgroups for each program).	
			Element 7: MHS should present data analysis in a clear and concise way that is easily understood, displays sufficient evidence, and includes consistent concepts.	
Reduction in Maternal and Infant Mortality	Clinical	Step 8: Assess the Improvement Strategies	Element 1: MHS should include existing evidence (published or unpublished) as to how the improvement strategy is likely to produce the desired improvement.	Timeliness of Care and Quality of Care
			Element 2: MHS should include evidence that the improvement strategy is related to confounding factors (barriers) identified through data analysis and quality improvement processes.	
			Element 3: MHS should present a minimum of one full PDSA cycle detailing each step utilized to implement improvement strategies on a rapid-cycle, PDSA basis.	
			Element 4: MHS should include evidence that the improvement strategy is culturally and linguistically appropriate for the target audience.	

Table 15. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
			Element 5: MHS should include evidence that improvement strategies are reflective of confounding factors (i.e., barriers) that could have an obvious impact on PIP outcomes.	
			Element 6: The MCE should include a discussion and evidence of how the improvement strategy was evaluated (e.g., PDSA) for success and indicate follow-up activities based on said evaluation.	
Member Experience	Nonclinical	Step 1: Review the Selected PIP Topic	Element 2: MHS should discuss the use or consideration of CMS Child or Adult Core Set measures.	Timeliness of Care and Quality of Care
			Element 3: MHS should clearly address how/if the PIP topic considered input from members or providers who are users of, or concerned with, specific service areas.	
			Element 5: MHS should note how the PIP topic aligned with the applicable Department of Health and Human Services (HHS)/CMS areas (relate the topic to a priority area).	
Member Experience	Nonclinical	Step 2: Review the PIP Aim Statement	Element 1: MHS PIP should clearly specify an improvement strategy in its aim statement.	Timeliness of Care and Quality of Care
			Element 3: MHS should clearly specify the PIP time period, such as January 1, 2024 – December 31, 2024, to ensure clarity.	
Member Experience	Nonclinical	Step 5: Review the Selected PIP Variables and Performance Measures	Element 1a: MHS should ensure the variables are objective, clearly defined, and time specific.	Quality of Care
			Element 1b: MHS should ensure the performance measure is available to measure performance and track improvement over time.	
			Element 2: MHS should ensure the performance measure assesses an important aspect of care that will make a difference to members' health or functional status and cite retrieval evidence.	

Table 15. PIP Weaknesses (AONs)

PIP	PIP Type	PIP Step	Weaknesses	Domain of Care
			Element 3: MHS should ensure the performance measures are appropriate based on the availability of data and resources to collect the data.	
			Element 4: MHS should specify if the performance measures are based on current clinical knowledge or health services research.	
			Element 5: MHS should include an appropriate discussion of how the performance measures can address and track performance at a point in time, compare performance measures to benchmarks; and inform the selection and evaluation of quality improvement strategies.	
			Element 6: MHS should address whether the performance measure considers existing measures.	
Member Experience	Nonclinical	Step 6: Review the Data Collection Procedures	Element 5: MHS should confirm the data collection plan connects to the data analysis plan to ensure appropriate data are available.	Timeliness of Care and Quality of Care
			Element 7: MHS should ensure the data collection plan specifies well-defined methods to collect meaningful and useful information by increasing the frequency of data through use of an additional and meaningful performance measure.	
Member Experience	Nonclinical	Step 7: Review the Data Analysis and Interpretation of PIP Results	Element 6: MHS should address the comparison and interpretation of data across multiple entities, as applicable, such as patient subgroups, which includes across programs.	Timeliness of Care and Quality of Care
Member Experience	Nonclinical	Step 8: Assess the Improvement Strategies	Element 1: MHS should address/include the evidence (published or unpublished) that supports selection of the improvement strategy.	Timeliness of Care and Quality of Care
			Element 2: MHS should clearly communicate how the improvement strategy relates to causes/barriers identified through data analysis and quality improvement processes.	

Table 15. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
			Element 6: MHS should discuss the improvement strategy in terms of success/lack of success and any identified follow-up activities.	
UHC				
Improving Glycemic Status Assessment Rates for Patients with Diabetes (GSD)	Clinical	Step 1: Review the Selected PIP Topic	Element 3: UHC should address consideration of input from enrollees or providers who are users of, or concerned with, specific service areas.	Access to Care
Improving Glycemic Status Assessment Rates for Patients with Diabetes (GSD)	Clinical	Step 2: Review the PIP Aim Statement	Element 1: UHC should clearly specify the PIP improvement strategy that was implemented during the performance period within the aim statement.	Timeliness of Care and Quality of Care
			Element 3: UHC should include an aim statement that indicates the time period relative to the PIP submission's performance period.	
			Element 6: UHC should ensure that the PIP aim statement includes a measurable unit of change for the goal.	
Improving Glycemic Status Assessment Rates for Patients with Diabetes (GSD)	Clinical	Step 3: Review the Identified PIP Population	Element 1: UHC should clearly define the PIP population, including demographics and characteristics, that is consistently applied throughout the PIP documentation.	Timeliness of Care and Quality of Care
Improving Glycemic Status Assessment Rates for Patients with Diabetes (GSD)	Clinical	Step 5: Review the Selected PIP Variables and Performance Measures	Element 1a: UHC should ensure the variable is objective, clearly defined, and time specific.	Quality of Care
			Element 1b: UHC should ensure that the performance measure is available to measure performance and track improvement over time.	
			Element 3: UHC should ensure the performance measure is appropriate based on the availability of data and resources to collect the data and that the data source is clear and consistent throughout the PIP.	

Table 15. PIP Weaknesses (AONs)

PIP	PIP Type	PIP Step	Weaknesses	Domain of Care
			Element 4: UHC should cite evidence that ensures the performance measure is based on current clinical knowledge or health services research.	
			Element 5: UHC should include evidence of how selected measures track the performance of improvement strategies at a point in time, how results compare to benchmarks, and how the information is used to inform improvement strategy selection.	
Improving Glycemic Status Assessment Rates for Patients with Diabetes (GSD)	Clinical	Step 6: Review the Data Collection Procedures	Element 1: UHC should ensure that the PIP data collection plan includes a systematic method for collecting valid and reliable data that is consistently applied throughout the PIP.	Timeliness of Care and Quality of Care
			Element 2: UHC should clearly specify the frequency of data collection.	
			Element 3: UHC should ensure the data collection plan clearly specifies data sources that are consistently applied and easily distinguished throughout the PIP.	
			Element 5: UHC should confirm that the data collection plan clearly connects to the data analysis plan to ensure appropriate data are available.	
			Element 6: UHC should ensure that the data collection plan includes data collection instruments that allow for consistent and accurate data collection over PIP time periods.	
Improving Glycemic Status Assessment Rates for Patients with Diabetes (GSD)	Clinical	Step 7: Review the Data Analysis and Interpretation of PIP Results	Element 1: UHC should ensure analysis and interpretation are conducted in accordance with the data analysis plan.	Timeliness of Care and Quality of Care
			Element 5: UHC should specifically address if the PIP's data analysis plan identifies factors that may threaten the internal or external validity of findings.	
			Element 8: UHC should specify if any lessons were learned related to less-than-optimal performance or at a minimum, indicate that no lessons were learned.	

Table 15. PIP Weaknesses (AONs)

PIP	PIP Type	PIP Step	Weaknesses	Domain of Care
Improving Glycemic Status Assessment Rates for Patients with Diabetes (GSD)	Clinical	Step 8: Assess the Improvement Strategies	Element 2: UHC should clearly address how the improvement strategies were related to causes/barriers identified through data analysis and quality improvement processes.	Timeliness of Care and Quality of Care
			Element 3: UHC should include a detailed account of how improvement strategies were implemented via a rapid-cycle, PDSA process.	
			Element 4: UHC should acknowledge the assessment of and determination of planned interventions for cultural and linguistic appropriateness.	
Improving Glycemic Status Assessment Rates for Patients with Diabetes (GSD)	Clinical	Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred	Element 1: UHC should include a discussion of how subsequent measurement year's methodology compares to the baseline methodology.	Timeliness of Care and Quality of Care
Improving Member Satisfaction with the Health Plan's Member Services	Nonclinical	Step 1: Review the Selected PIP Topic	Element 2: UHC should address how the PIP topic considers input from members or providers who are users of, or concerned with, specific service areas.	Timeliness of Care and Quality of Care
			Element 3: UHC should ensure the PIP topic considers performance on CMS Child or Adult Core Set measures even if they are not used.	
Improving Member Satisfaction with the Health Plan's Member Services	Nonclinical	Step 2: Review the PIP Aim Statement	Element 1: UHC should ensure that the PIP aim statement expands beyond "targeted interventions" and clearly specifies the PIP improvement strategy.	Timeliness of Care and Quality of Care
			Element 3: UHC should include an aim statement that indicates the specific time period relative to the PIP submission's performance period.	
			Element 4: UHC should include one concise aim statement for the PIP.	
			Element 6: UHC should ensure that the PIP aim statement includes a measurable unit of change for the goal.	

Table 15. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
Improving Member Satisfaction with the Health Plan's Member Services	Nonclinical	Step 5: Review the Selected PIP Variables and Performance Measures	Element 1a: UHC should ensure variables are objective, clearly defined, and time specific.	Quality of Care
			Element 1b: UHC should detail how the variable is available to measure performance and track improvement over time.	
			Element 3: UHC should describe how performance measures are appropriate based on the availability of data and resources to collect data.	
			Element 4: UHC should discuss and cite evidence that performance measures are based on current clinical knowledge or health services research.	
			Element 5: UHC should include evidence of how selected measures track the performance of improvement strategies at a point in time, how results compare to benchmarks, and how the information is used to inform improvement strategy selection.	
			Element 7: UHC should clearly identify clinical guidelines, criteria, and data sources for internally developed PIP performance measures.	
Improving Member Satisfaction with the Health Plan's Member Services	Nonclinical	Step 6: Review the Data Collection Procedures	Element 1: UHC should ensure the data collection plan includes a systematic method for collecting valid and reliable data that represents the PIP population.	Timeliness of Care and Quality of Care
			Element 2: UHC should ensure the data collection plan includes the frequency of data collection and is consistently applied throughout the PIP.	
			Element 3: UHC should ensure the data collection plan clearly specifies the data sources.	
			Element 4: UHC should ensure the data collection plan clearly specifies the data elements to be collected.	
			Element 5: UHC should ensure the data collection plan clearly connects to the data analysis plan.	

Table 15. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
			Element 6: UHC should ensure the data collection plan includes data collection instruments that allow for consistent and accurate data collection over PIP time periods.	
			Element 7: UHC should ensure the data collection plan specifies well-defined methods to collect meaningful and useful information for qualitative data collection methods utilized.	
			Element 8: UHC should address the estimated degree of data completeness for administrative data collection methods and how it is determined.	
Improving Member Satisfaction with the Health Plan's Member Services	Nonclinical	Step 7: Review the Data Analysis and Interpretation of PIP Results	Element 1: UHC should address whether any analysis and interpretation of data was conducted in accordance with the data analysis plan.	Timeliness of Care and Quality of Care
			Element 5: UHC should specifically address if the PIP's data analysis plan identifies factors that may threaten the internal or external validity of findings.	
			Element 7: UHC should ensure analysis and interpretation are presented in a concise and easily understood manner.	
			Element 8: UHC should address any lessons learned about less-than-optimal performance or indicate that there were none.	
Improving Member Satisfaction with the Health Plan's Member Services	Nonclinical	Step 8: Assess the Improvement Strategies	Element 1: UHC should address whether the improvement strategy is evidence based and cite the evidence.	Timeliness of Care and Quality of Care
			Element 2: UHC should ensure the improvement strategies are related to the causes/barriers identified through data analysis and quality improvement processes.	
			Element 3: UHC should include a detailed account of how improvement strategies were implemented via a rapid-cycle, PDSA process.	

Table 15. PIP Weaknesses (AONs)				
PIP	PIP Type	PIP Step	Weaknesses	Domain of Care
			Element 4: UHC should address how the member-facing improvement strategies were determined to be culturally and linguistically appropriate.	
Improving Member Satisfaction with the Health Plan's Member Services	Nonclinical	Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred	Element 1: UHC should include a discussion of how subsequent measurement year methodology compares to the baseline methodology.	Timeliness of Care and Quality of Care

Improvements Since the MY 2024 PIP Validation

For PIPs that received AONs for any element, Qsource provides technical assistance to help the MCEs understand CMS protocols and OMPP guidelines and revise PIPs as needed to improve performance. For the first time in the 2025 PIP validation, OMPP required MCEs to submit a Corrective Action Plan (CAP) for any AONs. The PIP Corrective Action Plans are comprised of direct MCE responses for each PIP element validated as an AON. These responses will be evaluated by Qsource and OMPP to determine overall effectiveness; the details of each PIP CAP response and evaluation will be presented under MCE improvements within the 2026 EQR Technical Report.

All MCE PIPs assessed during the 2024 Validation were retired as of January 2025 and did not include the PIP CAP process; therefore, no applicable comparisons were available for PIPs validated in 2025.

Conclusions and Recommendations

Anthem

Anthem submitted two PIP topics for MY 2024: a clinical PIP titled *Improving Diabetes Management* and a nonclinical PIP titled *Triple Care Triumph: Harnessing SDOH Driven Wellness in Diabetes, Asthma, and Cardio Health.* Both PIPs were in their Baseline Measurement Year. The PIPs received scores of 89.74% and 92.86%, achieving a Validation 1 Rating of Moderate Confidence and High Confidence, respectively. Both PIPs received a Validation 2 Rating of NA, due to the PIPs being in their Baseline year.

Each of Anthem's PIP Summary Forms contained varying degrees of missing or incomplete information that could be improved by acknowledging each element according to the PIP

Summary Form Instructions. A detailed explanation of process measures, objectives, and performance measures were missing in one or both PIPs. The missing information compromised the PIP results and the validity of the studies. The MCE should use CMS guidance, OMPP directives, and the PIP Summary Form Instructions for clarification and increased understanding of the protocol requirements.

The Diabetes Management PIP topic addresses quality and access to care delivered to members with a principal diagnosis of diabetes (type 1 or type 2), given that access to care and quality of care are key factors in managing chronic disease. The SDOH PIP topic addresses access to care, noting that by addressing SDOHs that affect the members, each member can better manage their diagnoses.

CareSource

CareSource submitted three PIPs for MY 2024: two clinical PIPs titled *Improve Access to Annual Kidney Health Evaluation for Members Diagnosed with Diabetes* and *Improve Birth Outcomes for Pregnant Members at Risk for Preeclampsia*, and a nonclinical PIP titled *Improve Member Satisfaction and Reported Perception of the Health Plan.* All three PIPs were in their Baseline Measurement Year. The three PIPs received scores of 95.12%, 93.02%, and 88.10%, achieving a Validation 1 Rating of High Confidence, High Confidence, and Moderate Confidence, respectively. All three PIPs received a Validation 2 Rating of NA, due to the PIPs being in their Baseline Year. Clear specifications regarding problems identified, benchmarks, performance measures, and time periods were missing in one or more than one PIP.

The Diabetes Management PIP topic addresses quality and access to care delivered to members with a principal diagnosis of diabetes (type 1 or type 2), given that access to care and quality of care are key factors in managing chronic disease. The Maternal/Child Health topic incorporates timeliness of care and access to care by assessing timely visits and monitoring for risk factors. The Member Satisfaction topic addresses quality of care by measuring members' feedback, as well as timeliness of, and access to, care based on the specific questions within the survey.

MDwise

MDwise submitted three PIPs for MY 2024: two clinical PIPs titled *Disease Management: Diabetes Care* and *Post-Partum Care*, and a nonclinical PIP titled *Member Satisfaction*. All three PIPs were in their Baseline Measurement Year. The three PIPs received scores of 90.91%, 69.77%, and 82.61%, achieving a Validation 1 Rating of High Confidence, No Confidence, and Moderate Confidence, respectively. Additionally, all three PIPs received a Validation 2 Rating of NA, due to the PIPs being in their Baseline year. A detailed explanation of measurement processes, data analysis plans, and performance measures were missing one, or more than one, of the PIPs. The MCE should use CMS guidance, OMPP directives, and the PIP Summary Form Instructions for clarification and increased understanding of the protocol requirements.

The Diabetes Management PIP topic addresses quality and access to care delivered to members with a principal diagnosis of diabetes (type 1 or type 2), given that access to care and quality of care are key factors in managing chronic disease. The Maternal/Child Health topic incorporates timeliness of care and access to care by assessing timely visits during a member's vulnerable condition. The Member Satisfaction topic addresses quality of care by measuring members' feedback.

MHS

MHS submitted three PIPs for MY 2024: two clinical PIPs titled *Improving Diabetes Management* and *Reduction in Maternal and Infant Mortality,* and a nonclinical PIP titled *Member Experience.* All three PIPs were in their Baseline Measurement Year. The PIPs received scores of 56.10%, 29.27%, and 55.00%, respectively, achieving a Validation 1 Rating of No Confidence for all three PIPs. Additionally, all three PIPs received a Validation 2 Rating of NA, due to the PIPs being in their Baseline year. Clarity regarding measurement processes, data analysis plans, improvement strategies, research, analysis across IHCPs, and performance measures were missing in one or more than one PIP. The missing information compromised the PIP results and the validity of the studies. The MCE should use CMS guidance, OMPP directives, and the PIP Summary Form Instructions for clarification and increased understanding of the protocol requirements.

The Diabetes Management PIP topic addresses quality and access to care delivered to members with a principal diagnosis of diabetes (type 1 or type 2), given that access to care and quality of care are key factors in managing chronic disease. The Maternal/Child Health topic incorporates access to care and timeliness of care as well, by ensuring that pregnant and postpartum members receive the care they need in a vulnerable time. The Member Satisfaction topic addresses quality of care by measuring the members' feedback.

UHC

UnitedHealthcare submitted two PIPs for MY 2024: a clinical PIP, *Improving Glycemic Status Assessment Rates for Patients with Diabetes (GSD)*, and a nonclinical PIP, *Improving Member Satisfaction with the Health Plan's Member Services.* Both of these PIPs are in the Baseline Measurement Year. The clinical PIP scored 46.34% and the nonclinical PIP scored 29.27%; both PIPs received a Validation 1 Rating of No Confidence, and a Validation Rating 2 of NA due to the Baseline Year. Detailed explanations of the population, the improvement strategies, the variables, the time period, the performance measures and evidence, benchmarks, and data analysis plans were among the missing details for one or both PIPs. Overall, the MCE should continue to refer to OMPP and CMS guidance as well as the PIP Summary Form Instructions for clarification and increased understanding of the protocol requirements.

The Diabetes Management PIP topic addresses quality and access to care delivered to members with a principal diagnosis of diabetes (type one or two) whose most recent glycemic status (HbA1c or GMI) was at the following levels during the MY:

Glycemic Status <8.0%, or Glycemic Status >9.0%; the access to quality healthcare is a key focus in the management of chronic illness. The Member Satisfaction PIP topic incorporates quality of care by assessing how satisfied members are with the care they receive from the MCE's providers.

Protocol 2: Performance Measure Validation (PMV)

Objectives

The *Balanced Budget Act* of 1997 established certain managed care quality safeguards that were further described by Title 42 of the Code of Federal Regulations, Section 438.320 (42 CFR § 438.320), which defines "external quality review" as the "analysis and evaluation…of aggregated information on quality, timeliness, and access to health care services. Qsource's overarching goal is to evaluate each plan over multiple activities to ensure quality, timeliness, and access to care. FSSA OMPP has contracted with Qsource to conduct mandatory EQR activities required by 42 CFR § 438.358. One of the mandatory activities is performance measure validation (PMV) of the MCEs.

The 2025 PMV validates performance measures for the 2024 MY, January 1, 2024, to December 31, 2024. The PMV validations were conducted virtually. The validation activities for these measures were conducted as outlined in CMS's EQR *Protocol 2: Validation of Performance Measures (February 2023)*. This report includes findings from the MCE's Information Systems Capabilities Assessment Tool (ISCAT) that the EQRO used to validate information systems, processes, data, and MCE-reported results. Protocol guidance indicates that the EQRO may review results from a recent comprehensive, independent assessment of the MCE's information systems, such as the HEDIS® Compliance Audit, conducted in the previous two years, provided that the HEDIS® measures were calculated using NCQA HEDIS®-certified software and all non-HEDIS® rates were included under the scope of the HEDIS® audit.

This report includes findings from review of HEDIS® measure rates submitted through the NCQA Interactive Data Submission System (IDSS), non-HEDIS® measure rates reported by the MCE through its data system, and the auditor findings.

OMPP identified performance measures to be calculated and reported by the contracted MCEs as required in Activity 1 of the Protocols. The MCEs are also held accountable for other performance standards for PMV that are defined by OMPP. These performance measures look at quality, timeliness, and access to care for the enrollees.

Specific findings from the virtual systems reviews and ISCATs for the MCEs are in the *2025 Performance Measure Validation Reports*.

At the end of the protocol, Qsource presented the MCE with an overall Performance Measure Validation rating. This rating takes into account all processes and performance metrics that are examined. **Table 16** presents the criteria used to determine the MCE's rating.

Table 16. Performance Measure Validation Status	
Rating	**Criteria**
Fully Met	The MCE fully met all the criteria necessary for producing accurate and reliable performance metrics with a well-developed and complete data receipt, integration, and reporting process.
Partially Met	The MCE partially met the criteria necessary for producing accurate and reliable performance metrics.
Not Met	The MCE did not meet the criteria necessary for producing accurate and reliable performance metrics.

Technical Methods of Data Collection and Analysis

Performance Measures

Qsource obtained the list of quality measures and technical specifications for the measures from OMPP's *Indiana Health Coverage Programs 2024-2027 Quality Strategy Plan*. Qsource requested source code and source data for selected measures from the MCE. The source code and source data were used to validate the rates that MCEs provided. From the data, Qsource randomly selected 10 numerator positive files with 5 oversamples for primary source verification. Additional performance measures' validation was extrapolated from the virtual systems review and the source code validation.

HEDIS® Measures

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

This section is intended to provide an overview of MCE performance using appropriate and available comparison data. Qsource used these data to determine overall performance in a distribution of statistical values that represent the lowest to highest percentiles achieved. For example, the 50th percentile represents the point at which half of the reported rates are below, and half of the reported rates are above that value.

Per NCQA HEDIS® Measurement Year 2024 Volume 5; HEDIS® Compliance Audit: Standards, Policies and Procedures, rates are not reported if the denominator is too small (<30).

The MCEs noted that NCQA-certified software was used to calculate the measures. Qsource reviewed calculated rates and compared them to national benchmarks for the current

measurement period. The MCEs included a designation of one of the following for each measure:

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

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

Description of Data Obtained

OMPP selected measures for specific primary data source review, and the MCEs were required to submit the source code and source data as the focus for this year's PMV. The source code and source data were used to validate the rates that MCEs reported in Qsource's Performance Measure Template. From the data, Qsource randomly selected 10 numerator positive files with 5 oversamples for primary source verification. Each file review included identifying the relevant data (e.g., date of birth, gender, numerator positive claim, as applicable). The sample was provided five business days prior to the review. The MCEs demonstrated the numerator source data.

In performing all validation activities, Qsource performed primary source verification to ensure that the MCEs have processes in place to manage the data. Qsource then validated the ability of those processes to produce the performance measures for a more thorough investigation. The validation results uncovered by the Qsource auditors were then extrapolated to all other measures.

The Performance Measures that underwent primary source verification are listed in **Table 17**.

Table 17. Performance Measures

Measure Name	Domain of Care
Completion of Initial Health Needs Screening within 30 Days or 90 Days of MCE Enrollment Based on Care Program	Timeliness of Care
Completion of Comprehensive Health Assessment Tool within 30 Days or 90 Days of MCE Enrollment Based on Care Program	Timeliness of Care
Institution for Mental Disease Member Use	Quality of Care and Access to Care
Postpartum Care Coordination	Quality of Care and Access to Care

The validation results were extrapolated to the additional performance measures listed in **Table 18**.

Table 18. Additional Performance Measures	
Measure Name	**Domain of Care**
Dentists and Oral Surgeons Network Adequacy	Access to Care
Plan All-Cause Readmission	Timeliness and Access to Care and Quality of Care

Data Integration, Data Control, and Performance Measure Documentation

Claims/Encounter Data System

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

Enrollment/Eligibility Data System

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

Provider Systems

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

Data Integration, Software Integration, and Measure Development

The organizational infrastructure for housing both HEDIS® and non-HEDIS® measure data must be verified for standard control procedures and completeness of data.

Table 19 presents the validation findings across all MCEs.

Table 19. Data Integration, Data Control, and Performance Measure Documentation					
Measure	**Anthem**	**CareSource**	**MDwise**	**MHS**	**UHC**
Claims/Encounter Data System	No issues identified	No issues identified	No issues identified	No issues identified	No issues identified
Enrollment/Eligibility Data System	No issues identified	No issues identified	No issues identified	No issues identified	No issues identified
Provider Systems	No issues identified	No issues identified	No issues identified	No issues identified	No issues identified

Table 19. Data Integration, Data Control, and Performance Measure Documentation

Measure	Anthem	CareSource	MDwise	MHS	UHC
Data Integration, Software Integration, and Measure Development	No issues identified	No issues identified	No issues identified	No issues identified	No issues identified

Performance Measure Data Validation

Performance Measures

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

Qsource determined validation results for each performance measure for each MCE. These results are displayed in Table 20. Table 21, Table 22, and Table 23 include reported rates for each measure by MCE and IHCP. There is no data table for the Postpartum Care Coordination measure, due to the data format primarily including member health information and inherent inconsistencies with this measure across MCEs. These rates are listed to the first or second decimal points based on how the data was reported by the MCE.

Table 20. Key Performance Measure Review Results

Measure	Anthem	CareSource	MDwise	MHS	UHC
Completion of Initial Health Needs Screening within 30 days or 90 Days of MCE Enrollment based on care program	The MCE described the Healthy Innovations Platform used to validate the source data for this performance measure. The findings associated with this measure included a lack of EQR preparedness including subject matter expert staff to review screening documentation.	The MCE demonstrated the Guiding Care system used to validate the source data for this performance measure. Data validation for this measure revealed issues between the annual reported rate and raw data files.	The MCE demonstrated the Jiva system and Data Warehouse used to validate the source data for this performance measure. No issues were identified.	The MCE demonstrated the Enterprise Data Warehouse systems used to validate the source data for this performance measure. No issues identified.	The MCE demonstrated the HealthEdge system used to validate the source data for this performance measure. The findings associated with this measure include issues with numerator positive data extraction in preparation for the EQR and a noted lack of Health Needs Screening completions.

Table 20. Key Performance Measure Review Results					
Measure	**Anthem**	**CareSource**	**MDwise**	**MHS**	**UHC**
Completion of Comprehensive Health Assessment Tool within 30 days or 90 Days of MCE Enrollment based on care program	The MCE demonstrated the Healthy Innovations Platform used to validate the source data for this performance measure. The findings associated with this measure included a lack of EQR preparedness and discrepancies found between the identified initiation and completion date of this performance measure's assessment.	Not applicable; Hoosier Care Connect only.	Not applicable; Hoosier Care Connect only.	The MCE demonstrated the TruCare system used to validate the source data for this performance measure. The findings associated with this measure include inconsistencies found in the reporting stratification of applicable performance measure assessments and failure to complete said member assessments during the review period.	The MCE demonstrated the HealthEdge system used to validate the source data for this performance measure. The findings associated with this measure include issues with numerator positive data extraction in preparation for the EQR.
Institution for Mental Disease Member Use	The MCE described the Operations Data Warehouse (ODW) system used to validate the source data for this performance measure. The findings associated with this measure included a lack of EQR preparedness, issues with the identification of raw primary source data files utilized for performance measure production and acknowledged variations between the data collected versus reported.	The MCE demonstrated the Facets system used to validate the source data for this performance measure. No issues found.	The MCE demonstrated the Jiva system used to validate the source data for this performance measure. No issues were identified.	The MCE demonstrated the TruCare system used to validate the source data for this performance measure. No issues identified.	The MCE demonstrated the Behavioral Health Utilization Management system used to validate the source data for this performance measure. The findings associated with this measure include discrepancies noted in the length of stay reported versus what was indicated by the source document.

Table 20. Key Performance Measure Review Results					
Measure	**Anthem**	**CareSource**	**MDwise**	**MHS**	**UHC**
Postpartum Care Coordination	The MCE demonstrated the Healthy Innovations Platform used to validate the source data for this performance measure. The findings included a general lack of preparedness for EQR activities; discrepancies within the care coordination timeline; member assessments and screenings included in this measure were not completed by the MCE; and there was an inability to account for missing data elements.	The MCE demonstrated the Guiding Care system used to validate the source data for this performance measure. The findings include discrepancies noted for the timespan of care coordination activities.	The MCE demonstrated the Jiva system used to validate the source data for this performance measure. The findings associated with this performance measure include discrepancies noted during the data review period, lack of evidenced completion related to member assessments and screenings. The MCE noted a systematic error that was identified for this measure and detailed a mitigation plan to avoid such errors in future reporting.	The MCE demonstrated the TruCare and Enterprise Data Warehouse systems used to validate the source data for this performance measure. The findings associated with this measure include issues with the timespan of reported care coordination and inappropriate assessment stratifications.	The MCE demonstrated the Facets system used to validate the source data for this performance measure. The findings associated with this measure include a lack of assessments completed for numerator positive files.

Table 21. 2025 PMV: Initial Health Needs Screening Performance Measure								
MCE	**# of New Eligible Members in Reporting Period**	**# of Members in Column 1 Terminated in First 90 Days**	**# of Members Net of Terminated**	**# of Members in Column 1 Deemed Unreachable**	**# of Members Net of Terminated and Unreachable**	**# of New Members in Column 1 Screened Within 90 Days**	**% Screened Within 90 Days (Except Terminated)**	**% Screened Within 90 Days (Except Terminated and Unreachable)**
Anthem	**HIP**							
	48,768	3,867	44,901	18,724	26,177	26,032	58.0%	99.4%
	HHW							
	46,618	3,189	45,429	25,852	19,577	19,411	42.7%	99.2%
	HCC							
	5,273	766	4,507	1,717	2,790	2,777	61.6%	99.5%

Table 21. 2025 PMV: Initial Health Needs Screening Performance Measure								
MCE	# of New Eligible Members in Reporting Period	# of Members in Column 1 Terminated in First 90 Days	# of Members Net of Terminated	# of Members in Column 1 Deemed Unreachable	# of Members Net of Terminated and Unreachable	# of New Members in Column 1 Screened Within 90 Days	% Screened Within 90 Days (Except Terminated)	% Screened Within 90 Days (Except Terminated and Unreachable)
CareSource	**HIP**							
	18,760	2,334	16,426	6,880	9,546	10,991	66.9%	115.1%*
	HHW							
	18,601	1,411	17,190	5,568	11,622	12,127	70.5%	104.3%*
MDwise	**HIP**							
	21,998	1,863	20,135	8,272	11,863	11,534	57.3%	97.2%
	HHW							
	25,885	1,544	24,341	12,687	11,654	11,509	47.3%	98.8%
MHS	**HIP**							
	21,312	2,042	21,270	2,938	18,332	12,973	60.99%	70.77%
	HHW							
	26,715	2,363	24,352	420	23,932	12,674	52.05%	52.96%
	HCC							
	4,219	570	3,649	140	3,509	2,466	67.58%	70.28%
UHC	**HCC**							
	3,103	427	2,676	22	2,654	1,641	61.3%	61.8%

**The calculation of performance measure target rates displayed both an inflated numerator of members screened as well as a deflated denominator of eligible new members, despite the MCE calculating the reporting for this measure in accordance with the 2024 OMPP Managed Care Entity Reporting Manual Instructions. These variances resulted in erroneously high reporting rates of members screened within the compliant timeframe during each reporting period. Considerations for the state's MCE reporting structure for this measure will be provided to OMPP.*

Table 22. 2025 PMV: Comprehensive Health Assessment Tool Performance Measure – HCC Only				
MCE	# of Members in Complex Case Management, Care Management, and Right Choices Program	# of Members in Programs Minus Terminated Members	# of Members Screened with Comprehensive Assessment Tool	% of Members Screened with Comprehensive Assessment Tool
Anthem	2,785	2,196	1,854	84.43%
CareSource				
MDwise				
MHS	8,716	8,580	7,811	91.04%
UHC	139	113	73	64.60%

Shaded cells denote a lack of data due to this measure only applying to the HCC population.

Table 23. 2025 PMV: Institution for Mental Disease Member Use Performance Measure					
MCE	Type of Institutional Stay	# of Days of Stays	Average Length of Stay	# of Members with Stays	# of Members Awaiting Placement
Anthem	**HIP**				
	Serious Mental Illness (SMI) Impatient	17,552	7.4	1,819	0
	Substance Use Disorder (SUD) Inpatient	10,422	5.5	1,349	0
	SUD Residential	139,333	13.9	5,866	0
	Other Institutions for Mental Disease (IMDs)	2,724	7.3	334	0
	HHW				
	SMI Inpatient	135	7.5	15	0
	SUD Inpatient	44	4.9	7	0
	SUD Residential	583	13.3	30	0

Table 23. 2025 PMV: Institution for Mental Disease Member Use Performance Measure					
MCE	**Type of Institutional Stay**	**# of Days of Stays**	**Average Length of Stay**	**# of Members with Stays**	**# of Members Awaiting Placement**
	Other IMDs	2	2	1	0
	HCC				
	SMI Impatient	5,299	8.2	417	0
	SUD Inpatient	582	5.9	65	0
	SUD Residential	11,035	12.8	476	0
	Other IMDs	615	7.2	75	0
CareSource	**HIP**				
	SMI Impatient	3,807	6.9	489	0
	SUD Inpatient	1,714	5.2	291	0
	SUD Residential	50,533	19.5	4,601	0
	Other IMDs	1,245	7.2	157	0
	HHW				
	SMI Impatient	11	5.5	2	0
	SUD Inpatient	0	0	0	0
	SUD Residential	217	18.1	10	0
	Other IMDs	29	7.3	3	0
MDwise	**HIP**				
	SMI Impatient	5,984	8.1	670	0
	SUD Inpatient	2,974	5.4	492	0
	SUD Residential	79,918	22.0	3,175	0
	Other IMDs	2,832	9.9	270	0
	HHW				

Table 23. 2025 PMV: Institution for Mental Disease Member Use Performance Measure					
MCE	Type of Institutional Stay	# of Days of Stays	Average Length of Stay	# of Members with Stays	# of Members Awaiting Placement
	SMI Inpatient	97	7.5	12	0
	SUD Inpatient	19	6.3	3	0
	SUD Residential	439	20.0	21	0
	Other IMDs	69	8.6	7	0
MHS	**HIP**				
	SMI Inpatient	4,159	5.4	738	0
	SUD Inpatient	1,973	4.5	426	0
	SUD Residential	80,743	14.0	4,429	0
	Other IMDs	2,573	5.5	451	0
	HHW				
	SMI Inpatient	51	5.7	9	0
	SUD Inpatient	13	6.5	2	0
	SUD Residential	665	15.5	23	0
	Other IMDs	56	6.2	7	0
	HCC				
	SMI Inpatient	1,348	6.0	212	0
	SUD Inpatient	262	5.1	51	0
	SUD Residential	8,858	13.5	511	0
	Other IMDs	1,178	5.8	184	0
UHC	**HCC**				
	SMI Inpatient	400	7.3	38	0
	SUD Inpatient	99	4.5	16	0

Table 23. 2025 PMV: Institution for Mental Disease Member Use Performance Measure					
MCE	Type of Institutional Stay	# of Days of Stays	Average Length of Stay	# of Members with Stays	# of Members Awaiting Placement
	SUD Residential	1,311	17.5	56	0
	Other IMDs	352	6.6	34	0

Additional Performance Measures

During the 2025 PMV, the validation for additional performances measures, shown below, were extrapolated from the validation of the aforementioned measures. Table 24 displays the overall outcomes for the State counties that met or did not meet the goal for the performance measure, Dentists and Oral Surgeons Network Adequacy per IHCP. OMPP's goal for the measure was 2 within 60 miles per county. None of the MCEs met this performance measure. UHC's HCC program was the most compliant with 9.78% of counties compliant.

Table 24. 2025 PMV: Dentists and Oral Surgeons Network Adequacy Performance Measure				
MCE	Total # of Counties	# of Counties Meeting Standard	# of Counties Not Meeting Standard	Percentage Met
Anthem	**HIP**			
	92	0	92	0.00%
	HHW			
	92	1	91	1.09%
	HCC			
	92	0	92	0.00%
CareSource	**HIP**			
	92	6	86	6.52%
	HHW			
	92	2	90	2.17%

Table 24. 2025 PMV: Dentists and Oral Surgeons Network Adequacy Performance Measure				
MCE	**Total # of Counties**	**# of Counties Meeting Standard**	**# of Counties Not Meeting Standard**	**Percentage Met**
MDwise	**HIP**			
	92	2	90	2.17%
	HHW			
	92	2	90	2.17%
MHS	**HIP**			
	92	1	91	1.09%
	HHW			
	92	1	91	1.09%
	HCC			
	92	1	91	1.09%
UHC	**HCC**			
	92	9	83	9.78%

As an additional performance measure, OMPP asked the MCEs to track the NCQA measure of Plan All-Cause Readmission (PCR) which measures the readmission rate for any diagnosis within 30 days of an acute hospitalization. The goal for this measure is 0.9124. Table 25 displays the PCR data. All MCEs and their programs had more hospital readmissions than the goal, with the exception of MDwise's HHW program, which had a PCR rate of 0.5595.

Table 25. 2025 PMV: Plan All-Cause Readmission		
MCE	**IHCP**	**Rate**
Anthem	HIP	1.0155
	HHW	0.9531
	HCC	1.1338

Table 25. 2025 PMV: Plan All-Cause Readmission

MCE	IHCP	Rate
CareSource	HIP	1.1459
	HHW	1.1633
MDwise	HIP	1.0481
	HHW	0.5595
MHS	HIP	1.1373
	HHW	1.1849
	HCC	1.2365
UHC	HCC	1.5265

HEDIS® Measures

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

Table 26 provides the color and measure designation used in this report. Per NCQA HEDIS® Measurement Year 2024 Volume 5; HEDIS® Compliance Audit: Standards, Policies and Procedures, rates are not reported if the denominator is too small (<30).

Table 26. 2025 PMV: HEDIS® Color and Measure Designations

Color Designation	National Percentile Achieved
(green)	Greater than or equal to the goal rate
(white)	Rate is NA or NB; Rate is new and the goal rate is TBD
(red)	Less than the goal rate

Table 26. 2025 PMV: HEDIS® Color and Measure Designations

Measure Designation	Definition
R	Reportable: a reportable rate was submitted for the measure.
NA	Not Applicable: the MCE followed the specifications, but the denominator was too small (<30) to report a valid rate; thus, results are not presented.
NB	No Benefit: the MCE did not offer the health benefit required by the measure.
NR	Not Reported: the MCE chose not to report the measure.
NQ	Not Required: the MCE was not required to report the measure.
BR	Biased Rate: the calculated rate was materially biased.
UN	Un-Audited: the MCE chose to report a measure that is not required to be audited. This result applies to only a limited set of measures.
TBD	To Be Determined: the NCQA measure is new for MY 2024. MY 2024 is considered the baseline year.

OMPP designated specific goals for different HEDIS® measures for each MCE based upon the population the MCE serves. Table 27 presents the HEDIS® measures for each MCE with which HIP contracts. Table 28 presents the HEDIS® measures for each MCE with whom HHW contracts. Table 29 presents the HEDIS® measures for each MCE whom HCC contracts.

Table 27. 2025 PMV: HIP HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Adults' Access to Preventive/ Ambulatory Health Services	TBD*	75.00%	R	69.96%	R	70.31%	R	73.32%	R		
Acute Hospital Utilization	TBD		NR		NR		NR		NR		

Table 27. 2025 PMV: HIP HEDIS® Measures											
Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Blood Pressure Control for Patients with Diabetes	TBD	74.21%	R	70.07%	R	70.32%	R	76.64%	R		
Controlling High Blood Pressure	63.38%	70.80%	R	66.42%	R	61.61%	R	69.59%	R		
Childhood Immunization Status – Combo 10	34.00%		NA		NA		NA		NA		
Emergency Department Utilization	TBD		NR		NR		NR		NR		
Eye Exam for Patients with Diabetes	52.00%	59.61%	R	55.96%	R	54.01%	R	59.12%	R		
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)	29.00%	30.34%	R	32.78%	R	26.16%	R	29.24%	R		

Table 27. 2025 PMV: HIP HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)	40.00%	41.55%	R	44.54%	R	36.02%	R	38.26%	R		
Follow-Up After Hospitalization for Mental Illness – 7 Days	38.00%	32.51%	R	38.50%	R	24.19%	R	31.36%	R		
Follow-Up After Hospitalization for Mental Illness – 30 Days	56.00%	51.99%	R	59.59%	R	41.77%	R	52.85%	R		
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	40.00%	35.42%	R	49.86%	R	35.67%	R	36.31%	R		

Table 27. 2025 PMV: HIP HEDIS® Measures											
Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	54.00%	47.30%	R	56.66%	R	45.91%	R	47.53%	R		
Glycemic Status Assessment for Patients with Diabetes – Glycemic Status <8.0%	55.00%	67.15%	R	59.61%	R	56.45%	R	63.75%	R		
Glycemic Status Assessment for Patients with Diabetes – Glycemic Status >9.0%	TBD	24.84%	R	31.14%	R	33.82%	R	26.52%	R		
Initiation and Engagement of Alcohol and Other Drug – Initiation of SUD Treatment (Total)	43.00%	48.19%	R	44.94%	R	41.05%	R	43.40%	R		

Table 27. 2025 PMV: HIP HEDIS® Measures											
Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Initiation and Engagement of Alcohol and Other Drug – Engagement of SUD Treatment (Total)	TBD	26.96%	R	27.56%	R	22.84%	R	24.18%	R		
Immunizations for Adolescents – Combo 2	35.00%		NA		NA		NA		NA		
Kidney Health Evaluation for Patients with Diabetes	36.00%	37.34%	R	41.64%	R	33.38%	R	38.04%	R		
Oral Evaluation, Dental Services	TBD	26.00%	R	19.91%	R	26.37%	R	27.24%	R		
Prenatal and Postpartum Care – Timeliness of Prenatal Care	85.00%	91.73%	R	86.86%	R	89.61%	R	86.37%	R		
Prenatal and Postpartum Care – Postpartum Care	83.00%	88.32%	R	86.13%	R	81.00%	R	82.97%	R		

Table 27. 2025 PMV: HIP HEDIS® Measures											
Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	58.82%	50.89%	R	47.57%	R	45.78%	R	55.83%	R		
Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia	73.42%	85.29%	R	60.00%	R		NA		NA		
Diabetes Monitoring for Persons with Diabetes and Schizophrenia	64.87%	76.29%	R	72.73%	R	68.00%	R	65.00%	R		
Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications	82.55%	83.68%	R	83.52%	R	80.94%	R	83.38%	R		
Child and Adolescent Well-Care Visits (Total)	51.78%	24.02%	R	23.79%	R	19.80%	R	25.39%	R		
Well-Child Visits in the First 30 Months of Life (First 15 Months)	61.00%		NA		NA		NA		NA		

Table 27. 2025 PMV: HIP HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	69.00%		NA		NA		NA		NA		

To Be Determined. This measure is a newly introduced measure by NCQA, and this year is being considered as a baseline measurement year.

Table 28. 2025 PMV: HHW HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Adults' Access to Preventive/ Ambulatory Health Services	TBD	84.70%	R	86.70%	R	78.51%	R	84.55%	R		
Acute Hospital Utilization	TBD		NR		NR		NR		NR		
Metabolic Monitoring for Children and Adolescents on Antipsychotics – Blood Glucose Testing	51.17%	51.23%	R	48.88%	R	49.45%	R	54.16%	R		

Table 28. 2025 PMV: HHW HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Metabolic Monitoring for Children and Adolescents on Antipsychotics – Cholesterol Testing	33.09%	32.50%	R	34.38%	R	31.07%	R	36.28%	R		
Metabolic Monitoring for Children and Adolescents on Antipsychotics – Blood Glucose and Cholesterol Testing	32.11%	31.52%	R	33.26%	R	29.97%	R	34.43%	R		
Blood Pressure Control for Patients with Diabetes	72.99%	80.50%	R	81.82%	R	73.17%	R	82.03%	R		
Controlling High Blood Pressure	63.38%	73.02%	R		NA	51.69%	R	62.32%	R		
Childhood Immunization Status – Combo 10	34.00%	22.93%	R	30.41%	R	22.38%	R	25.30%	R		
Emergency Department Utilization	TBD*		NR		NR		NR		NR		

Table 28. 2025 PMV: HHW HEDIS® Measures											
Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Eye Exam for Patients with Diabetes	52.00%	50.21%	R	52.27%	R	56.10%	R	53.13%	R		
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 days (Total)	17.78%	21.98%	R	30.30%	R	15.03%	R	18.11%	R		
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 days (Total)	27.77%	28.02%	R	37.88%	R	23.70%	R	29.13%	R		
Follow-Up After Hospitalization for Mental Illness – 7 Days	43.44%	52.81%	R	60.92%	R	39.49%	R	48.19%	R		
Follow-Up After Hospitalization for Mental Illness – 30 Days	67.47%	74.49%	R	82.53%	R	60.11%	R	73.17%	R		

Table 28. 2025 PMV: HHW HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	47.14%	52.61%	R	61.39%	R	51.35%	R	51.97%	R		
Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	61.58%	70.21%	R	75.00%	R	69.14%	R	70.79%	R		
Glycemic Status Assessment for Patients with Diabetes – Glycemic Status <8.0%	55.00%	50.62%	R	47.73%	R	45.12%	R	29.69%	R		
Glycemic Status Assessment for Patients with Diabetes – Glycemic Status >9.0%	TBD	40.66%	R	45.45%	R	49.39%	R	69.53%	R		

Table 28. 2025 PMV: HHW HEDIS® Measures											
Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Initiation and Engagement of Alcohol and Other Drug – Initiation of SUD Treatment (Total)	43.00%	49.20%	R	41.35%	R	43.33%	R	43.74%	R		
Initiation and Engagement of Alcohol and Other Drug – Engagement of SUD Treatment (Total)	TBD	16.57%	R	13.50%	R	14.93%	R	16.71%	R		
Immunizations for Adolescents – Combo 2	35.00%	30.93%	R	29.80%	R	31.60%	R	33.34%	R		
Kidney Health Evaluation for Patients with Diabetes	36.00%	19.59%	R	27.91%	R	20.36%	R	18.75%	R		
Oral Evaluation, Dental Services	40.00%	46.08%	R	41.70%	R	47.65%	R	48.44%	R		
Prenatal and Postpartum Care – Timeliness of Prenatal Care	85.00%	88.32%	R	91.24%	R	87.31%	R	86.37%	R		

Table 28. 2025 PMV: HHW HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Prenatal and Postpartum Care – Postpartum Care	83.00%	83.45%	R	91.48%	R	83.46%	R	86.37%	R		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	58.82%		NA		NA		NA		NA		
Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia	73.17%		NA		NA		NA		NA		
Diabetes Monitoring for Persons with Diabetes and Schizophrenia	70.05%		NA		NA		NA		NA		
Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications	82.55%	81.41%	R	87.50%	R	74.16%	R	85.14%	R		
Child and Adolescent Well-Care Visits (Total)	51.65%	55.54%	R	55.00%	R	50.33%	R	57.23%	R		

Table 28. 2025 PMV: HHW HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Well-Child Visits in the First 30 Months of Life (First 15 Months)	61.00%	69.87%	R	64.20%	R	60.24%	R	66.13%	R		
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	69.00%	72.39%	R	72.85%	R	68.33%	R	72.34%	R		

**To Be Determined. This measure is a newly introduced measure by NCQA, and this year is being considered as a baseline measurement year.*

Table 29. 2025 PMV: HCC HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Adults' Access to Preventive/ Ambulatory Health Services	TBD*	81.64%	R					77.65%	R	76.97%	R
Acute Hospital Utilization	TBD		NR						NR		NR
Metabolic Monitoring for Children and Adolescents on Antipsychotics – Blood	51.17%	52.37%	R					55.26%	R	56.69%	R

Table 29. 2025 PMV: HCC HEDIS® Measures

Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Glucose Testing											
Metabolic Monitoring for Children and Adolescents on Antipsychotics – Cholesterol Testing	33.09%	35.92%	R					39.21%	R	39.37%	R
Metabolic Monitoring for Children and Adolescents on Antipsychotics – Blood Glucose and Cholesterol Testing	32.11%	34.89%	R					37.83%	R	39.37%	R
Blood Pressure Control for Patients with Diabetes	72.99%	73.48%	R					71.05%	R	61.80%	R
Controlling High Blood Pressure	63.38%	70.56%	R					70.32%	R	62.29%	R
Childhood Immunization Status – Combo 10	34.00%	22.82%	R					20.71%	R	16.33%	R
Emergency Department	TBD		NR						NR		NR

Table 29. 2025 PMV: HCC HEDIS® Measures											
Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Utilization											
Eye Exam for Patients with Diabetes	52.00%	58.39%	R					57.42%	R	47.20%	R
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 days (Total)	29.00%	32.12%	R					23.31%	R	27.40%	R
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 days (Total)	40.00%	43.98%	R					40.20%	R	36.99%	R
Follow-Up After Hospitalization for Mental Illness – 7 Days	38.00%	43.93%	R					36.29%	R	43.90%	R
Follow-Up After Hospitalization for Mental Illness – 30	56.00%	62.98%	R					59.90%	R	60.49%	R

Table 29. 2025 PMV: HCC HEDIS® Measures											
Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Days											
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	40.00%	48.60%	R					42.51%	R	51.22%	R
Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	54.00%	62.98%	R					59.98%	R	65.85%	R
Glycemic Status Assessment for Patients with Diabetes – Glycemic Status <8.0%	55.00%	63.75%	R					58.64%	R	51.24%	R
Glycemic Status Assessment for Patients with Diabetes – Glycemic Status >9.0%	TBD	27.01%	R					30.41%	R	42.24%	R
Initiation and Engagement of Alcohol and Other Drug – Initiation of SUD	43.00%	44.16%	R					40.35%	R	39.85%	R

Table 29. 2025 PMV: HCC HEDIS® Measures											
Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Treatment (Total)											
Initiation and Engagement of Alcohol and Other Drug – Engagement of SUD Treatment (Total)	TBD	18.40%	R					16.74%	R	12.26%	R
Immunizations for Adolescents – Combo 2	35.00%	27.62%	R					34.26%	R	27.59%	R
Kidney Health Evaluation for Patients with Diabetes	36.00%	35.51%	R					35.55%	R	29.97%	R
Oral Evaluation, Dental Services	40.00%	50.47%	R					51.96%	R	43.93%	R
Prenatal and Postpartum Care – Timeliness of Prenatal Care	85.00%	81.12%	R					83.19%	R		NA
Prenatal and Postpartum Care – Postpartum Care	83.00%	73.49%	R					73.11%	R		NA
Adherence to Antipsychotic	58.82%	69.15%	R					73.08%	R	58.82%	R

Table 29. 2025 PMV: HCC HEDIS® Measures											
Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Medications for Individuals with Schizophrenia											
Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia	73.17%	81.40%	R						NA		NA
Diabetes Monitoring for Persons with Diabetes and Schizophrenia	70.05%	78.59%	R					76.59%	R		NA
Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications	82.55%	83.17%	R					81.85%	R	82.39%	R
Child and Adolescent Well-Care Visits (Total)	61.00%	57.34%	R					58.26%	R	55.82%	R
Well-Child Visits in the First 30 Months of Life (First 15 Months)	69.00%	50.00%	R					58.33%	R		NA
Well-Child Visits in the	51.65%	83.73%	R					77.14%	R	61.96%	R

Table 29. 2025 PMV: HCC HEDIS® Measures											
Measure Name	Goal	Anthem		CareSource		MDwise		MHS		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
First 30 Months of Life (15 Months-30 Months)											

To Be Determined. This measure is a newly introduced measure by NCQA, and this year is being considered as a baseline measurement year.

Table 30 highlights the HEDIS® measures that specifically target Access/Availability of Care and Effectiveness of Care.

Table 30. HEDIS® Findings Summary by MCE and IHCP					
MCE	IHCP	Number of Compliant Measures	Number of Noncompliant Measures	Number of New Baseline Measures	Number of Reportable Measures
Access/Availability of Care					
Anthem	HIP	3	0	2	5
	HHW	3	0	2	5
	HCC	1	2	2	5
CareSource	HIP	3	0	2	5
	HHW	0	1	2	3
MDwise	HIP	1	2	2	5
	HHW	3	0	2	5
MHS	HIP	1	2	2	5
	HHW	3	0	2	5
	HCC	0	3	2	5
UHC	HCC	0	1	2	3

Table 30. HEDIS® Findings Summary by MCE and IHCP					
MCE	IHCP	Number of Compliant Measures	Number of Noncompliant Measures	Number of New Baseline Measures	Number of Reportable Measures
Effectiveness of Care					
Anthem	HIP	8	6	3	17
	HHW	9	4	1	14
	HCC	14	1	1	16
CareSource	HIP	11	3	3	17
	HHW	10	4	1	15
MDwise	HIP	5	9	3	16
	HHW	5	7	1	13
MHS	HIP	5	8	3	15
	HHW	10	2	1	13
	HCC	7	6	1	14
UHC	HCC	5	7	1	13

Improvements from 2024 PMV

Qsource did not identify any areas for improvement related to the MCE's data collection and performance measure reporting processes during the 2024 PMV protocol. Each MCE was independently deemed fully compliant with all NCQA-defined Information System Standards for HEDIS®-applied data and processes.

No weaknesses were identified for the MCEs in the MY 2023 PMV review; therefore, the degree to which the plans addressed a recommendation could not be made as there are no improvements to report in the MY 2024 review.

Strengths and Weaknesses

The PMV review assists OMPP, Qsource, and the MCEs in identifying strengths and weaknesses in information systems capabilities and performance measures. 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. Weaknesses are identified where the MCE achieved less than 100% compliance and reflect what the MCE should do to improve performance.

Table 31 displays the strengths demonstrated in the PMV, and **Table 32** displays the weaknesses.

Table 31. PMV Strengths

MCE	Strength
Anthem (HHW/HIP/HCC)	None identified.
CareSource (HHW/HIP)	None identified.
MDwise (HHW/HIP)	None identified.
MHS (HHW/HIP/HCC)	None identified.
UHC (HCC)	None identified.

Table 32. PMV Weaknesses

MCE	Weakness
Anthem (HHW/HIP/HCC)	Anthem displayed discrepancies between reported and collected data.
	Anthem did not collect member assessments and screenings, nor was there an ability to account for missing data elements within the Postpartum Care performance measure.
	Anthem was noncompliant in all but one county in the dentist and oral surgeon network adequacy performance measure.

Table 32. PMV Weaknesses	
MCE	**Weakness**
	Anthem did not meet the PCR rate performance measure.
	Anthem was noncompliant with 13 applicable HEDIS® measures across its three programs.
CareSource (HHW/HIP)	CareSource displayed issues between reported rates and the raw data files.
	CareSource displayed discrepancies in its timespan of care coordination activities.
	CareSource was compliant in eight counties in the dentist and oral surgeon network adequacy performance measure across both programs.
	CareSource did not meet the PCR rate performance measure.
	CareSource was noncompliant with 8 applicable HEDIS® measures across its two programs.
MDwise (HHW/HIP)	MDwise displayed discrepancies during the data review period, lack of evidenced completion related to member assessments and screenings for the Postpartum Care performance measure
	MDwise was compliant in four counties in the dentist and oral surgeon network adequacy performance measure across both programs.
	MDwise did not meet the PCR rate performance measure for one of its two programs.
	MDwise was noncompliant with 18 applicable HEDIS® measures across its two programs.
MHS (HHW/HIP/HCC)	MHS displayed inconsistencies and failure to complete said member assessments during the review period for the Initial HNS performance measure.
	MHS displayed issues with the timespan of reported care coordination and assessment stratifications for the Postpartum Care performance measure.
	MHS was compliant in three counties in the dentist and oral surgeon network adequacy performance measure across all three programs.
	MHS did not meet the PCR rate performance measure.
	MHS was noncompliant with 21 applicable HEDIS® measures across its three programs.
UHC (HCC)	UHC displayed issues with numerator positive data extraction and a lack of completed screenings in the Initial HNS and CHAT performance measures.
	UHC displayed a lack of assessments completed for numerator positive files for the Postpartum Care performance

Table 32. PMV Weaknesses	
MCE	Weakness
	measure.
	UHC was compliant in 9 counties in the dentist and oral surgeon network adequacy performance measure.
	UHC did not meet the PCR rate performance measure.
	UHC was noncompliant with eight applicable HEDIS® measures.

Conclusions and Recommendations

The MCEs' information systems capabilities were determined to have no issues. However, Qsource determined that there were problems in the performance measure validation and in the data assessments. Due to these issues, according to **Table 16**, all MCEs achieved the Performance Measure Validation status of partially met.

Anthem

Anthem's main difficulties with the PMV specifically surrounded identification of raw primary source data files for performance measure production and acknowledged variations between the data collected versus reported as well as timelines for gathering performance measure data.

Qsource made the following recommendations for Anthem:

- Anthem should ensure that subject matter expert staff are prepared for performance measure validations.
- Anthem should work to mitigate discrepancies found between the identified initiation and completion date of Health Needs Screenings.
- Anthem should work to mitigate issues with the identification of raw primary source data files utilized for performance measure production and acknowledged variations between the data collected versus reported.
- Anthem should work to mitigate discrepancies within the care coordination timeline, member assessments, and screenings not completed by the MCE, and the inability to account for missing data elements.
- Anthem should continue to focus on HEDIS® measures where performance fell below national benchmarks.
- Anthem should work to improve the Dentists and Oral Surgeons Network Adequacy performance measure.

CareSource

CareSource's main difficulties with the PMV specifically surrounded identified problems in the timespan of care coordination activities and differences between annual reported rates and the raw data files. These results, in conjunction with findings from the virtual review, culminated in a validation rating of partially met for CareSource's ability to provide quality, accurate, and timely services for its members.

Qsource made the following recommendations for CareSource:

- CareSource should ensure that the annually reported rates match the raw data files submitted for validation.
- CareSource should work to mitigate discrepancies noted for the timespan of care coordination activities.
- CareSource should continue to focus on HEDIS® measures where performance fell below national benchmarks.
- CareSource should work to improve the Dentists and Oral Surgeons Network Adequacy performance measure.

MDwise

MDwise's main difficulties with the PMV specifically surrounded a lack of evidenced completion of member assessments and screenings. While MDwise noted that they had discovered this problem prior to the systems review and detailed a mitigation plan to reviewers, this issue must still be noted in this report as well.

Qsource made the following recommendations for MDwise:

- MDwise should continue to work towards mitigating discrepancies noted during the data review period for the PPC performance measure including the lack of evidenced completion related to member assessments and screenings. MDwise did note that they found a systematic error and detailed a mitigation plan to avoid such errors in future reporting.
- MDwise should continue to focus on HEDIS® measures where performance fell below national benchmarks.
- MDwise should work to improve the Dentists and Oral Surgeons Network Adequacy performance measure.

MHS

MHS's main difficulties with the PMV specifically surrounded reporting stratification of applicable, appropriate assessments and reporting timespans.

Qsource made the following recommendations for MHS:

- MHS should work to mitigate inconsistencies found in the reporting stratification of applicable performance measure assessments and failure to complete member assessments during the review period.
- MHS should work to mitigate issues with the timespan of reported care coordination and inappropriate assessment stratifications.
- MHS should continue to focus on HEDIS® measures where performance fell below national benchmarks.
- MHS should work to improve the Dentists and Oral Surgeons Network Adequacy performance measure.

UHC

UHC's main difficulties with the PMV specifically surrounded issues with numerator positive data extraction and assessments done on those extractions, as well as discrepancies noted in reported timelines.

Qsource made the following recommendations for UHC:

- UHC should work to mitigate issues with numerator positive data extraction in preparation for the Health Needs Screening and Comprehensive Health Assessment Tool performance measures.
- UHC should work to ensure reported rates accurately reflect source data.

- UHC should work to mitigate the lack of assessments completed for numerator positive files in the PPC performance measure.
- UHC should continue to focus on HEDIS® measures where performance fell below national benchmarks.
- UHC should work to improve the Dentists and Oral Surgeons Network Adequacy performance measure.

Protocol 3: Compliance Assessment (CA)

Objectives

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

As required by 42 CFR § 438.358, one of the mandatory EQR activities is a review within the previous three-year period to determine each MCE's compliance with federal and state EQR regulations, as noted in **Table 33**. Qsource reviewed all measures in 2024 and in 2021; the 2021 scores are compared in **Table 39**. CMS introduced three new standards in its 2023 EQR Protocol: Disenrollment Requirements and Limitation, Emergency and Post-Stabilization Services, and Enrollee Rights Requirements. The current three-year cycle is 2024–2026. The current measurement year in which Qsource conducted activities for this report was MY 2023.

Table 33. Compliance Standards

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

Table 33. Compliance Standards		
CFR Citation	**2024 Standard**	**Domain of Care**
42 CFR § 438.56	Disenrollment Requirements and Limitations	Access to Care
42 CFR § 438.100	Enrollee Rights Requirements	Quality of Care
42 CFR § 438.10	Information Requirements	Access to Care/Quality of Care/Timeliness of Care
42 CFR § 441.56	Early and Periodic Screening, Diagnostic, and Treatment	Access to Care/Quality of Care/Timeliness of Care

Technical Methods for Data Collection and Analysis

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

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

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

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

Table 34 presents the rating criteria used in the CA validation.

Table 34. Compliance Rating Criteria

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

Description of Data Obtained

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

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

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

Table 35 presents overall compliance scores for all standards by MCE evaluated for the 2024 CA.

Table 35. 2024 Compliance Standard Scores

Standards	Anthem		CareSource		MDwise		MHS		UHC	
	Score	Compliance Rating	Score	Compliance Rating	Score	Compliance Rating	Score	Compliance Rating	Score	Compliance Rating
Availability of Services	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Assurances of Adequate Capacity and Services	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance
Coordination and Continuity of Care	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance	100%	High Compliance

Table 35. 2024 Compliance Standard Scores

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

Table 36 presents the file review score for each MCE.

Table 36. 2024 File Review Score

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

Strengths and Weaknesses

Table 37 provides strengths by compliance standard or file review for the CA, while the AONs, or weaknesses, are identified in Table 38. Qsource also identified suggestions where an element was fully compliant, but a revision/update could further strengthen that element's compliance. The MCEs were not held accountable for addressing suggestions; therefore, this report did not monitor or include suggestions. If an MCE was not listed, it had no identified strengths or weaknesses in those areas.

Table 37. CA Strengths by Standard

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

Table 38. CA Weaknesses (AONs) by Standard

Standard Title	AON	Domain of Care
Anthem		
Disenrollment Requirements and Limitations #1: Notification for Disenrollment	The MCE should create documentation addressing each of the enumerated reasons for disenrollment, and this documentation will need to be provided to OMPP within 30 days from receipt of report.	Access to Care

Table 38. CA Weaknesses (AONs) by Standard		
Standard Title	**AON**	**Domain of Care**
File Review: UM Denials	The MCE should ensure appropriate review criteria are used and documented on all UM Denial cases.	Access to Care
File Review: Grievances	The MCE should ensure that all grievance acknowledgments are sent to the enrollee within the established timeframe.	Timeliness of Care
	The MCE should ensure that all grievances are investigated and documented as part of the grievance process.	Access to Care
File Review: Appeals	The MCE should ensure that all appeal acknowledgments are sent to the enrollee within the established timeframe.	Timeliness of Care
	The MCE should include verbiage regarding appeals and the precise verbiage, “resolution at each level of the appeal or grievance, if applicable,” into the policy.	Access to Care
CareSource		
Grievance and Appeals System #30: Expedited Resolution of Appeals Requirements	The MCE should include the verbiage “makes reasonable efforts to give the member prompt oral notice of the delay” within their Grievance and Appeals policy regarding expedited resolution requests.	Access to Care and Timeliness and Quality of Care
Grievance and Appeals System #33: Recordkeeping Requirements – Information	The MCE should include verbiage regarding appeals and the precise verbiage, “resolution at each level of the appeal or grievance, if applicable,” into the policy.	Access to Care and Timeliness and Quality of Care
MDwise		
File Review: UM Denials	The MCE should ensure that all enrollees are notified of the denial decisions within the established timeframe.	Timeliness of Care
	The MCE should ensure that appropriate review criteria are used for all denials.	Access to Care
File Review: Grievances	The MCE should ensure that all grievances are acknowledged, and the acknowledgement standards are met. This discrepancy was observed in two files.	Access and Availability of Care

Table 38. CA Weaknesses (AONs) by Standard		
Standard Title	**AON**	**Domain of Care**
	The MCE should ensure that all grievances are investigated properly. This discrepancy was observed in three files.	Access and Availability of Care
	The MCE should ensure that resolution standards are met on all Grievances. This discrepancy was observed in one file.	Access and Availability of Care
	The MCE should ensure that enrollees are notified of the resolution of their grievances within the established timeframe and notification standards are met. This discrepancy was observed in one file.	Timeliness of Care
MHS		
Grievance and Appeals System #13: Exceptions from Advance Notice	The MCE should have a policy that acknowledges exceptions from Advance Notice.	Access to Care and Timeliness and Quality of Care
File Review: Appeals	The MCE should ensure that the acknowledgement is sent in a timely fashion for all Appeals.	Timeliness of Care
File Review: Grievances	The MCE should ensure that the acknowledgement is sent in a timely fashion for all Grievances.	Timeliness of Care
UHC		
Disenrollment Requirement and Limitations #1: Notification for Disenrollment	The MCE should create a policy that addresses each of the enumerated reasons for disenrollment in this element, and this policy should be provided to OMPP within 30 days of receipt of report unless otherwise provided.	Access to Care
File Review: Grievances	The MCE should ensure that all Grievances are investigated properly.	Access to Care
File Review: Appeals	The MCE should ensure that notifications of resolutions are sent for all Appeals cases.	Availability of Care
	The MCE should ensure that all Appeal acknowledgment letters are sent within the stipulated timeframe.	Timeliness of Care

Performance Improvement

Table 39 compares the CA scores in 2024 (MY 2023) and 2021 (MY 2020). Where comparisons were not included, the results either showed no change or were not applicable in 2021. Improvements from the last MY in which these standards were assessed are indicated using an upward arrow (↑), and decreases in performance are indicated using a downward arrow (↓).

Table 39. 2024 Compliance Standard Score Comparison

Standards	Anthem		CareSource		MDwise		MHS		UHC*
	2021	2024	2021	2024	2021	2024	2021	2024	2024
Availability of Services	100%	100%	84.60%	↑ 100%	100%	100%	100%	100%	100%
Assurances of Adequate Capacity and Services	50.00%	↑ 100%	50.00%	↑ 100%	50.00%	↑ 100%	50.00%	↑ 100%	100%
Coordination and Continuity of Care	100%	100%	100%	100%	100%	100%	100%	100%	100%
Coverage and Authorization of Services	100%	100%	95.90%	↑ 100%	99.40%	↑ 100%	98.00%	↑ 100%	100%
Emergency and Poststabilization		100%		100%		100%		100%	100%
Confidentiality	100%	100%	100%	100%	100%	100%	100%	100%	100%
Grievance and Appeals System	100%	100%	100%	↓ 94.74%	100%	100%	97.70%	↓ 97.37%	100%
Subcontractual Relationships and Delegation	100%	100%	100%	100%	93.80%	↑ 100%	100%	100%	100%
Practice Guidelines	100%	100%	100%	100%	100%	100%	100%	100%	100%
Health Information Systems	100%	100%	100%	100%	100%	100%	100%	100%	100%
Quality Assessment and Performance Improvement	100%	100%	100%	100%	100%	100%	100%	100%	100%
Disenrollment Requirements and Limitations		0.00%		100%		100%		100%	0.00%
Enrollee Rights Requirements		100%		100%		100%		100%	100%
Information Requirements		100%		100%		100%		100%	100%
Early and Periodic Screening, Diagnostic, and Treatment		100%		100%		100%		100%	100%

Table 39. 2024 Compliance Standard Score Comparison

Standards	Anthem		CareSource		MDwise		MHS		UHC*
	2021	2024	2021	2024	2021	2024	2021	2024	2024
Provider Selection	100%	100%	100%	100%	100%	100%	100%	100%	100%
Overall Compliance Standard Score	**95.45%**	**93.75%**	**93.68%**	**98.40%**	**94.84%**	**100%**	**97.8%**	**99.20%**	**99.20%**

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

Table 40 displays the rating criteria for how the plan addressed the recommendations given the last time these CA standards were assessed.

Table 40. Improvement Rating Criteria

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

Recommendations

Table 41 displays the degree to which the plan addressed the recommendations given in 2021. It includes only plans that received recommendations the last year in which these standards were assessed.

Table 41. 2021 Recommendations Addressed in 2024

Recommendations	2024 Results	Degree to Which Plan Addressed Recommendation(s)
Anthem		
Assurances of Adequate Capacity and Services:	Anthem was fully compliant with the Assurances of Adequate Capacity and Services standard.	High

Table 41. 2021 Recommendations Addressed in 2024		
Recommendations	**2024 Results**	**Degree to Which Plan Addressed Recommendation(s)**
a. The MCE should have sufficient access to specialty services for enrollees.		
CareSource		
Availability of Services: a. CareSource should have policies and procedures on maintaining and monitoring an appropriate provider network, along with a policy and procedures stating that CareSource has agreements. b. CareSource should also include how they maintain and monitor an appropriate provider network sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities in their policy and procedures. c. CareSource should have a policy that states out-of-network costs to the enrollee are no greater than they would be if the services were furnished within the network and that the out-of-network provider must coordinate with CareSource for payment.	CareSource was fully compliant with the Availability of Services standard.	High
Assurances of Adequate Capacity and Services: a. CareSource should have a policy and procedure discussing how they monitor and ensure the network has sufficient coverage. b. CareSource should have sufficient access to specialty services for enrollees.	CareSource was fully compliant with the Assurances of Adequate Capacity and Services standard.	High
Coverage and Authorization of Services: a. CareSource should have a policy that indicates, “Advance directive information must reflect changes in Indiana law as soon as possible, but no	CareSource was fully compliant with the Coverage and Authorization of Services standard.	High

Table 41. 2021 Recommendations Addressed in 2024

Recommendations	2024 Results	Degree to Which Plan Addressed Recommendation(s)
later than 90 days after the effective date of the change." b. CareSource should have a policy and member notification/right, that states "information is available in paper form without charge upon request, to be received within five business days." The policy should include details where this tagline is available on the websites. c. CareSource should have a policy that states, "The MCE will provide written notice of termination of a contracted provider to each enrollee who received their primary care from, or was seen regularly by, the terminated provider. Notice to the enrollee must be within 15 calendar days after receipt or issuance of the termination notice." In addition, CareSource should consult OMPP about their current contract language to ensure it is meeting the 42 CFR 438.10(f)(1) 15-day requirement.		
MDwise		
Assurances of Adequate Capacity and Services: a. MDwise should have sufficient access to specialty services for enrollees.	MDwise was fully compliant with the Assurances of Adequate Capacity and Services standard.	High
Coverage and Authorization of Services: a. Include "font size no smaller than 12 points" in the "Readability, Accuracy and Translation of Member Materials Policy and Procedure" document. b. Change pg. 2, section 2 of the "Member Handbook Design and Format Guidelines" where it states in step 1: "Use 10-point or 11-point type for body copy" to "no smaller than 12 points."	MDwise was fully compliant with the Coverage and Authorization of Services standard.	High

Table 41. 2021 Recommendations Addressed in 2024		
Recommendations	**2024 Results**	**Degree to Which Plan Addressed Recommendation(s)**
Subcontractual Relationships and Delegation: a. MDwise should have a policy or language in its subcontractor contracts that states that the MCE has a right to audit subcontractors under 42 CFR 438.230 (c)(3)(i) up to 10 years from the final date of the contract period or from the completion date of any audit, whichever is later.	MDwise was fully compliant with the Subcontractual Relationships and Delegation standard.	High
MHS		
Assurances of Adequate Capacity and Services: a. MHS should have sufficient access to specialty services for enrollees.	MHS was fully compliant with the Assurances of Adequate Capacity and Services standard.	High
Coverage and Authorization of Services: a. MHS should have a policy that states, "The enrollee is informed that the information provided electronically is available in paper form without charge upon request and provided within five business days of the request." The policy should also include details where the tagline is available on all electronic formats via the web for those items that are required in paper format. b. The MCE should change current language in the Member Reassignment policy, pg. 1 to: "In the event that MHS is not notified by the provider timely, members will be notified by letter no later than fifteen (15) days from receipt of the provider termination request."	MHS was fully compliant with the Coverage and Authorization of Services standard.	High
Grievance and Appeals System a. MHS should include enrollee may file a grievance with the MCE at any time in the policy. Current policy states a grievance may be filed within 60	While MHS had a lower Grievance and Appeal Systems score in 2024 than 2021 at 97.37% and 97.70% respectively, MHS had one AON in that standard during both assessments. MHS was fully compliant with this criteria in 2024.	High

Table 41. 2021 Recommendations Addressed in 2024		
Recommendations	2024 Results	Degree to Which Plan Addressed Recommendation(s)
calendar days of the occurrence of the matter that is the subject of the grievance.		
UHC		
UHC was not contracted in 2021 (MY 2020).		Not Applicable

Conclusions

Anthem

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

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

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

CareSource

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

In the 2024 CA, CareSource addressed the AON for Assurances of Adequate Capacity and Services it received during the 2021 CA relating to how CareSource monitors the overall network

and specific enrollees to ensure everyone has access to sufficient services. Likewise, CareSource addressed the Availability of Services AONs regarding out-of-network payments and maintaining appropriate provider networks, and three AONs for Coverage and Authorization of Services regarding provider termination notices, advance directives, and electronic information. CareSource addressed 2021 recommendations to a high degree.

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

MDwise

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

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

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

MHS

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

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

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

UHC

UHC was not a contracted MCE in the delivery of coverage of HCC for OMPP during 2021; therefore, there is no comparison data available to display. The degree to which UHC addressed the 2021 recommendations in 2024 is not applicable.

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

Protocol 4: Annual Network Adequacy (ANA) Overview

Objectives

CMS EQR *Protocol 4: Validation of Network Adequacy (2023)* outlines activities for validation of network adequacy. Per the Protocol, this includes validating data to determine whether the network standards, as defined by the state, were met. The Protocol dictates that the MCEs must conduct activities to assess the adequacy of their networks. States have flexibility in determining the strategies used to assess network adequacy. This activity is conducted by Myers & Stauffer Limited Liability Company (MSLC), Qsource's subcontractor, at the direction of OMPP.

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

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

The 2025 ANA review covered the period of January 1 to December 31, 2024, and measured member access to provider service types. MSLC analyzed the following:

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

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

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

Geographic Network Adequacy Analysis

Objectives

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

The calculation of network adequacy involves Geomapping at a particular point in time. Geomapping involved obtaining data as of October 1, 2024. For this report, the findings from the specified point in time were aggregated to the previous 12 months. Environmental Systems Research Institute, Inc. ArcGIS™ (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. Results were summarized by county and program to identify potential issues. Underserved members were measured by count and by percentage of members impacted within analysis groupings. Provider service type was determined from the MCE-supplied IHCP Provider Type and IHCP Provider Specialty. Provider taxonomy was also used for applicable service types.

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

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

Technical Methods of Data Collection and Analysis

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

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

- HIP

- HHW
- HCC

In addition to including the detailed data outlined above, Qsource's written request to the MCEs specified the listings should include only members and providers who were eligible on October 1, 2024. The written request also specified that the provider listings should include a separate record for each location at which the individual practitioner was eligible to perform services for the plan on that date. Additionally, the written request specified the MCE provider types and specialties that qualify as providers.

Analysis

All analyses were conducted based on a specified point in time, October 1, 2024. Results were based on the assumption that all variables utilized in the analyses were consistent across the entire period being reviewed.

Description of Data Obtained

All MCEs were requested to submit copies of the annual reports regarding provider networks submitted to the State as of the assessment time period (October 2024), specifically *Report 0902 (Count of Providers)* and *Report 0903 (Member Access to Providers)*. Additionally, all MCEs were asked to submit copies of the provider directories issued to the MCE members as of the assessment period (October 2024).

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

Table 42 presents the network adequacy rating criteria for the MCEs. Qsource developed the network adequacy rating to present comparative findings from the analysis.

Table 42. Annual Network Adequacy Validation Score

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

Table 43 presents the network adequacy ratings for each MCE.

Table 43. Annual Network Adequacy Validation Score

Review	Program	Percentage Met	Validation Rating
Anthem			
ISCA	HHW/HIP/HCC	100%	High Confidence
Provider to Member Ratio	HHW	96.00%	High Confidence

Table 43. Annual Network Adequacy Validation Score			
Review	**Program**	**Percentage Met**	**Validation Rating**
	HIP	96.00%	High Confidence
	HCC	100%	High Confidence
Member Access to Providers	HHW	98.44%	High Confidence
	HIP	98.78%	High Confidence
	HCC	98.61%	High Confidence
Appointment Wait Time	HHW	35.00%	Low Confidence
	HIP	33.33%	Low Confidence
	HCC	34.21%	Low Confidence
CareSource			
ISCA	HHW/HIP	100%	High Confidence
Provider to Member Ratio	HHW/HIP	100%	High Confidence
Member Access to Providers	HHW	98.55%	High Confidence
	HIP	98.63%	High Confidence
Appointment Wait Time	HHW	45.16%	Low Confidence
	HIP	51.61%	Moderate Confidence
MDwise			
ISCA	HHW/HIP	100%	High Confidence
Provider to Member Ratio	HHW/HIP	100%	High Confidence
Member Access to Providers	HHW	98.24%	High Confidence
	HIP	98.16%	High Confidence
Appointment Wait Time	HHW/HIP	56.82%	Moderate Confidence

Table 43. Annual Network Adequacy Validation Score

Review	Program	Percentage Met	Validation Rating
MHS			
ISCA	HHW/HIP/HCC	100%	High Confidence
Provider to Member Ratio	HHW/HIP/HCC	100%	High Confidence
Member Access to Providers	HHW	96.75%	High Confidence
	HIP	97.46%	High Confidence
	HCC	97.22%	High Confidence
Appointment Wait Time	HHW	62.00%	Moderate Confidence
	HIP	61.54%	Moderate Confidence
	HCC	56.86%	Moderate Confidence
UHC			
ISCA	HCC	100%	High Confidence
Provider to Member Ratio	HCC	100%	High Confidence
Member Access to Providers	HCC	98.60%	High Confidence
Appointment Wait Time	HCC	70.00%	Moderate Confidence

Provider Network Adequacy by Geography

Figures in this section graphically illustrate the MCEs' member population by county and program or illustrate the Indiana counties by provider service type where members do not have sufficient access to providers. Figures 2, 3, and 4 illustrate Anthem's member population; Figures 24 and 25 illustrate CareSource's member population; Figures 39 and 40 illustrate MDwise' s member population; Figures 51, 52, and 53 illustrates MHS's member population; Figure 109 illustrate UHC's member population. **Table 44** provides the accessibility standards and adequacy results for all provider service types for HHW, HIP, and HCC as well as links to the figures that illustrate where members do not have sufficient access to providers. If a MCE does not provide services to one of the IHCPs, that IHCP's column is grayed out so that there is no confusion.

Table 44. Accessibility by Provider Service Type										
Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Anthem										
Acute Care Hospitals	Urban - 1 within 30 miles; Rural - 1 within 60 miles	Met	Met	Met	-	-	-			
Anesthesiologists	2 within 60 miles	Met	Met	Met	-	-	-			
Behavioral Health Providers	Urban - 1 within 30 miles; Rural - 1 within 45 miles	Met	Met	Met	-	-	-			
Cardiologists	2 within 60 miles	Met	Met	Met	-	-	-			
Cardiothoracic Surgeons	1 within 90 miles	Met	Met	Met	-	-	-			
Cardiovascular Surgeons	1 within 90 miles	Met	Met	Met	-	-	-			
Dentists	1 within 30 miles	Met	Not Met	Met	-	1	-		Figure 11	
Dermatologists	1 within 90 miles	Met	Met	Met	-	-	-			
Diagnostic Testing	2 within 60 miles	Not Met	Not Met	Not Met	28	29	25	Figure 5	Figure 12	Figure 18
Durable Medical Equipment (DME)	2 per county	Met	Met	Met	-	-	-			
Endocrinologists	2 within 60 miles	Met	Met	Met	-	-	-			

Table 44. Accessibility by Provider Service Type										
Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
End-Stage Renal Disease (ESRD) Clinic	1 within 60 miles	Met	Met	Met	-	-	-			
Gastroenterologists	2 within 60 miles	Met	Met	Met	-	-	-			
General Surgeons	2 within 60 miles	Met	Met	Met	-	-	-			
Hematologists	2 within 60 miles	Met	Met	Met	-	-	-			
Home Health Providers	2 per county	Met	Met	Met	-	-	-			
Infectious Disease Specialists	1 within 90 miles	Met	Met	Met	-	-	-			
Inpatient Psychiatric Facilities	1 within 60 miles	Met	Met	Met	-	-	-			
Interventional Radiologists	1 within 90 miles	Met	Met	Met	-	-	-			
Nephrologists	2 within 60 miles	Met	Met	Met	-	-	-			
Neurological Surgeons	1 within 90 miles	Met	Met	Met	-	-	-			
Neurologists	2 within 60 miles	Met	Met	Met	-	-	-			
Nonhospital based Anesthesiologists	1 within 90 miles	Not Met	Not Met	Not Met	11	10	10	Figure 6	Figure 13	Figure 19
OB/GYN	2 within 60 miles	Met	Met	Met	-	-	-			

Table 44. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Occupational Therapists	2 within 60 miles	Met	Met	Met	-	-	-			
Oncologists	2 within 60 miles	Met	Met	Met	-	-	-			
Ophthalmologists	2 within 60 miles	Met	Met	Met	-	-	-			
Optometrists	2 within 60 miles	Met	Met	Met	-	-	-			
Oral Surgeons	2 within 60 miles	Not Met	Not Met	Not Met	14	14	12	Figure 7	Figure 14	Figure 20
Orthodontists*	2 within 60 miles	Not Met	Not Met	Not Met	57	61	57	Figure 8	Figure 15	Figure 21
Orthopedic Surgeons	2 within 60 miles	Met	Met	Met	-	-	-			
Otolaryngologists	2 within 60 miles	Met	Met	Met	-	-	-			
Pathologists	1 within 90 miles	Met	Met	Met	-	-	-			
Pharmacy	2 within 30 miles	Met	Met	Met	-	-	-			
Physical Therapists	2 within 60 miles	Met	Met	Met	-	-	-			
PMPs-Physicians	1 within 30 miles	Met	Met	Met	-	-	-			
Podiatrists†	2 within 60 miles			Met			-			

Table 44. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Prosthetic Suppliers	1 within 90 miles	Not Met	Not Met	Not Met	7	7	6	Figure 9	Figure 16	Figure 22
Psychiatrists	2 within 60 miles	Met	Met	Met	-	-	-			
Pulmonologists	2 within 60 miles	Met	Met	Met	-	-	-			
Radiation Oncologists	1 within 90 miles	Not Met	Not Met	Not Met	24	4	20	Figure 10	Figure 17	Figure 23
Radiologists	1 within 90 miles	Met	Met	Met	-	-	-			
Rheumatologists	1 within 90 miles	Met	Met	Met	-	-	-			
Speech Therapists	2 within 60 miles	Met	Met	Met	-	-	-			
Urologists	2 within 60 miles	Met	Met	Met	-	-	-			
CareSource										
Acute Care Hospitals	Urban - 1 within 30 miles; Rural - 1 within 60 miles	Met	Met		-	-				
Anesthesiologists	2 within 60 miles	Met	Met		-	-				
Behavioral Health Providers	Urban - 1 within 30 miles; Rural - 1 within 45 miles	Met	Met		-	-				

Table 44. Accessibility by Provider Service Type										
Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Cardiologists	2 within 60 miles	Met	Met		-	-				
Cardiothoracic Surgeons	1 within 90 miles	Met	Met		-	-				
Cardiovascular Surgeons	1 within 90 miles	Met	Met		-	-				
Dentists	1 within 30 miles	Not Met	Not Met		6	7		Figure 26	Figure 32	
Dermatologists	1 within 90 miles	Met	Met		-	-				
Diagnostic Testing	2 within 60 miles	Not Met	Not Met		18	18		Figure 27	Figure 33	
Durable Medical Equipment (DME)	2 per county	Met	Met		-	-				
Endocrinologists	2 within 60 miles	Met	Met		-	-				
End-Stage Renal Disease (ESRD) Clinic	1 within 60 miles	Met	Met		-	-				
Gastroenterologists	2 within 60 miles	Met	Met		-	-				
General Surgeons	2 within 60 miles	Met	Met		-	-				
Hematologists	2 within 60 miles	Met	Met		-	-				
Home Health Providers	2 per county	Not Met	Not Met		72	71		Figure 28	Figure 34	

Table 44. Accessibility by Provider Service Type										
Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Infectious Disease Specialists	1 within 90 miles	Met	Met		-	-				
Inpatient Psychiatric Facilities	1 within 60 miles	Not Met	Not Met		10	10		Figure 29	Figure 35	
Interventional Radiologists	1 within 90 miles	Not Met	Not Met		2	3		Figure 30	Figure 36	
Nephrologists	2 within 60 miles	Met	Met		-	-				
Neurological Surgeons	1 within 90 miles	Met	Met		-	-				
Neurologists	2 within 60 miles	Met	Met		-	-				
Nonhospital based Anesthesiologists	1 within 90 miles	Met	Met		-	-				
OB/GYN	2 within 60 miles	Met	Met		-	-				
Occupational Therapists	2 within 60 miles	Met	Met		-	-				
Oncologists	2 within 60 miles	Met	Met		-	-				
Ophthalmologists	2 within 60 miles	Met	Met		-	-				
Optometrists	2 within 60 miles	Met	Met		-	-				
Oral Surgeons	2 within 60 miles	Met	Not Met		-	5			Figure 37	

Table 44. Accessibility by Provider Service Type										
Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Orthodontists*	2 within 60 miles	Not Met	Not Met		54	54		Figure 31	Figure 38	
Orthopedic Surgeons	2 within 60 miles	Met	Met		-	-				
Otolaryngologists	2 within 60 miles	Met	Met		-	-				
Pathologists	1 within 90 miles	Met	Met		-	-				
Pharmacy	2 within 30 miles	Met	Met		-	-				
Physical Therapists	2 within 60 miles	Met	Met		-	-				
PMPs-Physicians	1 within 30 miles	Met	Met		-	-				
Podiatrists†	2 within 60 miles									
Prosthetic Suppliers	1 within 90 miles	Met	Met		-	-				
Psychiatrists	2 within 60 miles	Met	Met		-	-				
Pulmonologists	2 within 60 miles	Met	Met		-	-				
Radiation Oncologists	1 within 90 miles	Met	Met		-	-				
Radiologists	1 within 90 miles	Met	Met		-	-				
Rheumatologists	1 within 90	Met	Met		-	-				

Table 44. Accessibility by Provider Service Type										
Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
	miles									
Speech Therapists	2 within 60 miles	Met	Met		-	-				
Urologists	2 within 60 miles	Met	Met		-	-				
MDwise										
Acute Care Hospitals	Urban - 1 within 30 miles; Rural - 1 within 60 miles	Met	Met		-	-				
Anesthesiologists	2 within 60 miles	Met	Met		-	-				
Behavioral Health Providers	Urban - 1 within 30 miles; Rural - 1 within 45 miles	Met	Met		-	-				
Cardiologists	2 within 60 miles	Met	Met		-	-				
Cardiothoracic Surgeons	1 within 90 miles	Met	Met		-	-				
Cardiovascular Surgeons	1 within 90 miles	Met	Met		-	-				
Dentists	1 within 30 miles	Not Met	Not Met		4	4		Figure 41	Figure 46	
Dermatologists	1 within 90 miles	Met	Met		-	-				
Diagnostic Testing	2 within 60 miles	Not Met	Not Met		50	51		Figure 42	Figure 47	

Table 44. Accessibility by Provider Service Type										
Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Durable Medical Equipment (DME)	2 per county	Met	Met		-	-				
Endocrinologists	2 within 60 miles	Met	Met		-	-				
End-Stage Renal Disease (ESRD) Clinic	1 within 60 miles	Met	Met		-	-				
Gastroenterologists	2 within 60 miles	Met	Met		-	-				
General Surgeons	2 within 60 miles	Met	Met		-	-				
Hematologists	2 within 60 miles	Met	Met		-	-				
Home Health Providers	2 per county	Not Met	Not Met		78	76		Figure 43	Figure 48	
Infectious Disease Specialists	1 within 90 miles	Met	Met		-	-				
Inpatient Psychiatric Facilities	1 within 60 miles	Not Met	Not Met		10	10		Figure 44	Figure 49	
Interventional Radiologists	1 within 90 miles	Met	Met		-	-				
Nephrologists	2 within 60 miles	Met	Met		-	-				
Neurological Surgeons	1 within 90 miles	Met	Met		-	-				
Neurologists	2 within 60 miles	Met	Met		-	-				

Table 44. Accessibility by Provider Service Type										
Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Nonhospital based Anesthesiologists	1 within 90 miles	Met	Met		-	-				
OB/GYN	2 within 60 miles	Met	Met		-	-				
Occupational Therapists	2 within 60 miles	Met	Met		-	-				
Oncologists	2 within 60 miles	Met	Met		-	-				
Ophthalmologists	2 within 60 miles	Met	Met		-	-				
Optometrists	2 within 60 miles	Met	Met		-	-				
Oral Surgeons	2 within 60 miles	Met	Met		-	-				
Orthodontists*	2 within 60 miles	Not Met	Not Met		35	36		Figure 45	Figure 50	
Orthopedic Surgeons	2 within 60 miles	Met	Met		-	-				
Otolaryngologists	2 within 60 miles	Met	Met		-	-				
Pathologists	1 within 90 miles	Met	Met		-	-				
Pharmacy	2 within 30 miles	Met	Met		-	-				
Physical Therapists	2 within 60 miles	Met	Met		-	-				

Table 44. Accessibility by Provider Service Type										
Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
PMPs-Physicians	1 within 30 miles	Met	Met		-	-				
Podiatrists†	2 within 60 miles									
Prosthetic Suppliers	1 within 90 miles	Met	Met		-	-				
Psychiatrists	2 within 60 miles	Met	Met		-	-				
Pulmonologists	2 within 60 miles	Met	Met		-	-				
Radiation Oncologists	1 within 90 miles	Met	Met		-	-				
Radiologists	1 within 90 miles	Met	Met		-	-				
Rheumatologists	1 within 90 miles	Met	Met		-	-				
Speech Therapists	2 within 60 miles	Met	Met		-	-				
Urologists	2 within 60 miles	Met	Met		-	-				
MHS										
Acute Care Hospitals	Urban - 1 within 30 miles; Rural - 1 within 60 miles	Met	Met	Met	-	-	-			
Anesthesiologists	2 within 60 miles	Met	Met	Met	-	-	-			

Table 44. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Behavioral Health Providers	Urban - 1 within 30 miles; Rural - 1 within 45 miles	Met	Met	Met	-	-	-			
Cardiologists	2 within 60 miles	Met	Met	Met	-	-	-			
Cardiothoracic Surgeons	1 within 90 miles	Not Met	Not Met	Not Met	13	6	4	Figure 54	Figure 76	Figure 89
Cardiovascular Surgeons	1 within 90 miles	Not Met	Not Met	Not Met	18	2	4	Figure 55	Figure 77	Figure 90
Dentists	1 within 30 miles	Not Met	Not Met	Not Met	6	4	4	Figure 56	Figure 78	Figure 91
Dermatologists	1 within 90 miles	Not Met	Met	Not Met	2	-	14	Figure 57		Figure 92
Diagnostic Testing	2 within 60 miles	Not Met	Not Met	Not Met	69	68	68	Figure 58	Figure 79	Figure 93
Durable Medical Equipment (DME)	2 per county	Not Met	Not Met	Not Met	63	63	63	Figure 59	Figure 80	Figure 94
Endocrinologists	2 within 60 miles	Not Met	Not Met	Not Met	18	5	21	Figure 60	Figure 81	Figure 95
End-Stage Renal Disease (ESRD) Clinic	1 within 60 miles	Met	Met	Met	-	-	-			
Gastroenterologists	2 within 60 miles	Not Met	Met	Not Met	9	-	5	Figure 61		Figure 96
General Surgeons	2 within 60 miles	Met	Met	Met	-	-	-			

Table 44. Accessibility by Provider Service Type										
Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Hematologists	2 within 60 miles	Not Met	Not Met	Not Met	21	1	18	Figure 62	Figure 82	Figure 97
Home Health Providers	2 per county	Met	Met	Met	-	-	-			
Infectious Disease Specialists	1 within 90 miles	Met	Met	Met	-	-	-			
Inpatient Psychiatric Facilities	1 within 60 miles	Not Met	Not Met	Not Met	7	9	1	Figure 63	Figure 83	Figure 98
Interventional Radiologists	1 within 90 miles	Met	Met	Met	-	-	-			
Nephrologists	2 within 60 miles	Not Met	Met	Not Met	22	-	29	Figure 64		Figure 99
Neurological Surgeons	1 within 90 miles	Met	Met	Met	-	-	-			
Neurologists	2 within 60 miles	Met	Met	Met	-	-	-			
Nonhospital based Anesthesiologists	1 within 90 miles	Met	Met	Met	-	-	-			
OB/GYN	2 within 60 miles	Met	Met	Met	-	-	-			
Occupational Therapists	2 within 60 miles	Met	Met	Met	-	-	-			
Oncologists	2 within 60 miles	Not Met	Not Met	Not Met	18	1	16	Figure 65	Figure 84	Figure 100
Ophthalmologists	2 within 60 miles	Not Met	Met	Not Met	1	-	1	Figure 66		Figure 101

Table 44. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Optometrists	2 within 60 miles	Met	Met	Met	-	-	-			
Oral Surgeons	2 within 60 miles	Not Met	Not Met	Met	1	1	-	Figure 67	Figure 85	
Orthodontists*	2 within 60 miles	Not Met	Not Met	Not Met	36	39	34	Figure 68	Figure 86	Figure 102
Orthopedic Surgeons	2 within 60 miles	Met	Met	Met	-	-	-			
Otolaryngologists	2 within 60 miles	Not Met	Met	Not Met	5	-	1	Figure 69		Figure 103
Pathologists	1 within 90 miles	Met	Met	Met	-	-	-			
Pharmacy	2 within 30 miles	Met	Met	Met	-	-	-			
Physical Therapists	2 within 60 miles	Met	Met	Met	-	-	-			
PMPs-Physicians	1 within 30 miles	Not Met	Met	Not Met	1	-	1	Figure 70		Figure 104
Podiatrists†	2 within 60 miles			Not Met			3			Figure 105
Prosthetic Suppliers	1 within 90 miles	Met	Met	Met	-	-	-			
Psychiatrists	2 within 60 miles	Met	Met	Met	-	-	-			
Pulmonologists	2 within 60 miles	Not Met	Not Met	Not Met	7	1	5	Figure 71	Figure 87	Figure 106

Table 44. Accessibility by Provider Service Type										
Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Radiation Oncologists	1 within 90 miles	Not Met	Met	Met	6	-	-	Figure 72		
Radiologists	1 within 90 miles	Met	Met	Met	-	-	-			
Rheumatologists	1 within 90 miles	Not Met	Met	Not Met	10	-	5	Figure 73		Figure 107
Speech Therapists	2 within 60 miles	Not Met	Not Met	Not Met	3	3	3	Figure 74	Figure 88	Figure 108
Urologists	2 within 60 miles	Not Met	Met	Met	1	-	-	Figure 75		
UHC										
Acute Care Hospitals	Urban - 1 within 30 miles; Rural - 1 within 60 miles			Met			-			
Anesthesiologists	2 within 60 miles			Met			-			
Behavioral Health Providers	Urban - 1 within 30 miles; Rural - 1 within 45 miles			Met			-			
Cardiologists	2 within 60 miles			Met			-			
Cardiothoracic Surgeons	1 within 90 miles			Met			-			
Cardiovascular Surgeons	1 within 90 miles			Met			-			

Table 44. Accessibility by Provider Service Type										
Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Dentists	1 within 30 miles			Not Met			1			Figure 110
Dermatologists	1 within 90 miles			Met			-			
Diagnostic Testing	2 within 60 miles			Not Met			52			Figure 111
Durable Medical Equipment (DME)	2 per county			Met			-			
Endocrinologists	2 within 60 miles			Met			-			
End-Stage Renal Disease (ESRD) Clinic	1 within 60 miles			Met			-			
Gastroenterologists	2 within 60 miles			Met			-			
General Surgeons	2 within 60 miles			Met			-			
Hematologists	2 within 60 miles			Met			-			
Home Health Providers	2 per county			Met			-			
Infectious Disease Specialists	1 within 90 miles			Met			-			
Inpatient Psychiatric Facilities	1 within 60 miles			Met			-			
Interventional Radiologists	1 within 90 miles			Not Met			2			Figure 112

Table 44. Accessibility by Provider Service Type										
Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Nephrologists	2 within 60 miles			Met			-			
Neurological Surgeons	1 within 90 miles			Met			-			
Neurologists	2 within 60 miles			Met			-			
Nonhospital based Anesthesiologists	1 within 90 miles			Met			-			
OB/GYN	2 within 60 miles			Met			-			
Occupational Therapists	2 within 60 miles			Met			-			
Oncologists	2 within 60 miles			Met			-			
Ophthalmologists	2 within 60 miles			Met			-			
Optometrists	2 within 60 miles			Met			-			
Oral Surgeons	2 within 60 miles			Met			-			
Orthodontists*	2 within 60 miles			Not Met			60			Figure 113
Orthopedic Surgeons	2 within 60 miles			Met			-			
Otolaryngologists	2 within 60 miles			Met			-			

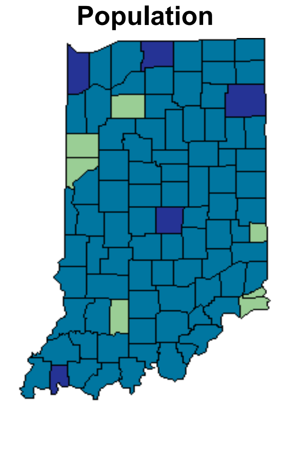
Table 44. Accessibility by Provider Service Type										
Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		HHW	HIP	HCC	HHW	HIP	HCC	HHW	HIP	HCC
Pathologists	1 within 90 miles			Met			-			
Pharmacy	2 within 30 miles			Met			-			
Physical Therapists	2 within 60 miles			Met			-			
PMPs-Physicians	1 within 30 miles			Met			-			
Podiatrists†	2 within 60 miles			Met			-			
Prosthetic Suppliers	1 within 90 miles			Met			-			
Psychiatrists	2 within 60 miles			Met			-			
Pulmonologists	2 within 60 miles			Met			-			
Radiation Oncologists	1 within 90 miles			Met			-			
Radiologists	1 within 90 miles			Met			-			
Rheumatologists	1 within 90 miles			Not Met			2			Figure 114
Speech Therapists	2 within 60 miles			Met			-			
Urologists	2 within 60 miles			Met			-			

*Orthodontic procedures for IHCP programs are covered only for members younger than 21 years old.
†Podiatrist is only covered by HCC.

Anthem Member Population

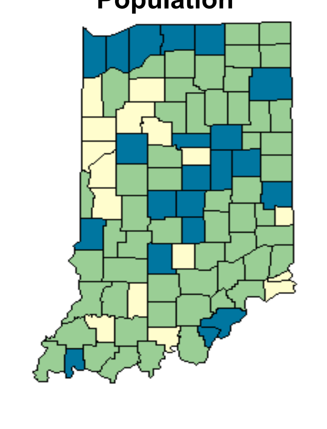
Figure 2. HHW – Member Population

Figure 3. HIP – Member Population



101-500 501-10,000 >10,000

Figure 4. HCC – Member Population



1-100 101-500 501-10,000

Anthem HHW Accessibility by Provider Type

Figure 5. HHW Diagnostic Testing

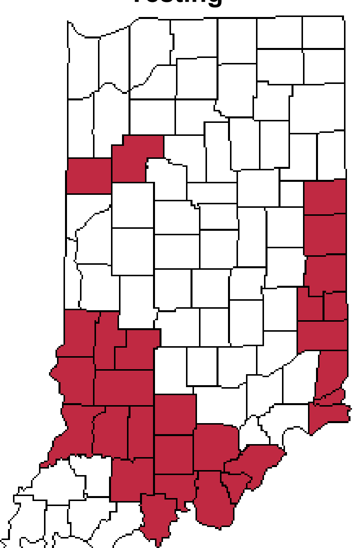


Figure 6. HHW Nonhospital Based Anesthesiologists

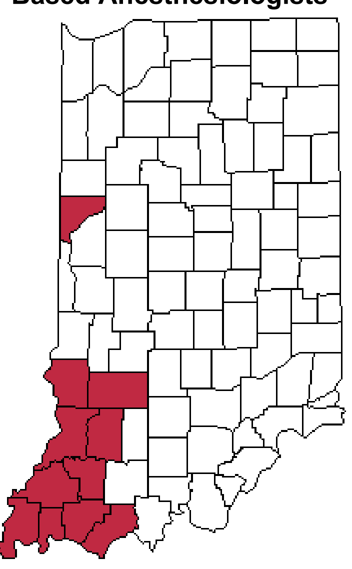


Figure 7. HHW Oral Surgeons

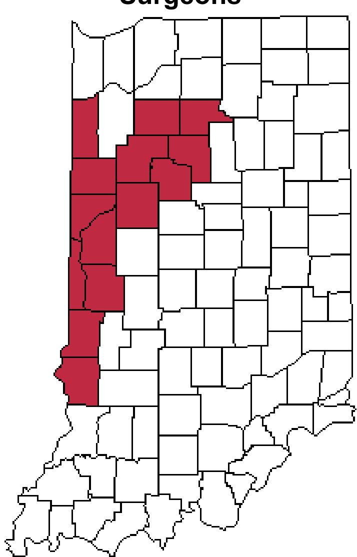


Figure 8. HHW Orthodontists

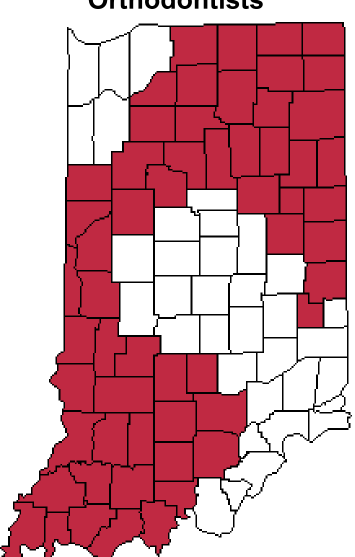


Figure 9. HHW Prosthetic Suppliers

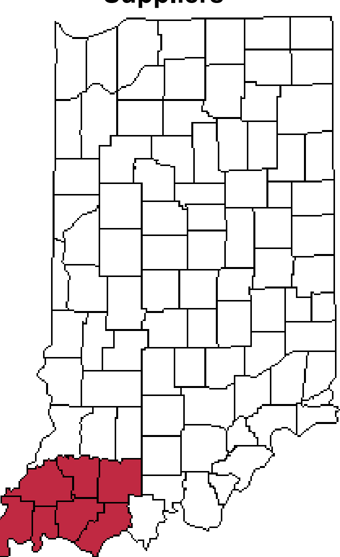
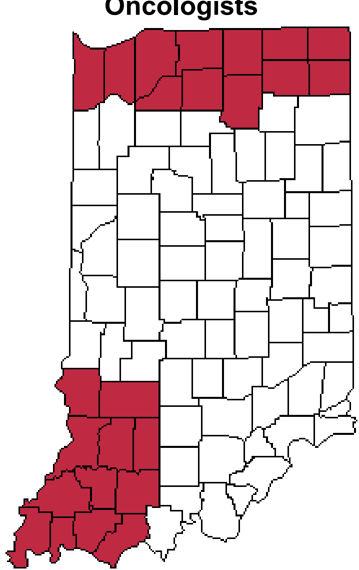


Figure 10. HHW Radiation Oncologists



Anthem HIP Accessibility by Provider Type

Figure 11. HIP Dentists

Figure 12. HIP Diagnostic Testing

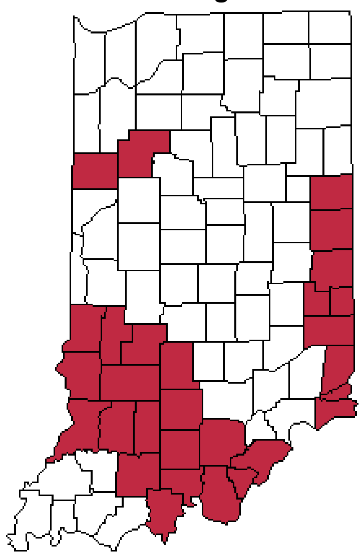


Figure 13. HIP Nonhospital Based Anesthesiologists

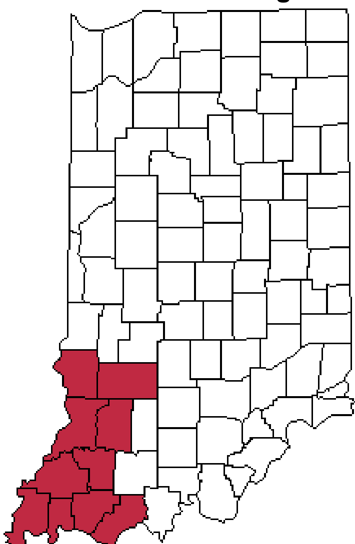


Figure 14. HIP Oral Surgeons

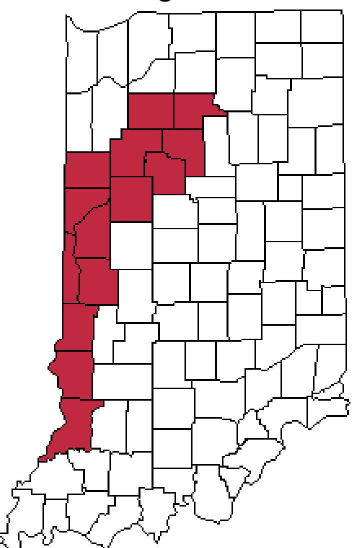


Figure 15. HIP Orthodontists

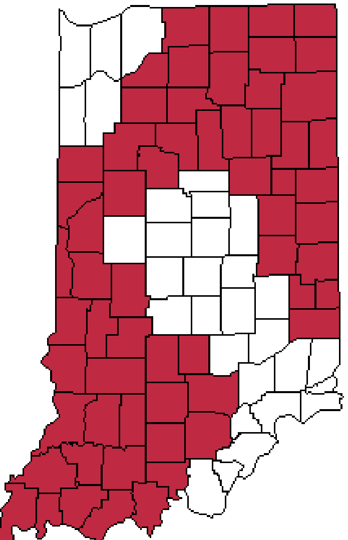


Figure 16. HIP Prosthetic Suppliers

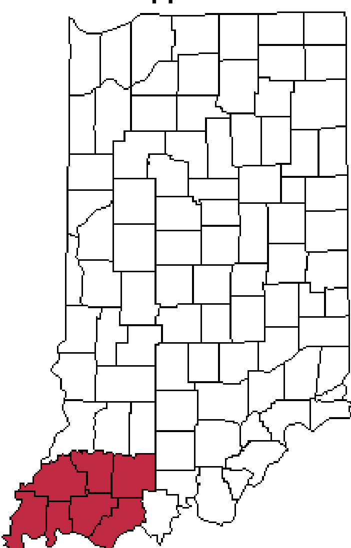


Figure 17. HIP Radiation Oncologists

Anthem HCC Accessibility by Provider Type

Figure 18. HCC Diagnostic Testing

Figure 19. HCC Nonhospital Based Anesthesiologist

Figure 20. HCC Oral Surgeons

Figure 21. HCC Orthodontists

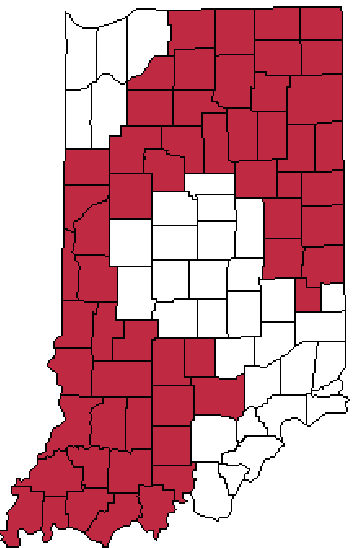


Figure 22. HCC Prosthetic Suppliers

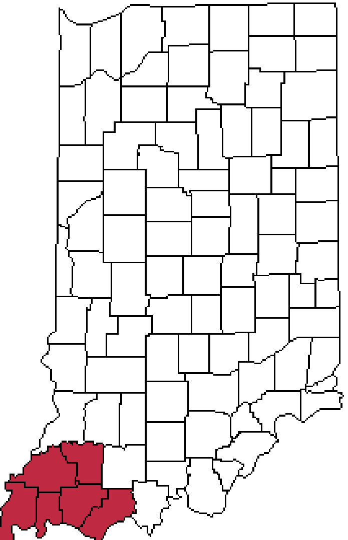
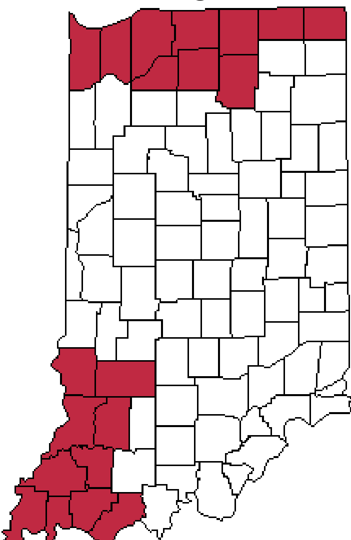


Figure 23. HCC Radiation Oncologists



CareSource Member Populations

Figure 24. HHW Member Population

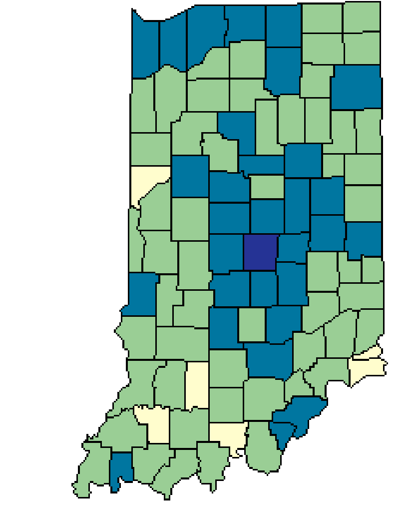
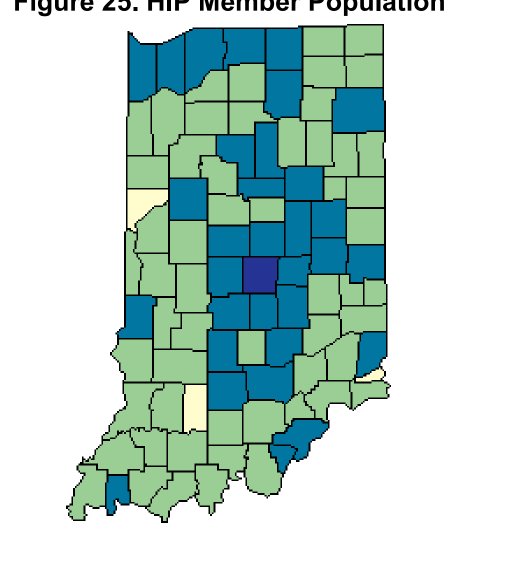


Figure 25. HIP Member Population



1-100 | 101-500 | 501-10,000 | >10,000

1-100 | 101-500 | 501-10,000 | >10,000

CareSource HHW Accessibility by Provider Service Type

Figure 26. HHW Dentists

Figure 27. HHW Diagnostic Testing

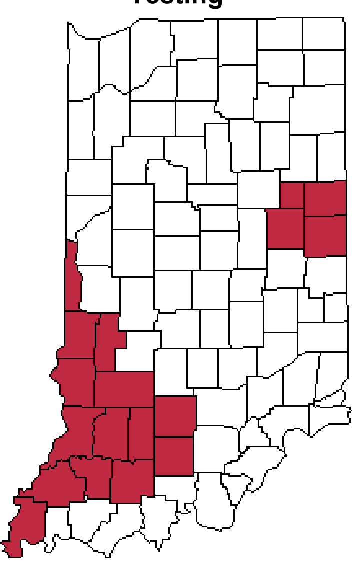


Figure 28. HHW Home Health Providers

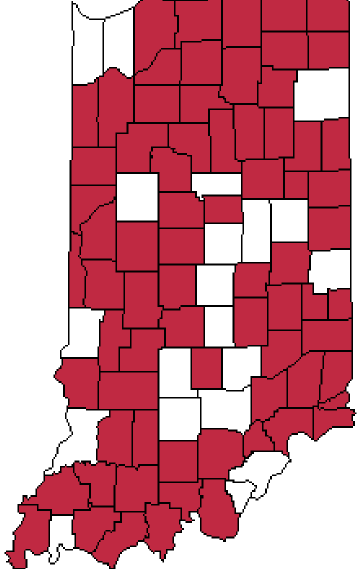


Figure 29. HHW Inpatient Psychiatric Facilities

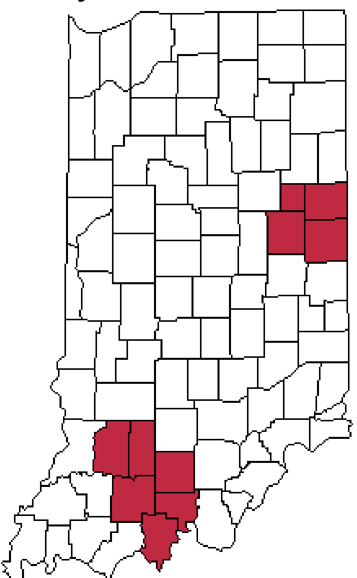


Figure 30. HHW Interventional Radiologist

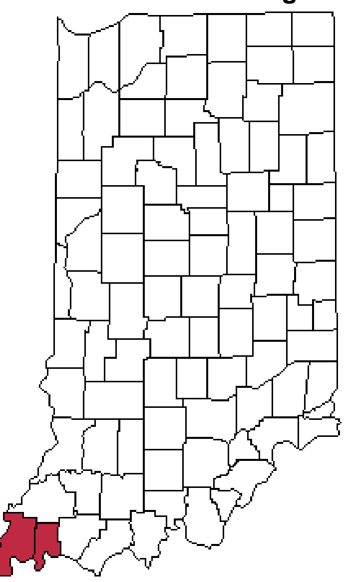
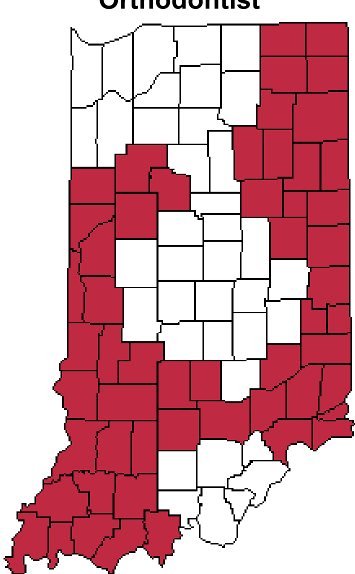


Figure 31. HHW Orthodontist



CareSource HIP Accessibility by Provider Type

Figure 32. HIP Dentists

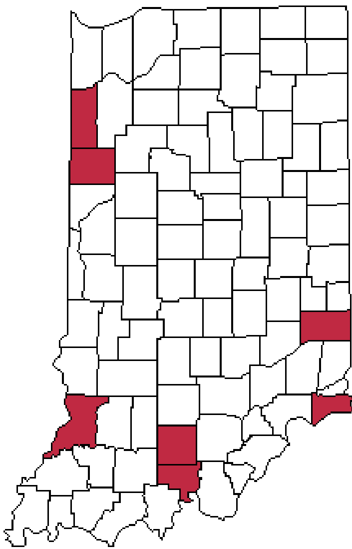


Figure 33. HIP Diagnostic Testing

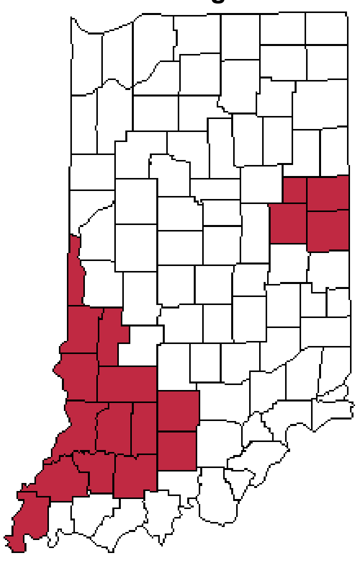


Figure 34. HIP Home Health Providers

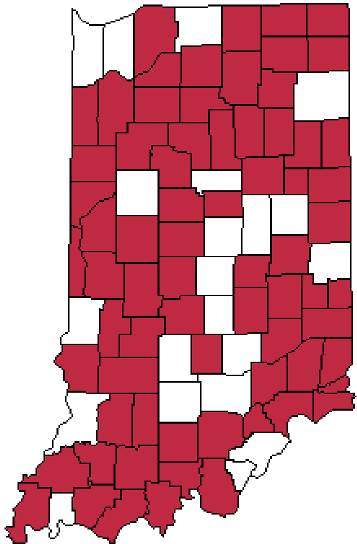


Figure 35. HIP Inpatient Psychiatric Facilities

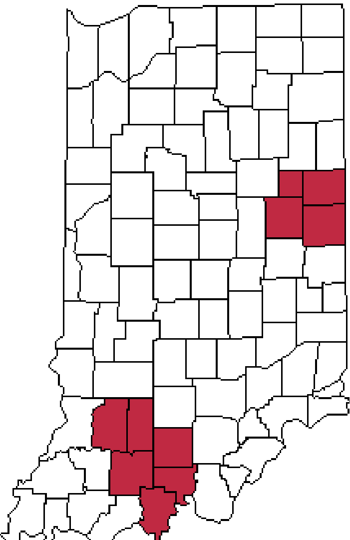


Figure 36. HIP Interventional Radiologists

Figure 37. HIP Oral Surgeons

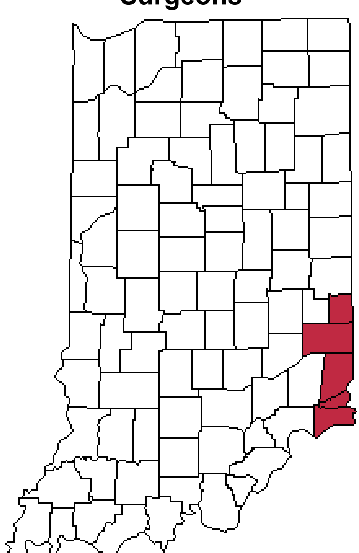
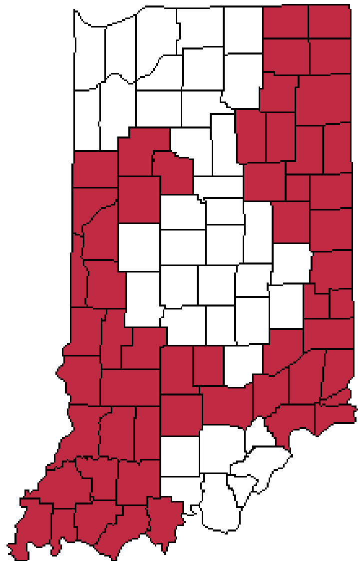
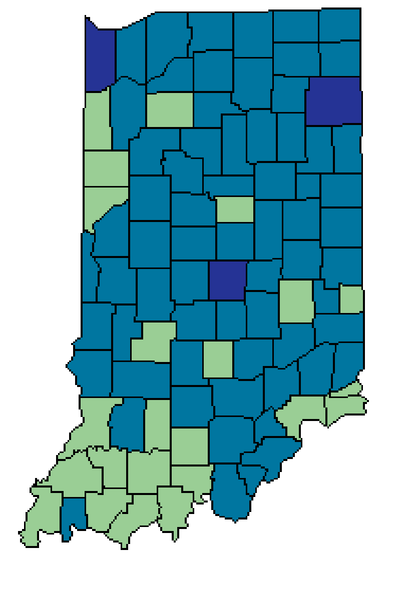


Figure 38. HIP Orthodontists



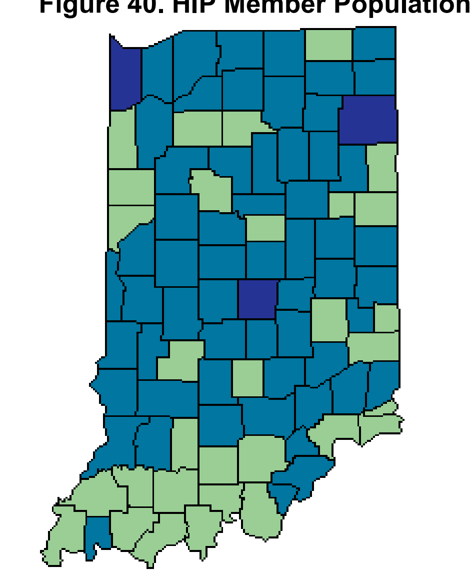
MDwise Member Population

Figure 39. HHW Member Population



101-500 501-10,000 >10,000

Figure 40. HIP Member Population



101-500 501-10,000 >10,000

MDwise HHW Accessibility by Provider Service Type

Figure 41. HHW Dentists

Figure 42. HHW Diagnostic Testing

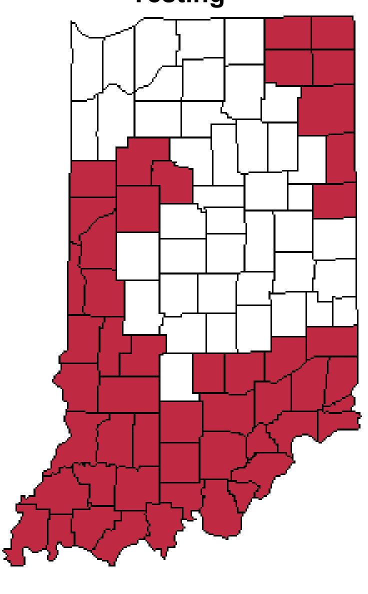


Figure 43. HHW Home Health Providers

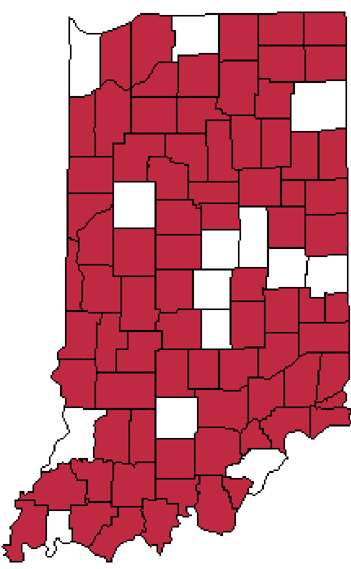
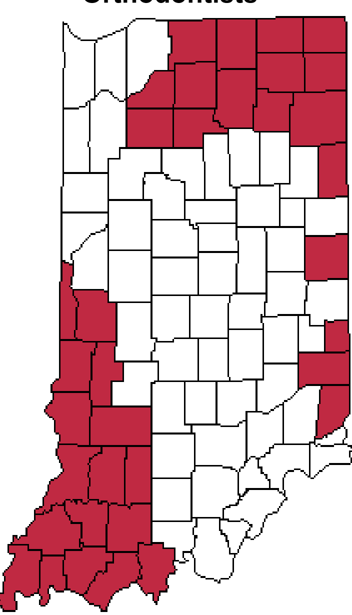


Figure 44. HHW Inpatient Psychiatric Facilities

Figure 45. HHW Orthodontists



MDwise HIP Accessibility by Provider Service Type

Figure 46. HIP Dentists

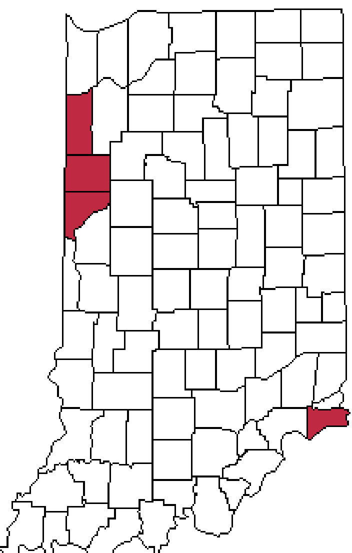


Figure 47. HIP Diagnostic Testing

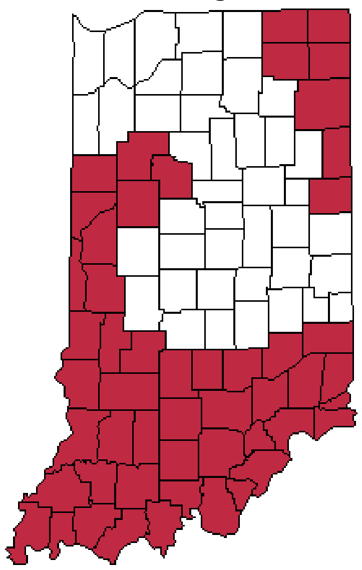


Figure 48. HIP Home Health Providers

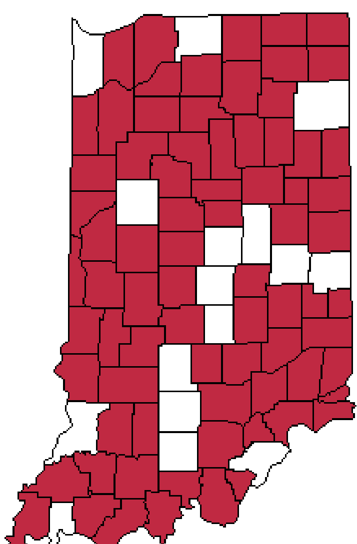


Figure 49. HIP Inpatient Psychiatric Facilities

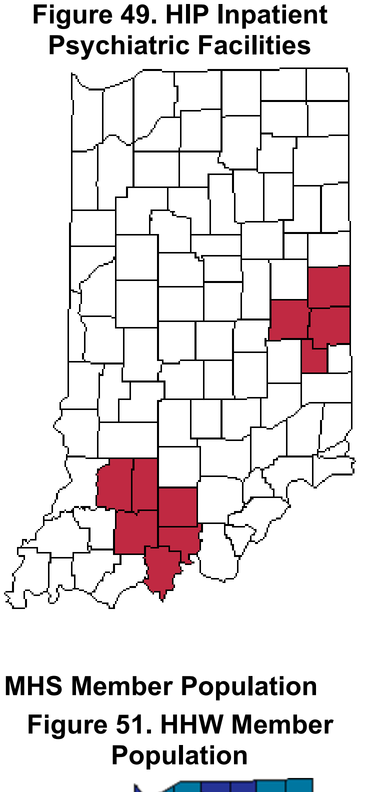


Figure 50. HIP Orthodontists

MHS Member Population

Figure 51. HHW Member Population

1-100 101-500 501-10,000 >10,000

Figure 52. HIP Member Population

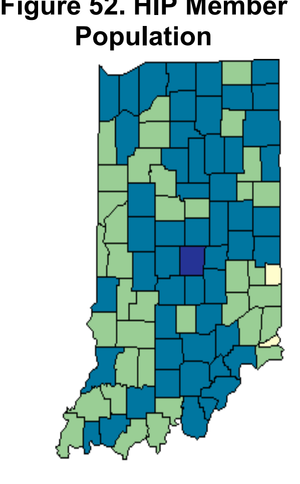
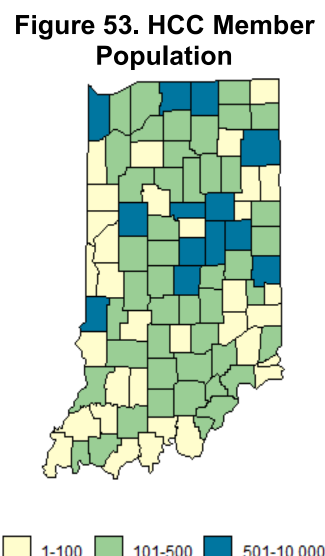


Figure 53. HCC Member Population



MHS HHW Accessibility by Provider Service Type

Figure 54. HHW Cardiothoracic Surgeons

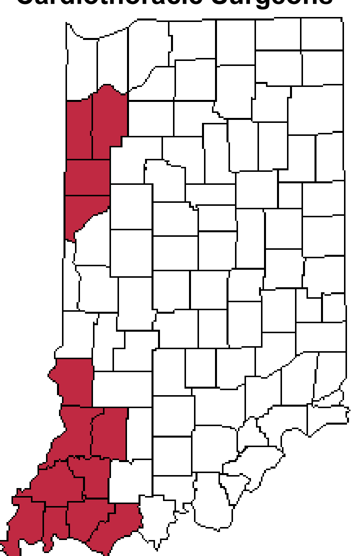


Figure 55. HHW Cardiovascular Surgeons

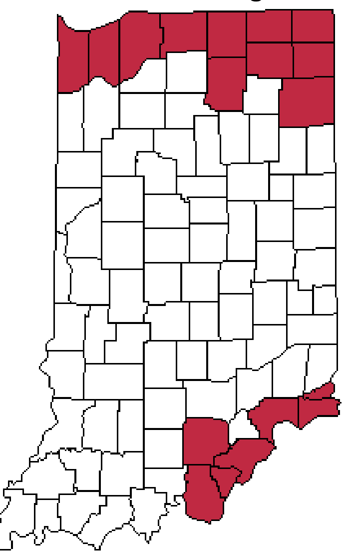


Figure 56. HHW Dentists

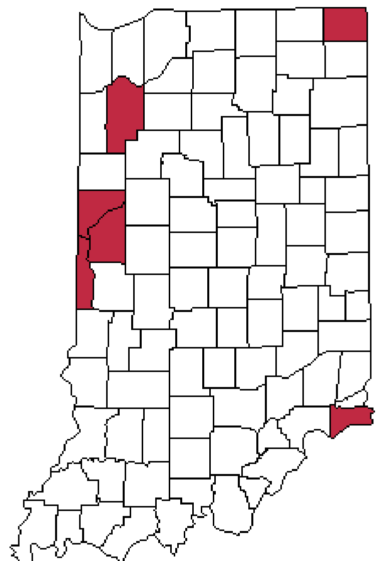


Figure 57. HHW Dermatologists

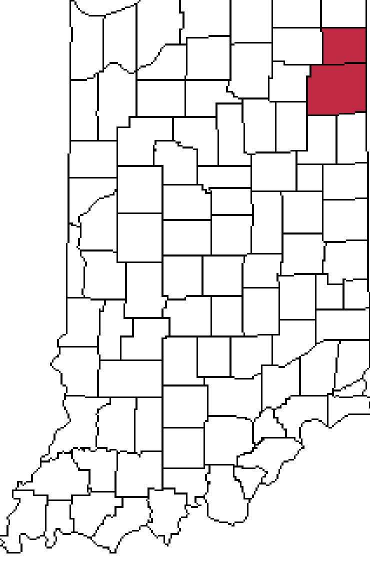


Figure 58. HHW Diagnostic Testing

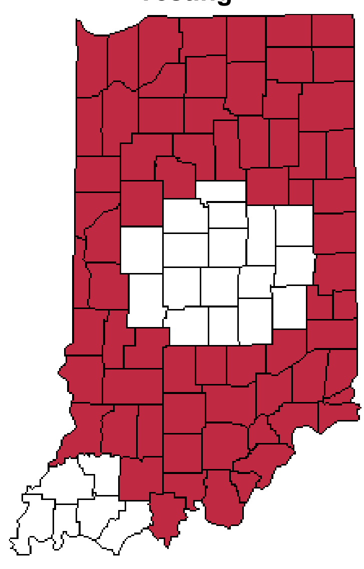


Figure 59. HHW DME

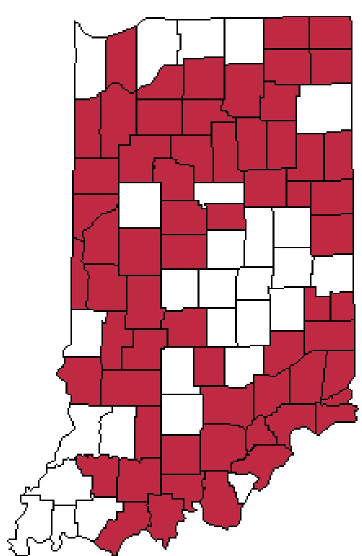


Figure 60. HHW Endocrinologists

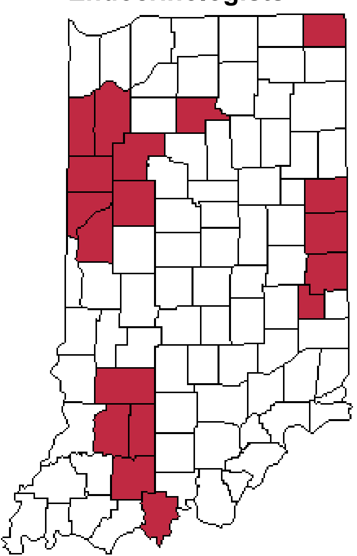


Figure 61. HHW Gastroenterologists

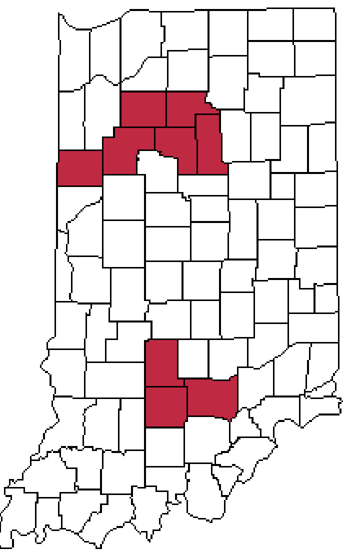


Figure 62. HHW Hematologists

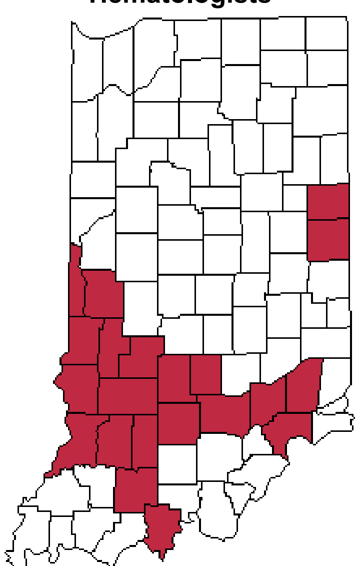


Figure 63. HHW Inpatient Psychiatric Facilities

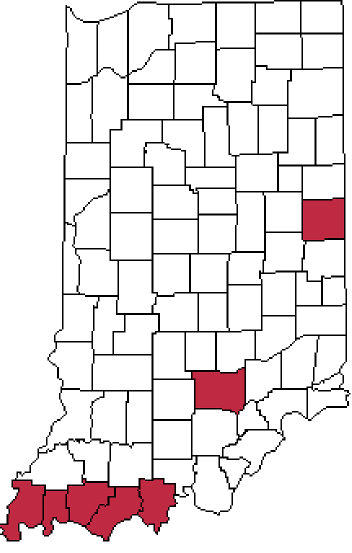


Figure 64. HHW Nephrologists

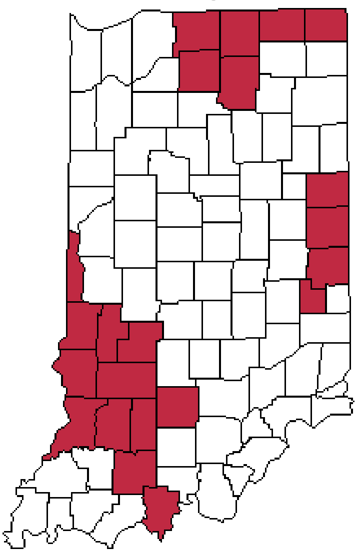


Figure 65. HHW Oncologists

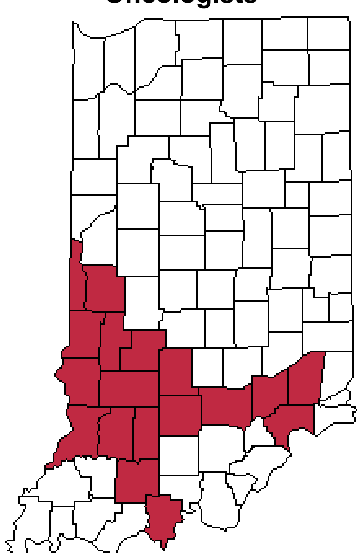


Figure 66. HHW Ophthalmologists

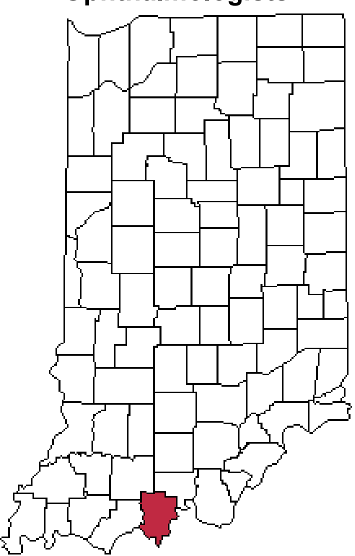


Figure 67. HHW Oral Surgeons

Figure 68. HHW Orthodontists

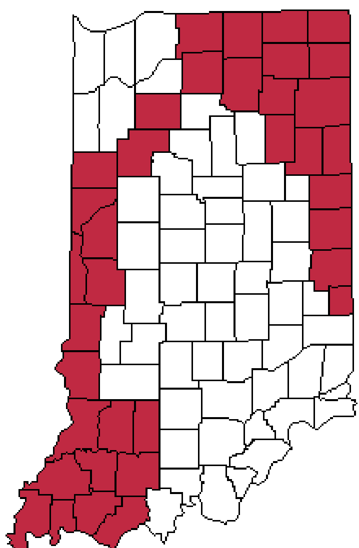


Figure 69. HHW Otolaryngologists

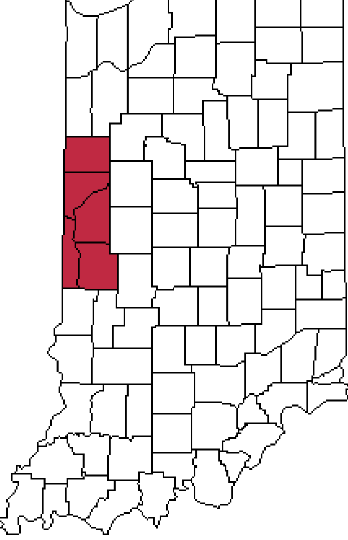


Figure 70. HHW PMP – Physicians

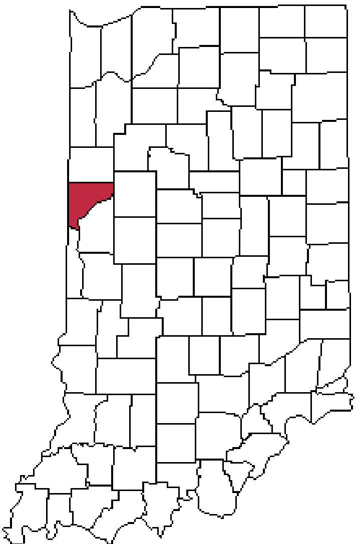


Figure 71. HHW Pulmonologists

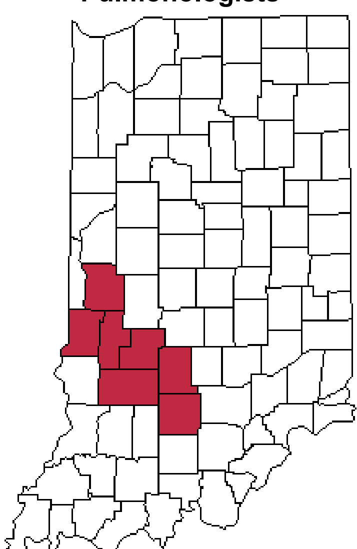


Figure 72. HHW Radiation Oncologists

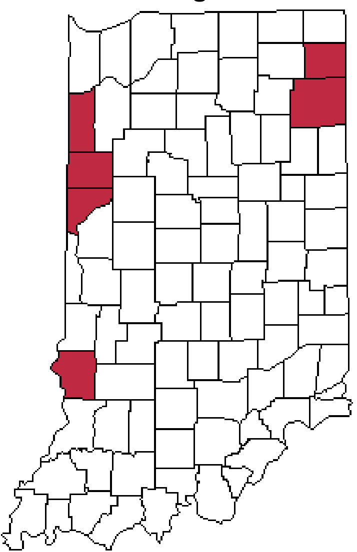


Figure 73. HHW Rheumatologists

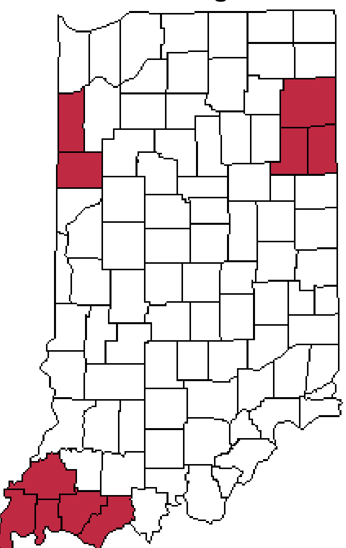


Figure 74. HHW Speech Therapists

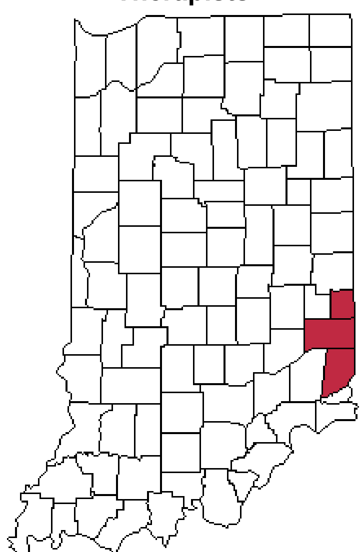


Figure 75. HHW Urologists

MHS HIP Accessibility by Provider Service Type

Figure 76. HIP Cardiothoracic Surgeons

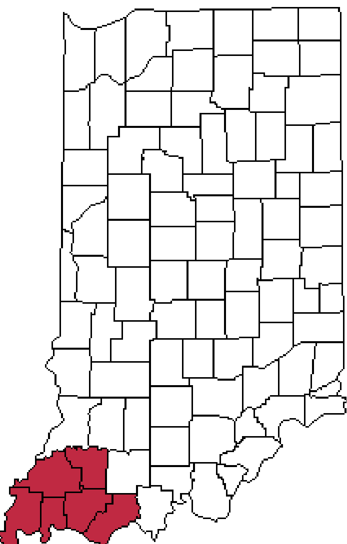


Figure 77. HIP Cardiovascular Surgeons

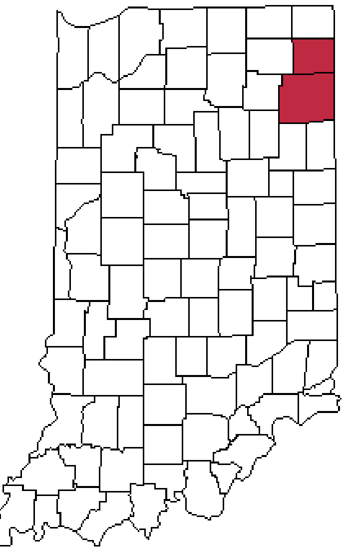


Figure 78. HIP Dentists

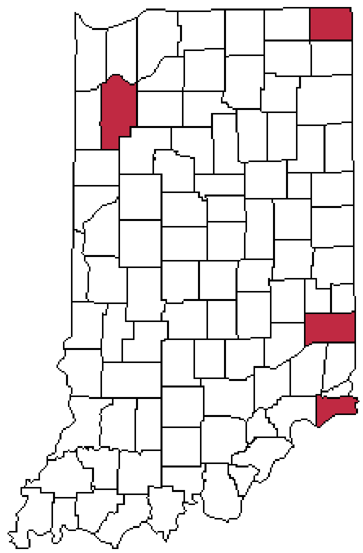


Figure 79. HIP Diagnostic Testing

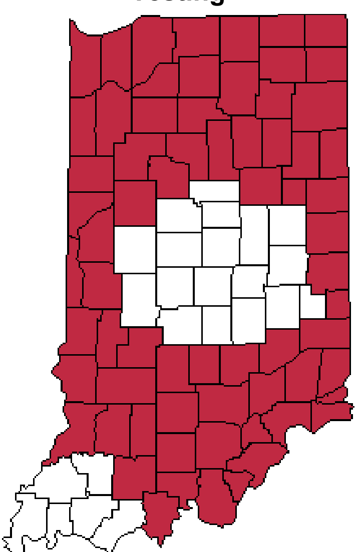


Figure 80. HIP DME

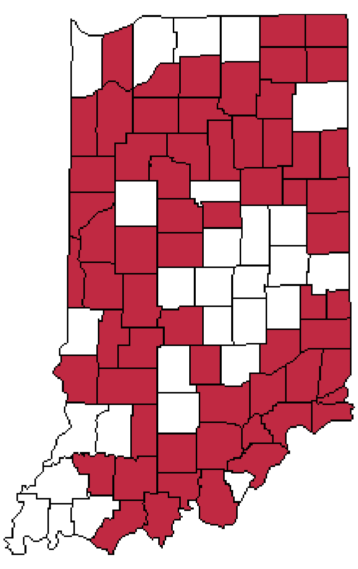


Figure 81. HIP Endocrinologists

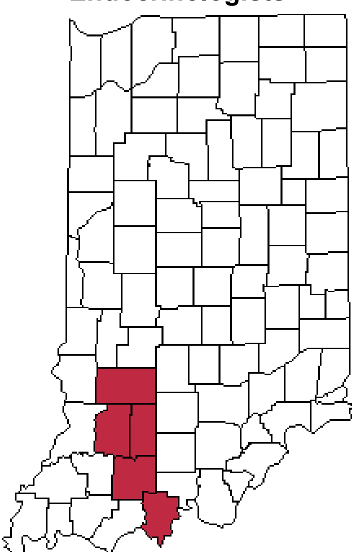


Figure 82. HIP Hematologists

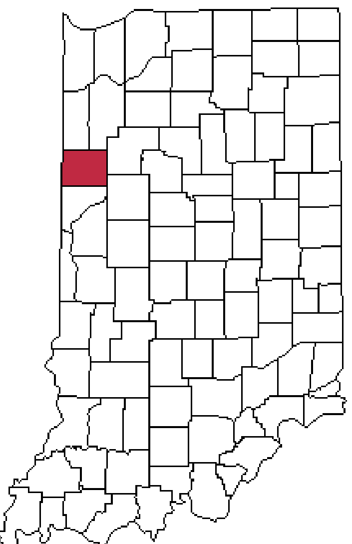


Figure 83. HIP Inpatient Psychiatric Facilities

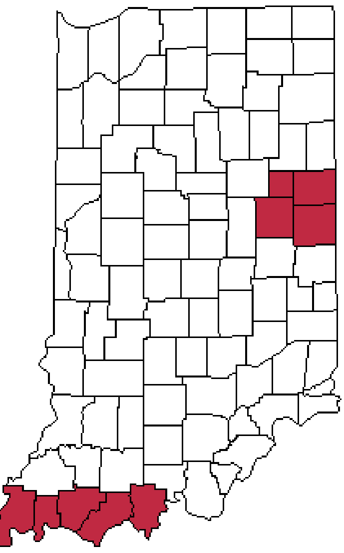


Figure 84. HIP Oncologists

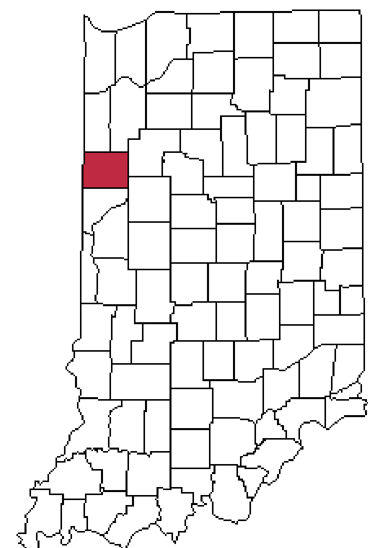


Figure 85. HIP Oral Surgeons

Figure 86. HIP Orthodontists

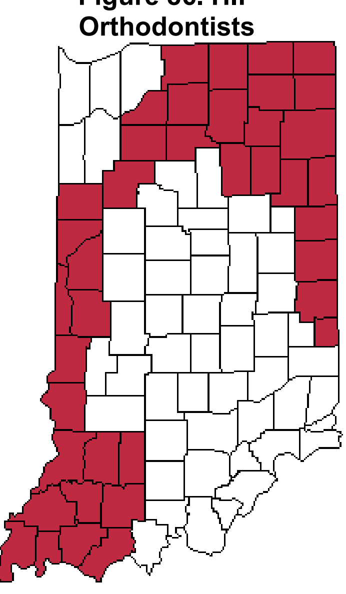


Figure 87. HIP Pulmonologists

Figure 88. HIP Speech Therapists

MHS HCC Accessibility by Provider Service Type

Figure 89. HCC Cardiothoracic Surgeons

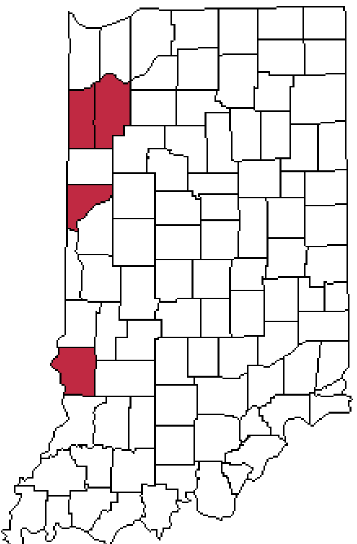


Figure 90. HCC Cardiovascular Surgeons

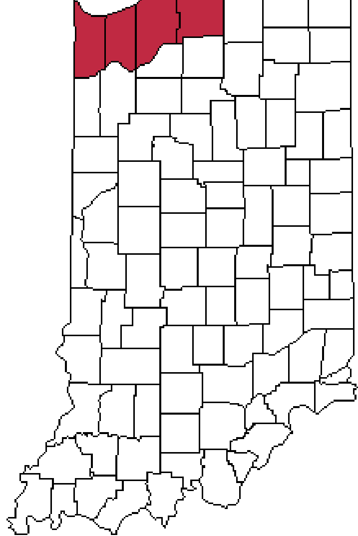


Figure 91. HCC Dentists

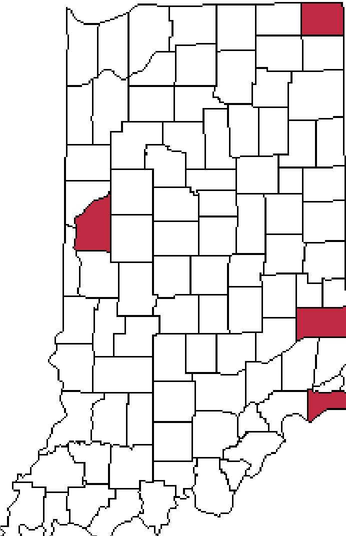


Figure 92. HCC Dermatologists

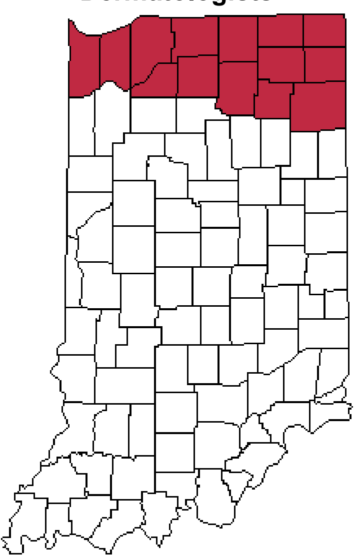


Figure 93. HCC Diagnostic Testing

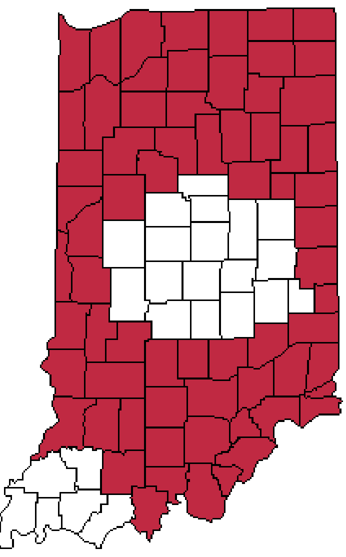


Figure 94. HCC DME

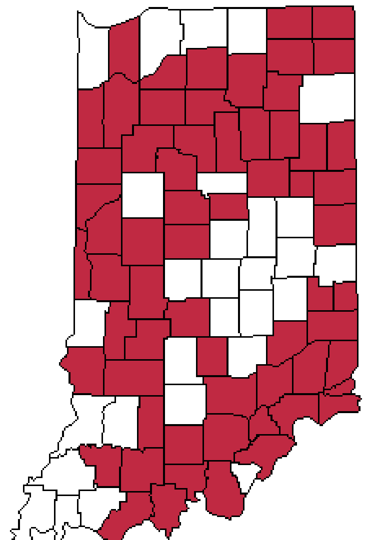


Figure 95. HCC Endocrinologists

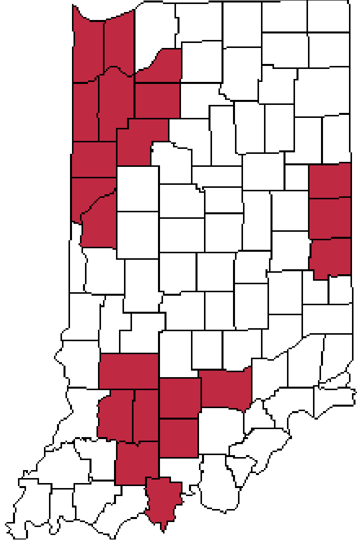


Figure 96. HCC Gastroenterologists

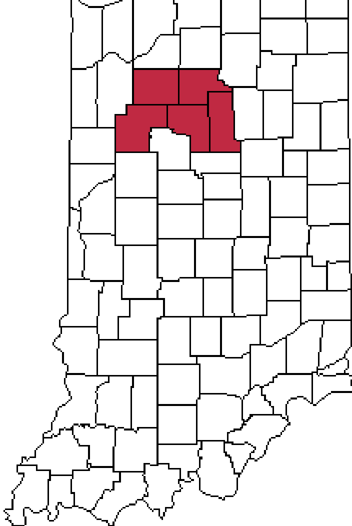


Figure 97. HCC Hematologists

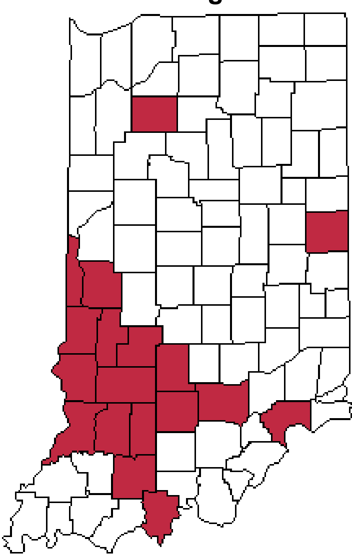


Figure 98. HCC Inpatient Psychiatric Facilities

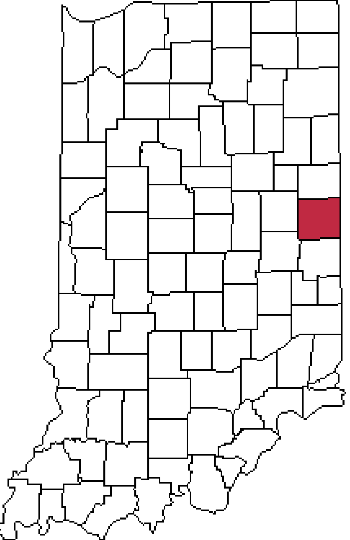


Figure 99. HCC Nephrologists

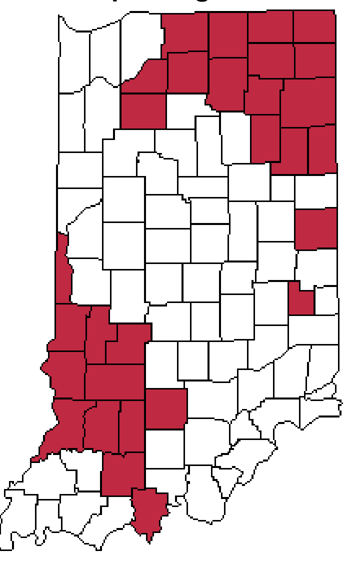


Figure 100. HCC Oncologists

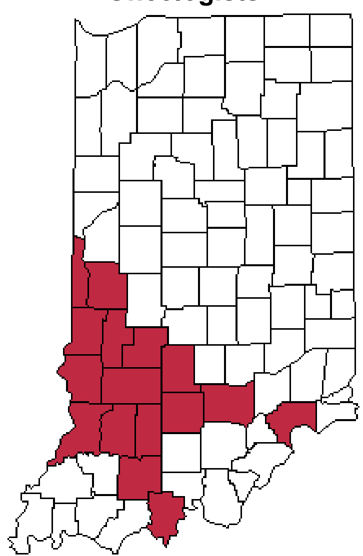


Figure 101. HCC Ophthalmologists

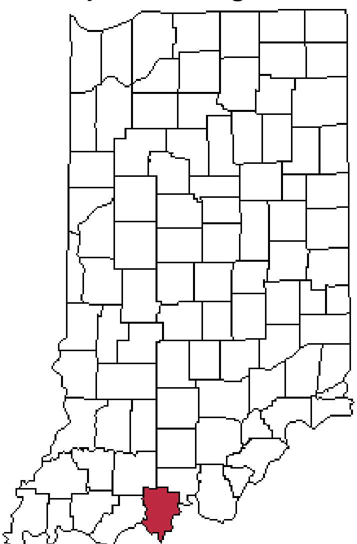


Figure 102. HCC Orthodontists

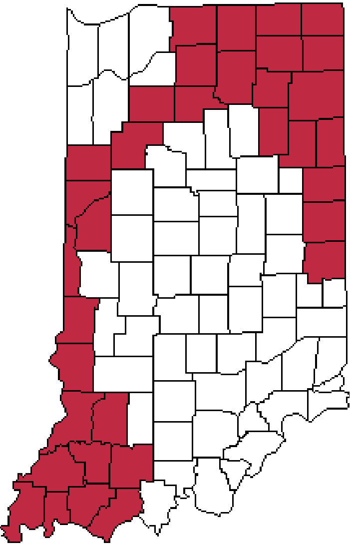


Figure 103. HCC Otolaryngologists

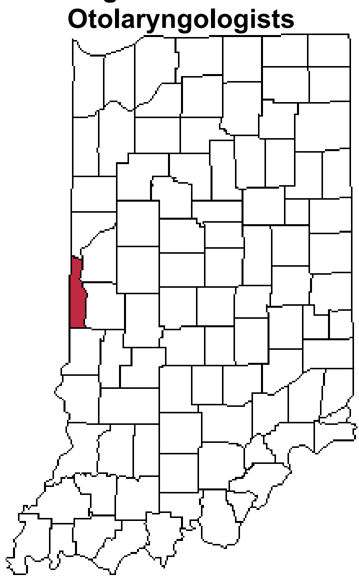


Figure 104. HCC PMP – Physicians

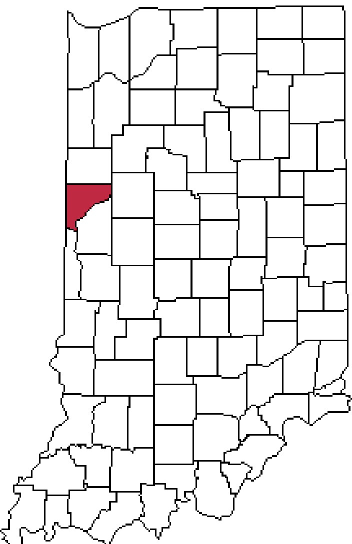


Figure 105. HCC Podiatrists

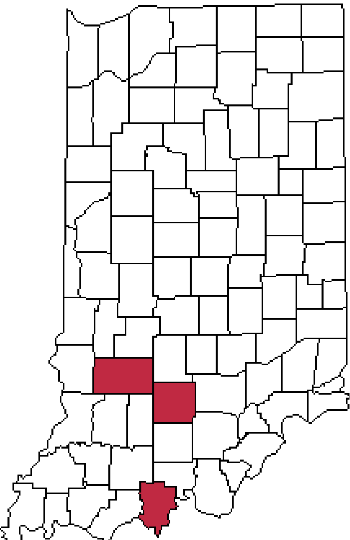


Figure 106. HCC Pulmonologists

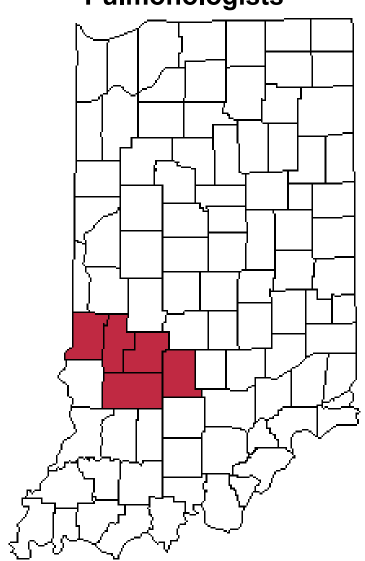


Figure 107. HCC Rheumatologists

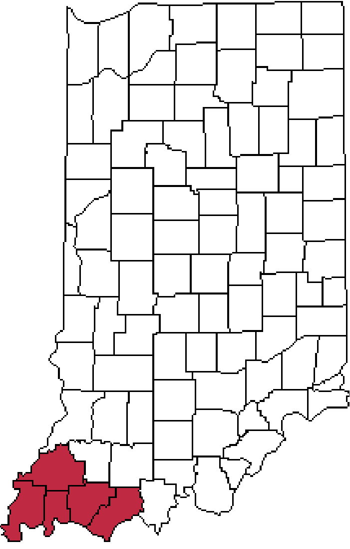
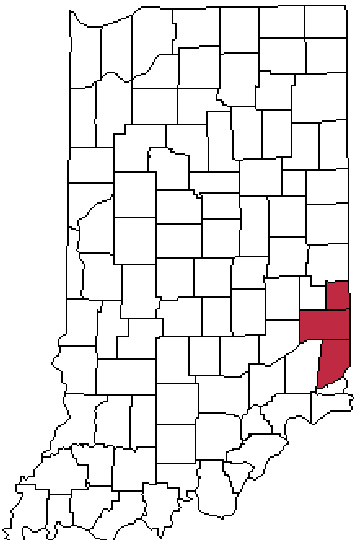
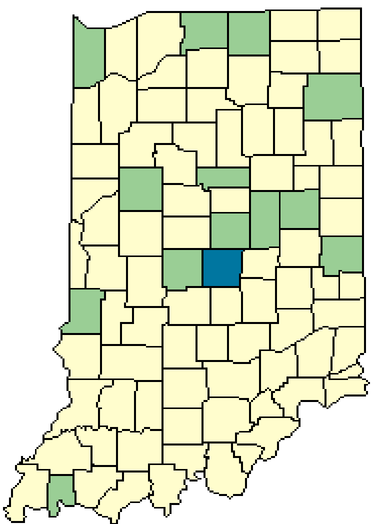


Figure 108. HCC Speech Therapists



UHC Member Population

Figure 109. HCC Member Population



1-100 101-500 501-10,000

UHC HCC Accessibility by Provider Service Type

Figure 110. HCC Dentists

Figure 111. HCC Diagnostic Testing

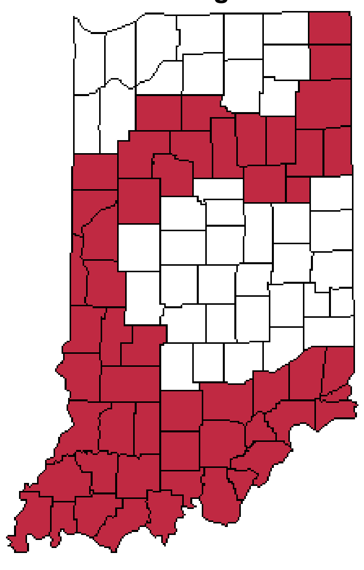


Figure 112. HCC Interventional Radiologist

Figure 113. HCC Orthodontists

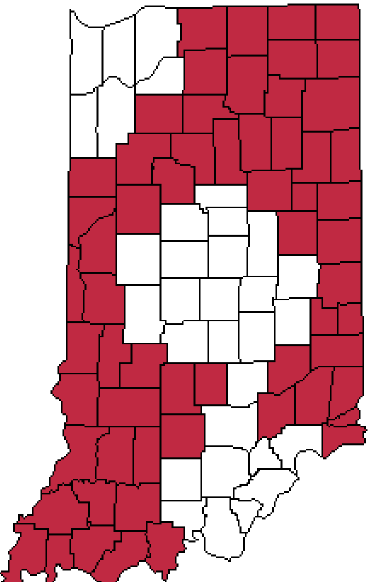


Figure 114. HCC Rheumatologists

Assessment of Annual Reports 0902 and 0903 Issued to the State

The MCE's annual *Report 0902 (Count of Providers)* was compared to the State, comparing provider counts per county to the provider rosters the MCEs submitted for analysis. This analysis is displayed in **Table 45**.

Table 45. Count of Providers – Verification of Report 0902

MCE	IHCP	All Provider Service Types		
		MCE Report 0902	Calculated	Over (Under) Reported
Anthem	HHW	37,735	46,018	(8,283)
	HIP	37,124	44,875	(7,751)
	HCC	38,244	30,253	7,991
CareSource	HHW	87,333	34,577	52,756
	HIP	86,338	33,297	53,041
MDwise	HHW	40,470	47,860	(7,390)
	HIP	40,821	47,763	(6,942)
MHS	HHW	19,545	14,934	4,611
	HIP	19,772	14,979	4,793
	HCC	19,978	15,155	4,823
UHC	HCC	31,430	30,983	447

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

The MCEs' *Report 0903 (Member Access to Providers)* was compared to the State's counts of members lacking sufficient access to providers by county to the results of provider network assessments. The over and undercalculation of the *0903 Report* is displayed in **Table 46**. The detailed comparison by county is found in Appendix C.

Table 46. Member Access to Providers – Verification of Report 0903

Program	Service Type	Number of Enrolled Members			Members Without Sufficient Access		
		MCE Report 0903	Calculated	Over (Under)	MCE Report 0903	Calculated	Over (Under)
Anthem							
HHW	Acute Care Hospitals	302,994	301,718	1,276	24	0	24
HHW	Diagnostic Testing	302,994	301,718	1,276	0	18,517	(18,517)
HHW	Nonhospital based Anesthesiologists	302,994	301,718	1,276	0	23,595	(23,595)
HHW	Oral Surgeons	302,994	301,718	1,276	3	2,848	(2,845)
HHW	Orthodontists	302,994	301,718	1,276	45,128	95,211	(50,083)
HHW	Prosthetic Suppliers	302,994	301,718	1,276	0	18,307	(18,307)
HHW	Radiation Oncologists	302,994	301,718	1,276	0	46,819	(46,819)
HIP	Dentists	311,262	318,251	(6,989)	0	1	(1)
HIP	Diagnostic Testing	311,262	318,251	(6,989)	0	20,053	(20,053)
HIP	Nonhospital based Anesthesiologists	311,262	318,251	(6,989)	0	24,504	(24,504)
HIP	Oral Surgeons	311,262	318,251	(6,989)	0	3,428	(3,428)
HIP	Orthodontists	311,262	318,251	(6,989)	49,594	102,028	(52,434)
HIP	Prosthetic Suppliers	311,262	318,251	(6,989)	0	18,616	(18,616)
HIP	Radiation Oncologists	311,262	318,251	(6,989)	0	1,122	(1,122)
HCC	Diagnostic Testing	44,047	44,791	(744)	0	3,342	(3,342)
HCC	Nonhospital based Anesthesiologists	44,047	44,791	(744)	0	3,459	(3,459)
HCC	Oral Surgeons	44,047	44,791	(744)	0	614	(614)

Table 46. Member Access to Providers – Verification of Report 0903							
Program	Service Type	Number of Enrolled Members			Members Without Sufficient Access		
		MCE Report 0903	Calculated	Over (Under)	MCE Report 0903	Calculated	Over (Under)
	Orthodontists	44,047	44,791	(744)	7,074	14,975	(7,901)
	Prosthetic Suppliers	44,047	44,791	(744)	0	2,668	(2,668)
	Radiation Oncologists	44,047	44,791	(744)	0	2,666	(2,666)
CareSource							
HHW	Dentists	75,017	76,452	(1,435)	41	275	(234)
HHW	Diagnostic Testing	75,017	76,452	(1,435)	0	2,296	(2,296)
HHW	Home Health Providers	75,017	76,452	(1,435)	0	27,170	(27,170)
HHW	Inpatient Psychiatric Facilities	75,017	76,452	(1,435)	0	418	(418)
HHW	Interventional Radiologists	75,017	76,452	(1,435)	0	125	(125)
HHW	Oral Surgeons	75,017	76,452	(1,435)	16	0	16
HHW	Orthodontists	75,017	76,452	(1,435)	20,676	18,073	2,603
HIP	Dentists	76,346	81,486	(5,140)	38	77	(39)
HIP	Diagnostic Testing	76,346	81,486	(5,140)	0	2,444	(2,444)
HIP	Home Health Providers	76,346	81,486	(5,140)	0	25,770	(25,770)
HIP	Inpatient Psychiatric Facilities	76,346	81,486	(5,140)	0	423	(423)
HIP	Interventional Radiologists	76,346	81,486	(5,140)	0	166	(166)
HIP	Oral Surgeons	76,346	81,486	(5,140)	195	587	(392)

Table 46. Member Access to Providers – Verification of Report 0903							
Program	Service Type	Number of Enrolled Members			Members Without Sufficient Access		
		MCE Report 0903	Calculated	Over (Under)	MCE Report 0903	Calculated	Over (Under)
	Orthodontists	76,346	81,486	(5,140)	23,034	19,001	4,033
MDwise							
HHW	Dentists	194,703	193,803	900	0	137	(137)
HHW	Diagnostic Testing	194,703	193,803	900	66,461	32,247	34,214
HHW	ESRD Clinic	194,703	193,803	900	4,111	0	4,111
HHW	Home Health Providers	194,703	193,803	900	0	82,865	(82,865)
HHW	Inpatient Psychiatric Facilities	194,703	193,803	900	0	3,353	(3,353)
HHW	Interventional Radiologists	194,703	193,803	900	8	0	8
HHW	OBGYN	194,703	97,008	97,695	183	0	183
HHW	Oral Surgeons	194,703	193,803	900	180	0	180
HHW	Orthodontists	194,703	193,803	900	16,454	29,544	(13,090)
HIP	Behavioral Health Providers	160,391	154,552	5,839	1	0	1
HIP	Dentists	160,391	154,552	5,839	0	96	(96)
HIP	Diagnostic Testing	160,391	154,552	5,839	56,943	28,205	28,738
HIP	ESRD Clinic	160,391	154,552	5,839	2,954	0	2,954
HIP	Home Health Providers	160,391	154,552	5,839	0	67,070	(67,070)
HIP	Inpatient Psychiatric Facilities	160,391	154,552	5,839	0	2,824	(2,824)

Table 46. Member Access to Providers – Verification of Report 0903							
Program	Service Type	Number of Enrolled Members			Members Without Sufficient Access		
		MCE Report 0903	Calculated	Over (Under)	MCE Report 0903	Calculated	Over (Under)
	Interventional Radiologists	160,391	154,552	5,839	4	0	4
	OBGYN	160,391	95,506	64,885	221	0	221
	Oral Surgeons	160,391	154,552	5,839	175	0	175
	Orthodontists	160,391	154,552	5,839	16,263	25,525	(9,262)
	Pharmacy	160,391	154,552	5,839	5	0	5
MHS							
HHW	Cardiothoracic Surgeons	174,010	172,071	1,939	0	5,099	(5,099)
	Cardiovascular Surgeons	174,010	172,071	1,939	0	32,563	(32,563)
	Dentists	174,010	172,071	1,939	0	101	(101)
	Dermatologists	174,010	172,071	1,939	0	117	(117)
	Diagnostic Testing	174,010	172,071	1,939	97,267	90,534	6,733
	Durable Medical Equipment (DME)	174,010	172,071	1,939	0	47,266	(47,266)
	Endocrinologists	174,010	172,071	1,939	0	2,448	(2,448)
	Gastroenterologists	174,010	172,071	1,939	0	949	(949)
	Hematologists	174,010	172,071	1,939	0	3,090	(3,090)
	Inpatient Psychiatric Facilities	174,010	172,071	1,939	0	1,127	(1,127)
	Nephrologists	174,010	172,071	1,939	0	12,182	(12,182)

Table 46. Member Access to Providers – Verification of Report 0903

Program	Service Type	Number of Enrolled Members			Members Without Sufficient Access		
		MCE Report 0903	Calculated	Over (Under)	MCE Report 0903	Calculated	Over (Under)
	Oncologists	174,010	172,071	1,939	0	2,853	(2,853)
	Ophthalmologists	174,010	172,071	1,939	0	11	(11)
	Oral Surgeons	174,010	172,071	1,939	117	9	108
	Orthodontists	174,010	172,071	1,939	50,309	41,317	8,992
	Otolaryngologists	174,010	172,071	1,939	0	154	(154)
	PMPs-Physicians	174,010	172,071	1,939	0	4	(4)
	Pulmonologists	174,010	172,071	1,939	0	500	(500)
	Radiation Oncologists	174,010	172,071	1,939	0	202	(202)
	Rheumatologists	174,010	172,071	1,939	0	2,855	(2,855)
	Speech Therapists	174,010	172,071	1,939	0	125	(125)
	Urologists	174,010	172,071	1,939	0	1	(1)
HIP	Cardiothoracic Surgeons	131,142	129,105	2,037	0	3,913	(3,913)
	Cardiovascular Surgeons	131,142	129,105	2,037	0	230	(230)
	Dentists	131,142	129,105	2,037	0	63	(63)
	Diagnostic Testing	131,142	129,105	2,037	71,035	63,743	7,292
	Durable Medical Equipment (DME)	131,142	129,105	2,037	0	35,327	(35,327)
	Endocrinologists	131,142	129,105	2,037	0	248	(248)
	Hematologists	131,142	129,105	2,037	0	6	(6)

Table 46. Member Access to Providers – Verification of Report 0903							
Program	Service Type	Number of Enrolled Members			Members Without Sufficient Access		
		MCE Report 0903	Calculated	Over (Under)	MCE Report 0903	Calculated	Over (Under)
	Inpatient Psychiatric Facilities	131,142	129,105	2,037	0	1,501	(1,501)
	Oncologists	131,142	129,105	2,037	0	6	(6)
	Oral Surgeons	131,142	129,105	2,037	132	6	126
	Orthodontists	131,142	129,105	2,037	34,494	37,886	(3,392)
	Pulmonologists	131,142	129,105	2,037	0	126	(126)
	Speech Therapists	131,142	129,105	2,037	0	103	(103)
HCC	Cardiothoracic Surgeons	27,841	27,954	(113)	0	20	(20)
	Cardiovascular Surgeons	27,841	27,954	(113)	0	824	(824)
	Dentists	27,841	27,954 (Does not align with Table)	(113)	0	10	(10)
	Dermatologists	27,841	27,954	(113)	0	1,489	(1,489)
	Diagnostic Testing	27,841	27,954	(113)	14,766	13,742	1,024
	Durable Medical Equipment (DME)	27,841	27,954	(113)	0	8,017	(8,017)
	Endocrinologists	27,841	27,954	(113)	0	381	(381)
	Gastroenterologists	27,841	27,954	(113)	0	67	(67)
	Hematologists	27,841	27,954	(113)	0	407	(407)
	Inpatient Psychiatric Facilities	27,841	27,954	(113)	0	2	(2)

Table 46. Member Access to Providers – Verification of Report 0903							
Program	Service Type	Number of Enrolled Members			Members Without Sufficient Access		
		MCE Report 0903	Calculated	Over (Under)	MCE Report 0903	Calculated	Over (Under)
	Nephrologists	27,841	27,954	(113)	0	2,065	(2,065)
	Oncologists	27,841	27,954	(113)	0	398	(398)
	Ophthalmologists	27,841	27,954	(113)	0	2	(2)
	Oral Surgeons	27,841	27,954	(113)	60	0	60
	Orthodontists	27,841	27,954	(113)	6,872	6,650	222
	Otolaryngologists	27,841	27,954	(113)	0	9	(9)
	PMPs-Physicians	27,841	27,954	(113)	0	2	(2)
	Podiatrists	27,841	27,954	(113)	0	9	(9)
	Pulmonologists	27,841	27,954	(113)	0	211	(211)
	Rheumatologists	27,841	27,954	(113)	0	238	(238)
	Speech Therapists	27,841	27,954	(113)	0	26	(26)
UHC							
HCC	Dentists	5,726	5,680	46	2	4	(2)
HCC	Diagnostic Testing	5,726	5,680	46	1,939	1,503	436
HCC	Interventional Radiologists	5,726	5,680	46	0	17	(17)
HCC	Oral Surgeons	5,726	5,680	46	242	0	242
HCC	Orthodontists	5,726	5,680	46	1,930	1,992	(62)
HCC	Rheumatologists	5,726	5,680	46	0	6	(6)

The MCEs submitted their annual *Report 0903 (Member Access to Providers)*. Each report was reviewed, comparing count of members lacking sufficient access to providers by service type and county to the results of the provider network assessments (see Appendix C). All MCEs' Report 0903 showed consistent differences between the report and the verification.

Assessment of Provider Directories Issued to Members

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

A random sample of 100 providers was selected from each MCE's submitted roster of all providers, consisting of two observations for each provider service type across all programs. These providers were then traced to the provider directory submitted by the MCE.

A systematic comparison process was performed to assess the completeness and accuracy of the provider service location addresses of enrolled providers within the members' provider directories as of October 1, 2024. The addresses in the provider directory were extracted and geocoded, resulting in a list of standardized address coordinates. These coordinates were compared to the existing provider address coordinates used in the provider network accessibility analysis. This method showed the percentage of enrolled provider addresses matching across all provider service types and programs as 83.98% for Anthem, 8.28% for CareSource, 75.74% for MDwise, 63.13% for MHS, and 77.06 % for UHC.

The overall provider directory completeness for each IHCP and MCE are displayed in **Table 47**, as is the percentage of locations matching that of the random sampling of Provider Directory Service Locations. Additionally, there is a comparison between the percentages from MY 2023 and MY 2024. A positive increase in matches are marked in green, while a decrease in matches in MY 2024 are marked in red.

Table 47. Provider Directory Completeness

MCE	IHCP	Percentage of Roster Match Between OMPP and MCE		Percentage of Geocoded Locations Match	
		MY 2023	MY 2024	MY 2023	MY 2024
Anthem	HHW	58.06%	50.00%	99.61%	83.39%
	HIP	67.65%	47.37%	99.61%	83.43%
	HCC	57.14%	57.89%	99.59%	85.21%
	All Programs	61.00%	52.00%	99.60%	83.98%
CareSource	HHW	70.91%	16.98%	99.86%	8.30%

Table 47. Provider Directory Completeness

MCE	IHCP	Percentage of Roster Match Between OMPP and MCE		Percentage of Geocoded Locations Match	
		MY 2023	MY 2024	MY 2023	MY 2024
	HIP	65.96%	25.53%	82.93%	8.27%
	All Programs	68.63%	21.00%	96.15%	8.28%
MDwise	HHW	90.00%	48.98%	99.80%	75.77%
	HIP	90.00%	49.02%	99.80%	75.71%
	All Programs	90.00%	49.00%	99.80%	75.74%
MHS	HHW	32.40%	70.00%	99.80%	62.65%
	HIP	31.00%	75.68%	99.80%	62.88%
	HCC	66.70%	66.67%	99.80%	63.85%
	All Programs	44.19%	71.00%	99.80%	63.13%
UHC	HCC	60.64%	64.00%	99.92%	77.06%

Overall, the percentage of MCE Provider Rosters that matched OMPP's Provider Rosters decreased from MY 2023, with the exception of Anthem's HCC program and UHC's HHC program, which both had minor increases and MHS's HHW and HIP programs which had significant increases. The percentage of geocoded provider addresses that matched the rosters also decreased across all programs.

Secret Shopper Survey

Objectives

In an upcoming proposed rule by CMS, it notes that surveys of providers can add a greater level of validity and accuracy to the validation of network adequacy and access. Based on the 2024 Managed Care proposed rule, CMS states that, while calls can be either secret, meaning the caller does not identify who they are performing the survey for, or revealed, meaning the caller identifies the entity for which they are performing the survey, CMS proposes that a secret shopper call can result in unbiased and credible findings. To that end, OMPP requested Qsource conduct a Secret Shopper Survey as a part of Protocol 4 to ensure accuracy of the following type of MCE's reporting:

- **Network Directory Accuracy:** Verifying if the provider contact details, address, in-network status, and other information listed in the directory are correct.

- **Provider Availability:** If the provider is accepting new patients and has open appointment date/time slots available.
- **Appointment Wait Times:** The earliest available appointment time offered, and in the event of appointment unavailability, if an appointment with a different provider and/or a telehealth appointment was offered.

Description of Data Obtained

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

Technical Methods of Data Collection and Analysis

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

A non-statistical randomized oversampling of 100 PMPs and 50 OB/GYNs were selected from each MCE's submitted roster of all providers. The physicians selected were based on provider type, provider specialty, and an active provider status per the MCE. Additionally, physicians selected were indicated as open panel in the submitted roster. To ensure the secret shopper calls were based on current information, the MCE's online provider directory was searched to verify the address, phone number, group/practice affiliation, provider availability, program/in-network status, provider type/specialty, and office hours for the providers selected for sampling.

After locating a provider in the health plan directory, the information was cross-checked with the provider's website if the online directory office name or specialty indicated the provider may not accept routine appointments, or the directory address was not an expected location based on the addresses submitted in the MCE data. The provider was excluded from the call list if it was verified the provider is a specialist. Alternatively, if it was determined the provider sees patients for routine appointments but at an alternative location, the callers were provided with the alternative contact information.

The PMPs were called to inquire about routine, in-person, non-urgent, appointments for a new patient, or child, if the provider was a pediatrician. The OB/GYNs were first called to obtain routine, in-person, appointments for a new, not-pregnant patient. Once these first OB/GYN calls were completed, the OB/GYNs that had been successfully reached and were scheduling appointments were called a second time. These calls requested in-person appointments for a new patient in a first-trimester pregnancy. Callers attempted to reach providers a maximum of three times during standard business hours.

Secret Shopper Results

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

Each call was categorized as follows:

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

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

- **Provider No Longer with Group/Practice**: The provider representative stated that the provider is no longer with the medical group/practice, the provider does not serve patients at the location contacted, the provider is retired or is retiring or the stated office/practice location is closed.
- **No Routine Appointments**: The provider is not scheduling routine appointments as it may be a hospitalist, specialist, see OB/GYN patients only, or see patients on a case-by-case basis. The facility/practice is a walk-in clinic or urgent care facility, or the provider accepts patients by referral only.
- **The Provider is on Leave**: The provider representative indicated the provider is currently on leave. Waitlists were documented for providers on leave as applicable and an approximate appointment date noted, if received.
- **Not Accepting Patients or Insurance**: The provider representative indicated the provider is not accepting new patients, is not accepting Medicaid, is not accepting the MCE's insurance, or is not accepting patients for a particular program (HHW or HIP).
- **Additional Information Needed**: The caller/member needs to register with the practice/healthcare system before scheduling an appointment, the provider requires the caller's medical records to be reviewed before scheduling an appointment, and/or lab work is required before scheduling an appointment.
- **Other**: The call was ended by the provider representative before appointment availability could be received.

Survey Results

Table 48 summarizes the number of providers sampled, providers who were unable to be reached, completed calls, appointments offered or unable to be obtained, and the percentages of appointments received out of total providers sampled and appointments received out of the completed calls.

Table 48. Secret Shopper Survey Results

Call Status	HHW			HIP			HCC		
	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant
Anthem									
Number of providers sampled *(denominator)*	94	49	22	92	50	22	81	49	22
Unable to Reach	10	6	2	10	7	2	8	6	2
Completed Calls	84	43	20	82	43	20	73	43	20
Unable to Obtain Appointments	72	23	12	71	23	12	63	23	12
Obtained Appointments	12	20	8	11	20	8	10	20	8
Appointments/Total Providers	**12.77%**	**40.82%**	**36.36%**	**11.96%**	**40.00%**	**36.36%**	**12.35%**	**40.82%**	**36.36%**
Percentage of Appointments/Completed Calls	**14.29%**	**46.51%**	**40.00%**	**13.41%**	**46.51%**	**40.00%**	**13.70%**	**46.51%**	**40.00%**
CareSource									
Number of providers sampled *(denominator)*	94	49	16	99	50	16			
Unable to Reach	15	4	1	15	4	1			
Completed Calls	79	45	15	84	46	15			
Unable to Obtain Appointments	69	33	8	74	33	7			
Obtained Appointments	10	12	7	10	13	8			

Table 48. Secret Shopper Survey Results

Call Status	HHW			HIP			HCC		
	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant
Appointments/Total Providers	**10.64%**	**24.49%**	**43.75%**	**10.10%**	**26.00%**	**50.00%**			
Percentage of Appointments/Completed Calls	**12.66%**	**26.67%**	**46.67%**	**11.90%**	**28.26%**	**53.33%**			
MDwise									
Number of providers sampled *(denominator)*	100	50	23	97	50	23			
Unable to Reach	28	6	2	28	6	2			
Completed Calls	72	44	21	69	44	21			
Unable to Obtain Appointments	62	21	10	59	21	10			
Obtained Appointments	10	23	11	10	23	11			
Appointments/Total Providers	**10.00%**	**46.00%**	**47.83%**	**10.31%**	**46.00%**	**47.83%**			
Percentage of Appointments/Completed Calls	**13.89%**	**52.27%**	**52.38%**	**14.49%**	**52.27%**	**52.38%**			
MHS									
Number of providers sampled *(denominator)*	93	46	21	88	49	21	94	45	21
Unable to Reach	8	1	3	7	1	3	8	1	3
Completed Calls	85	45	18	81	48	18	86	44	18
Unable to Obtain Appointments	64	25	9	61	27	7	64	24	9
Obtained Appointments	21	20	9	20	21	11	22	20	9

Table 48. Secret Shopper Survey Results

Call Status	HHW			HIP			HCC		
	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant
Percentage of Appointments/Total Providers	**22.58%**	**43.48%**	**42.86%**	**22.73%**	**42.86%**	**52.38%**	**23.40%**	**44.44%**	**42.86%**
Percentage of Appointments/Completed Calls	**24.71%**	**44.44%**	**50.00%**	**24.69%**	**43.75%**	**61.11%**	**25.58%**	**45.45%**	**50.00%**
UHC									
Number of providers sampled *(denominator)*							100	50	18
Unable to Reach							8	3	0
Completed Calls							92	47	18
Unable to Obtain Appointments							70	29	8
Obtained Appointments							22	18	10
Percentage of Appointments/Total Providers							**22.00%**	**36.00%**	**55.56%**
Percentage of Appointments/Completed Calls							**23.91%**	**38.30%**	**55.56%**

In the Secret Shopper Survey, the surveyors found that more than half of MCEs' programs had a percentage of appointments obtained that was less than 50.00% in the scenarios tested. The MCE with the highest response rate of 61.11% was MHS in their administration of the HIP program in the OB/GYN Pregnant scenario. The lowest response rate was 11.90% for CareSource's HIP program in the PMP scenario.

Because there are several reasons why providers may not have been able to be reached, Table 49 breaks down how many providers did not have a correctly listed phone number in the Provider Directory and how many were not responsive.

Table 49. Secret Shopper Unable to Reach Reasons

Call Status	HHW			HIP			HCC		
	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant
Anthem									
Unable to Reach – Invalid Phone Number	1	4	1	1	5	1	0	4	1
Unable to Reach – Non-Responsive Provider	9	2	1	9	2	1	8	2	1
Unable to Reach – Total	**10**	**6**	**2**	**10**	**7**	**2**	**8**	**6**	**2**
CareSource									
Unable to Reach – Invalid Phone Number	9	1	0	9	1	0			
Unable to Reach – Non-Responsive Provider	5	3	1	5	3	1			
Unable to Reach – Total	**14**	**4**	**1**	**14**	**4**	**1**			
MDwise									
Unable to Reach – Invalid Phone Number	19	3	1	16	3	1			
Unable to Reach – Non-Responsive Provider	9	3	1	12	3	1			
Unable to Reach – Total	**28**	**6**	**2**	**28**	**6**	**2**			
MHS									
Unable to Reach – Invalid Phone Number	4	1	0	3	1	0	4	1	0
Unable to Reach – Non-Responsive Provider	4	0	3	4	0	3	4	0	3

Table 49. Secret Shopper Unable to Reach Reasons									
Call Status	HHW			HIP			HCC		
	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant
Total Unable to Reach	**8**	**1**	**3**	**7**	**1**	**3**	**8**	**1**	**3**
UHC									
Unable to Reach – Invalid Phone Number							3	0	0
Unable to Reach – Non-Responsive Provider							5	3	0
Total Unable to Reach							**8**	**3**	**0**

Table 50 breaks down the reasons why a secret shopper was unable to obtain an appointment.

Table 50. Secret Shopper Unable to Obtain Appointment Reasons									
Call Status	HHW			HIP			HCC		
	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant
Anthem									
Provider no longer with group or indicated location	7	7	1	6	7	1	6	7	1
No routine appointments, not a PMP or OB/GYN, only an OB or GYN	0	2	0	0	2	0	0	2	0
The provider is on leave	1	3	0	1	3	0	0	3	0
Not accepting new patients and/or MCE insurance	40	10	3	39	10	3	36	10	3
Additional information needed to schedule an appointment	23	1	7	24	1	7	21	1	7

Table 50. Secret Shopper Unable to Obtain Appointment Reasons

Call Status	HHW			HIP			HCC		
	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant
Caller did not receive an appointment time	1	0	1	1	0	1	0	0	1
Total Unable to Obtain Appointments	**72**	**23**	**12**	**71**	**23**	**12**	**63**	**23**	**12**
CareSource									
Provider no longer with group or indicated location	11	16	4	11	16	3			
No routine appointments, not a PMP or OB/GYN, only an OB or GYN	5	2	0	5	2	0			
The provider is on leave	2	1	0	3	1	0			
Not accepting new patients and/ or MCE insurance	20	11	1	25	11	1			
Additional information needed to schedule an appointment	29	2	3	28	2	3			
Caller did not receive an appointment time	2	1	0	2	1	0			
Total Unable to Obtain Appointments	**69**	**33**	**8**	**74**	**33**	**7**			
MDwise									
Provider no longer with group or indicated location	13	7	1	11	7	1			
No routine appointments, not a PMP or OB/GYN, only an OB or GYN	2	2	2	2	2	2			
The provider is on leave	0	0	0	0	0	0			

Table 50. Secret Shopper Unable to Obtain Appointment Reasons

Call Status	HHW			HIP			HCC		
	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant
Not accepting new patients and/ or MCE insurance	36	9	1	36	9	1			
Additional information needed to schedule an appointment	11	3	6	10	3	6			
Caller did not receive an appointment time	0	0	0	0	0	0			
Total Unable to Obtain Appointments	**62**	**21**	**10**	**59**	**21**	**10**			
MHS									
Provider no longer with group or indicated location	11	8	1	11	8	1	11	7	1
No routine appointments, not a PMP or OB/GYN, only an OB or GYN	0	1	2	0	1	1	0	1	2
The provider is on leave	3	1	0	2	2	0	3	1	0
Not accepting new patients and/ or MCE insurance	28	11	1	29	11	1	28	10	1
Additional information needed to schedule an appointment	21	4	4	18	5	3	21	5	4
Caller did not receive an appointment time	1	0	1	1	0	1	1	0	1
Total Unable to Obtain Appointments	**64**	**25**	**9**	**61**	**27**	**7**	**64**	**24**	**9**
UHC									
Provider no longer with group or indicated location							4	8	0

Table 50. Secret Shopper Unable to Obtain Appointment Reasons									
Call Status	HHW			HIP			HCC		
	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	OB/GYN Not Pregnant	OB/GYN Pregnant
No routine appointments, not a PMP or OB/GYN, only an OB or GYN							1	0	2
The provider is on leave							0	3	1
Not accepting new patients and/ or MCE insurance							47	8	3
Additional information needed to schedule an appointment							17	10	1
Caller did not receive an appointment time							1	0	1
Total Unable to Obtain Appointments							**70**	**29**	**8**

Appointment Wait Times

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

Table 51 shows the percentage of appointments offered that met the MCE's standards. Please note that the PMP Pediatrics are grayed out for Anthem and CareSource due to the fact that pediatric PMP providers were not identified within their random sample.

Table 51. Appointment Wait Time Compliance												
Description	HHW				HIP				HCC			
	PMP	PMP* Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP* Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP* Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant
Anthem												
MCE Standards *(calendar days)*	21 days		21 days	14 days	21 days		21 days	14 days	21 days		21 days	14 days
Average Wait Time from Secret Shopper Survey *(calendar days)*	36 days		60 days	36 days	39 days		60 days	36 days	38 days		60 days	36 days
Number of appointments offered *(denominator)*	**12**		**20**	**8**	**11**		**20**	**8**	**10**		**20**	**8**
Number of appointments **not** meeting the standard	5		15	6	5		15	6	4		15	6
Number of appointments meeting the standard	7		5	2	6		5	2	6		5	2
Percentage of appointments meeting the standard	**58.33%**		**25.00%**	**25.00%**	**54.55%**		**25.00%**	**25.00%**	**60.00%**		**25.00%**	**25.00%**
Percentage from MY 2023	**40.00%**		**20.00%**	**20.00%**	**44.44%**		**25.00%**	**60.00%**	**36.36%**		**25.00%**	**12.50%**
CareSource												
MCE standards *(calendar days)*	14 days		30 days	30 days	14 days		30 days	30 days				
Average Wait Time from	98 days		50 days	22 days	98 days		48 days	23 days				

Table 51. Appointment Wait Time Compliance

Description	HHW				HIP				HCC			
	PMP	PMP* Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP* Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP* Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant
Secret Shopper Survey *(calendar days)*												
Number of appointments offered *(denominator)*	**10**		**12**	**7**	**10**		**13**	**8**				
Number of appointments not meeting the standard	7		6	2	7		6	2				
Number of appointments meeting the standard	3		6	5	3		7	6				
Percentage of appointments meeting the standard	**30.00%**		**50.00%**	**71.43%**	**30.00%**		**53.85%**	**75.00%**				
Percentage from MY 2023	**33.33%**		**42.86%**	**100%**	**25.00%**		**40.00%**	**0.00 %**				
MDwise												
MCE standards *(calendar days)*	90 days	30 days	90 days	30 days	90 days	30 days	90 days	30 days				
Average Wait Time from Secret Shopper Survey *(calendar days)*	47 days	42 days	75 days	48 days	47 days	42 days	75 days	48 days				
Number of appointments offered	**9**	**1**	**23**	**11**	**9**	**1**	**23**	**11**				

Table 51. Appointment Wait Time Compliance												
Description	HHW				HIP				HCC			
	PMP	PMP* Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP* Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP* Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant
(denominator)												
Number of appointments not meeting the standard	1	1	9	8	1	1	9	8				
Number of appointments meeting the standard	8	0	14	3	8	0	14	3				
Percentage of appointments meeting the standard	**88.89%**	**0.00%**	**60.87%**	**27.27%**	**88.89%**	**0.00%**	**60.87%**	**27.27%**				
Percentage from MY 2023	**100%**	**100%**	**40.00%**	**0.00%**	**83.33%**	**50.00%**	**100%**	**100%**				
MHS												
MCE standards *(calendar days)*	90 days	30 days	90 days	30 days	90 days	30 days	90 days	30 days	90 days	30 days	90 days	30 days
Average Wait Time from Secret Shopper Survey *(calendar days)*	53 days	31 days	81 days	45 days	53 days	31 days	81 days	45 days	53 days	31 days	81 days	45 days
Number of appointments offered *(denominator)*	**14**	**7**	**20**	**9**	**14**	**6**	**21**	**11**	**15**	**7**	**20**	**9**
Number of appointments not meeting the standard	2	2	8	7	2	2	7	9	3	2	8	9

Table 51. Appointment Wait Time Compliance												
Description	HHW				HIP				HCC			
	PMP	PMP* Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP* Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP* Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant
Number of appointments meeting the standard	12	5	12	2	12	4	14	2	12	5	12	0
Percentage of appointments meeting the standard	**85.71%**	**71.43%**	**60.00%**	**22.22%**	**85.71%**	**66.67%**	**66.67%**	**18.18%**	**80.00%**	**71.43%**	**60.00%**	**0.00%**
Percentage from MY 2023	**73.33%**	**100%**	**87.50%**	**85.71%**	**40.00%**	**-**	**80.00%**	**75.00%**	**90.00%**	**0.00%**	**50.00%**	**25.00%**
UHC												
MCE standards *(calendar days)*									90 days	30 days	90 days	30 days[2]
Average Wait Time from Secret Shopper Survey *(calendar days)*									60 days	17 days	49 days	35 days
Number of appointments offered *(denominator)*									**19**	**3**	**18**	**10**
Number of appointments not meeting the standard									6	1	3	5
Number of appointments meeting the standard									13	2	15	5

Table 51. Appointment Wait Time Compliance

Description	HHW				HIP				HCC			
	PMP	PMP* Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP* Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant	PMP	PMP* Pediatrics	OB/GYN Not Pregnant	OB/GYN Pregnant
Percentage of appointments meeting the standard									68.42%	66.67%	83.33 %	50.00%
Percentage from MY 2023									76.92%	60.00%	79.17%	87.50%

**Pediatric providers that identified as PMPs were not identified within the random sample of PMP secret shopper calls for Anthem nor CareSource.*

For Anthem, 36.59% of appointments offered were within the MCE's wait time standards as the average across the programs and scenarios. The data reported reflects the status of the individual provider sampled and does not take into account earlier appointments that may have been offered with other providers within the group/practice contacted.

For CareSource, 51.61% of appointments offered were within the MCE's wait time standards as the average across the programs and scenarios. The data reported reflects the status of the individual provider sampled and does not take into account earlier appointments that may have been offered with other providers within the group/practice contacted.

For MDwise, 56.82% of appointments offered were within the MCE's wait time standards as the average across the programs and scenarios. The data reported reflects the status of the individual provider sampled and does not take into account earlier appointments that may have been offered with other providers within the group/practice contacted.

For MHS, 60.00% of appointments offered were within the MCE's wait time standards as the average across the programs and scenarios. The data reported reflects the status of the individual provider sampled and does not take into account earlier appointments that may have been offered with other providers within the group/practice contacted.

For UHC, 70.00% of appointments offered were within the MCE's wait time standards as the average across the programs and scenarios. The data reported reflects the status of the individual provider sampled and does not take into account earlier appointments that may have been offered with other providers within the group/practice contacted.

Provider Directory Inaccuracies

Certain online provider directory information for the providers sampled was verified with the provider representatives during the secret shopper survey. Table 52 summarizes the inaccurate results of the provider's directory information verified, based on the provider representative's response. Providers who were non-responsive were excluded, as the directory information may have been correct, but the calls were not answered to validate the information. Multiple inaccuracies may be noted for the individual providers contacted; however, each provider was assigned only one category, as the call may have ended if the phone number was incorrect, the provider was no longer affiliated with the group/practice, not accepting new patients, etc.

Table 52. Provider Directory Inaccuracies

Description	PMP	OB/GYN
Anthem		
Number of providers sampled *(denominator)*	100	50
Phone Number (incorrect and/or Invalid)	15	8
Provider Location	2	0
Both Phone Number and Location	7	8
Number of providers with at least one provider directory inaccuracy	**24**	**16**
Percentage of providers with at least one provider directory inaccuracy	**24.00%**	**32.00%**
CareSource		
Number of providers sampled *(denominator)*	100	50
Phone Number (incorrect and/or Invalid)	1	0
Provider Location	2	0
Both Phone Number and Location	3	0
Number of providers with at least one provider directory inaccuracy	**6**	**0**
Percentage of providers with at least one provider directory inaccuracy	**6.00%**	**0.00%**
MDwise		
Number of providers sampled *(denominator)*	100	50

Table 52. Provider Directory Inaccuracies

Description	PMP	OB/GYN
Phone Number (incorrect and/or Invalid)	22	13
Provider Location	0	2
Both Phone Number and Location	10	3
Number of providers with at least one provider directory inaccuracy	**32**	**18**
Percentage of providers with at least one provider directory inaccuracy	**32.00%**	**36.00%**
MHS		
Number of providers sampled *(denominator)*	100	50
Phone Number (incorrect and/or Invalid)	0	3
Provider Location	1	0
Both Phone Number and Location	0	3
Number of providers with at least one provider directory inaccuracy	**1**	**6**
Percentage of providers with at least one provider directory inaccuracy	**1.00%**	**12.00%**
UHC		
Number of providers sampled *(denominator)*	100	50
Phone Number (incorrect and/or Invalid)	6	3
Provider Location	2	0
Both Phone Number and Location	6	1
Number of providers with at least one provider directory inaccuracy	**14**	**4**
Percentage of providers with at least one provider directory inaccuracy	**14.00%**	**8.00%**

Strengths and Weaknesses

The ANA review assists OMPP, Qsource, and the MCE in identifying strengths and weaknesses 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. Weaknesses are identified where the MCE achieved less than 100% compliance and reflect what the MCE should do to improve performance.

As shown in **Table 53**, all MCEs were compliant in their methods of data collection and maintaining network adequacy.

Table 53. ANA Strengths

MCE	Strength
Anthem (HHW/HIP/HCC)	Anthem demonstrated consistent and reliable data collection procedures for all state standards.
	Anthem demonstrated consistent and reliable network adequacy methods for all state standards.
	Anthem demonstrated consistent and reliable network adequacy results for all state standards.
CareSource (HHW/HIP)	CareSource demonstrated consistent and reliable data collection procedures for all state standards.
	CareSource demonstrated consistent and reliable network adequacy methods for all state standards.
	CareSource demonstrated consistent and reliable network adequacy results for all state standards.
MDwise (HHW/HIP)	MDwise demonstrated consistent and reliable data collection procedures for all state standards.
	MDwise demonstrated consistent and reliable network adequacy methods for all state standards.
	MDwise demonstrated consistent and reliable network adequacy results for all state standards.
MHS (HHW/HIP/HCC)	MHS demonstrated consistent and reliable data collection procedures for all state standards.
	MHS demonstrated consistent and reliable network adequacy methods for all state standards.
	MHS demonstrated consistent and reliable network adequacy results for all state standards.
UHC (HCC)	UHC demonstrated consistent and reliable data collection procedures for all state standards.
	UHC demonstrated consistent and reliable network adequacy methods for all state standards.
	UHC demonstrated consistent and reliable network adequacy results for all state standards.

Table 54 includes the MCEs' identified weaknesses.

<table>
<tr><th colspan="2">Table 54. ANA Weaknesses</th></tr>
<tr><td rowspan="2">Anthem (HHW/HIP/HCC)</td><td>Anthem did not meet the provider accessibility standards on the following provider service types:
♦ HHW Program
▪ Diagnostic Testing
▪ Nonhospital based Anesthesiologists
▪ Oral Surgeons
▪ Orthodontists
▪ Prosthetic Suppliers
▪ Radiation Oncologist
♦ HIP Program
▪ Dentists
▪ Diagnostic Testing
▪ Nonhospital based Anesthesiologists
▪ Oral Surgeons
▪ Orthodontists
▪ Prosthetic Suppliers
▪ Radiation Oncologists
♦ HCC Program
▪ Diagnostic Testing
▪ Nonhospital based Anesthesiologists
▪ Oral Surgeons
▪ Orthodontists
▪ Prosthetic Suppliers
▪ Radiation Oncologists</td></tr>
<tr><td>Anthem’s appointment wait times for the HHW, HIP, and HCC programs were in compliance with MCE standards 36.59% of the time.</td></tr>
</table>

<table>
<tr><th colspan="2">Table 54. ANA Weaknesses</th></tr>
<tr><td rowspan="2">CareSource (HHW/HIP)</td><td>CareSource did not meet the provider accessibility standards on the following provider service types:
♦ HHW Program:
▪ Dentists
▪ Diagnostic Testing
▪ Home Health Providers
▪ Inpatient Psychiatric Facilities
▪ Interventional Radiologists
▪ Orthodontists
♦ HIP Program:
▪ Dentists
▪ Diagnostic Testing
▪ Home Health Providers
▪ Inpatient Psychiatric Facilities
▪ Interventional Radiologists
▪ Oral Surgeons
▪ Orthodontists</td></tr>
<tr><td>CareSource's appointment wait times for the HHW and HIP programs were in compliance with MCE standards 51.61% of the time.</td></tr>
<tr><td>MDwise (HHW/HIP)</td><td>MDwise did not meet the provider accessibility standards on the following provider service types:
♦ HHW Program:
▪ Dentists
▪ Diagnostic Testing
▪ Home Health Providers
▪ Inpatient Psychiatric Facilities
▪ Orthodontists
♦ HIP Program:
▪ Dentists
▪ Diagnostic Testing
▪ Home Health Providers
▪ Inpatient Psychiatric Facilities</td></tr>
</table>

Table 54. ANA Weaknesses	
	▪ Orthodontists
	MDwise’s appointment wait times for the HHW and HIP programs were in compliance with MCE standards 56.82% of the time.
MHS (HHW/HIP/HCC)	MHS did not meet the provider accessibility standards on the following provider service types: ♦ HHW Program: ▪ Cardiothoracic Surgeons ▪ Cardiovascular Surgeons ▪ Dentists ▪ Dermatologists ▪ Diagnostic Testing ▪ Durable Medical Equipment (DME) ▪ Endocrinologists ▪ Gastroenterologists ▪ Hematologists ▪ Inpatient Psychiatric Facilities ▪ Nephrologists ▪ Oncologists ▪ Ophthalmologists ▪ Oral Surgeons ▪ Orthodontists ▪ Otolaryngologists ▪ PMPs-Physicians ▪ Pulmonologists ▪ Radiation Oncologists ▪ Rheumatologists ▪ Speech Therapists ▪ Urologists

Table 54. ANA Weaknesses	
	♦ HIP Program: ▪ Cardiothoracic Surgeons ▪ Cardiovascular Surgeons ▪ Dentists ▪ Diagnostic Testing ▪ Durable Medical Equipment (DME) ▪ Endocrinologists ▪ Hematologists ▪ Inpatient Psychiatric Facilities ▪ Oncologists ▪ Oral Surgeons ▪ Orthodontists ▪ Pulmonologists ▪ Speech Therapists ♦ HCC Program: ▪ Cardiothoracic Surgeons ▪ Cardiovascular Surgeons ▪ Dentists ▪ Dermatologists ▪ Diagnostic Testing ▪ Durable Medical Equipment (DME) ▪ Endocrinologists ▪ Gastroenterologists ▪ Hematologists ▪ Inpatient Psychiatric Facilities ▪ Nephrologists ▪ Oncologists ▪ Ophthalmologists ▪ Orthodontists ▪ Otolaryngologists

Table 54. ANA Weaknesses	
	▪ PMPs-Physicians ▪ Podiatrists ▪ Pulmonologists ▪ Rheumatologists ▪ Speech Therapists
	MHS's appointment wait times for the HHW, HIP, and HCC programs were in compliance with MCE standards 60.00% of the time.
UHC (HCC)	UHC did not meet the provider accessibility standards on the following provider service types: ♦ HCC Program: ▪ Dentists ▪ Diagnostic Testing ▪ Interventional Radiologists ▪ Orthodontists ▪ Rheumatologists
	UHC's appointment wait times for the HCC program were in compliance with MCE standards 70.00% of the time.

Improvements

Table 55 displays the rating criteria for the degree to which the plan addressed the MY 2023 recommendations.

Table 55. Improvement Rating Criteria

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

Table 56 displays the degree to which the MCEs addressed the previous year's AONs. Only plans that received AONs in the previous MY are included in the table.

MY 2023 Recommendations	MY 2024 Results	Degree to Which Plan Addressed Recommendation(s)
Anthem		
Anthem did not meet the provider accessibility standards on the following provider service types: ♦ HHW Program ▪ Acute Care Hospitals ▪ Behavioral Health Providers ▪ Diagnostic Testing ▪ DME ▪ Dentists ▪ Home Health Providers ▪ Inpatient Psychiatric Facilities ▪ Orthodontists ♦ HIP Program ▪ Acute Care Hospitals ▪ Behavioral Health Providers ▪ Diagnostic Testing ▪ DME ▪ Dentists ▪ Home Health Providers ▪ Inpatient Psychiatric Facilities ▪ Orthodontists ♦ HCC Program ▪ Acute Care Hospitals ▪ Behavioral Health Providers	Anthem did not meet the provider accessibility standards on the following provider categories: ♦ HHW Program ▪ Diagnostic Testing ▪ Nonhospital based Anesthesiologists ▪ Oral Surgeons ▪ Orthodontists ▪ Prosthetic Suppliers ▪ Radiation Oncologists ♦ HIP Program ▪ Dentists ▪ Diagnostic Testing ▪ Nonhospital based Anesthesiologists ▪ Oral Surgeons ▪ Orthodontists ▪ Prosthetic Suppliers ▪ Radiation Oncologists ♦ HCC Program ▪ Diagnostic Testing ▪ Nonhospital based Anesthesiologists ▪ Oral Surgeons ▪ Orthodontists ▪ Prosthetic Suppliers	Medium

Table 56. MY 2023 Recommendations Addressed in MY 2024

Table 56. MY 2023 Recommendations Addressed in MY 2024		
MY 2023 Recommendations	**MY 2024 Results**	**Degree to Which Plan Addressed Recommendation(s)**
▪ Diagnostic Testing ▪ DME ▪ Home Health Providers ▪ Inpatient Psychiatric Facilities ▪ Orthodontists	▪ Radiation Oncologists	
Anthem should consider reviewing the length of its appointment wait times for PMP and OB/GYN in the HHW, HIP and HCC programs. 31.67% of the appointments offered were within the MCE's wait time standards.	Anthem's appointment wait times for the HHW, HIP, and HCC programs were in compliance with MCE standards 36.59% of the time.	Medium
CareSource		
CareSource did not meet the provider accessibility standards on the following provider service types: ♦ HHW Program: ▪ Oral Surgeons ▪ Diagnostic Testing ▪ DME ▪ Endocrinologists ▪ Dentists ▪ Home Health Providers ▪ Inpatient Psychiatric Facilities ▪ Orthodontists ▪ Pharmacy ♦ HIP Program: ▪ Oral Surgeons ▪ Diagnostic Testing ▪ DME ▪ Endocrinologists	CareSource did not meet the provider accessibility standards on the following provider categories: ♦ HHW Program ▪ Dentists ▪ Diagnostic Testing ▪ Home Health Providers ▪ Inpatient Psychiatric Facilities ▪ Interventional Radiologists ▪ Orthodontists ♦ HIP Program ▪ Dentists ▪ Diagnostic Testing ▪ Home Health Providers ▪ Inpatient Psychiatric Facilities ▪ Interventional Radiologists ▪ Oral Surgeons ▪ Orthodontists	Medium

Table 56. MY 2023 Recommendations Addressed in MY 2024		
MY 2023 Recommendations	**MY 2024 Results**	**Degree to Which Plan Addressed Recommendation(s)**
▪ Dentists ▪ Home Health Providers ▪ Inpatient Psychiatric Facilities ▪ Orthodontists ▪ Pharmacy		
CareSource should consider reviewing the length of its appointment wait times for PMP and OB/GYN in the HHW and HIP programs. 38.46% of the appointments offered were within the MCE's wait time standards.	CareSource's appointment wait times for the HHW and HIP programs were in compliance with MCE standards 51.61% of the time.	Medium
MDwise		
MDwise did not meet the provider accessibility standards on the following provider service types: ♦ HHW Program: ▪ Oral Surgeons ▪ Diagnostic Testing ▪ DME ▪ Gastroenterologists ▪ Dentists ▪ Home Health Providers ▪ Inpatient Psychiatric Facilities ▪ Orthodontists ♦ HIP Program: ▪ Acute Care Hospitals ▪ Oral Surgeons ▪ Diagnostic Testing ▪ DME ▪ Gastroenterologists	MDwise did not meet the provider accessibility standards on the following provider categories: ♦ HHW Program ▪ Dentists ▪ Diagnostic Testing ▪ Home Health Providers ▪ Inpatient Psychiatric Facilities ▪ Orthodontists ♦ HIP Program ▪ Dentists ▪ Diagnostic Testing ▪ Home Health Providers ▪ Inpatient Psychiatric Facilities ▪ Orthodontists	Medium

Table 56. MY 2023 Recommendations Addressed in MY 2024		
MY 2023 Recommendations	**MY 2024 Results**	**Degree to Which Plan Addressed Recommendation(s)**
▪ Dentists ▪ Home Health Providers ▪ Inpatient Psychiatric Facilities ▪ Orthodontists		
MDwise may want to consider reviewing the length of its appointment wait times for PMP and OB/GYN in the HHW and HIP programs. 72.00% of the appointments offered were within the MCE's wait time standards.	MDwise's appointment wait times for the HHW and HIP programs were in compliance with MCE standards 56.82% of the time.	Low
MHS		
MHS did not meet the provider accessibility standards on the following provider service types: ♦ HHW Program ▪ Acute Care Hospitals ▪ Oral Surgeons ▪ Diagnostic Testing ▪ DME ▪ Endocrinologists ▪ Dentists ▪ Home Health Providers ▪ Inpatient Psychiatric Facilities ▪ Orthodontists ▪ Otolaryngologists ♦ HIP Program ▪ Acute Care Hospitals ▪ Oral Surgeons ▪ Diagnostic Testing ▪ DME ▪ Endocrinologists ▪ Dentists	MHS did not meet the provider accessibility standards on the following provider categories: ♦ HHW Program ▪ Cardiothoracic Surgeons ▪ Cardiovascular Surgeons ▪ Dentists ▪ Dermatologists ▪ Diagnostic Testing ▪ DME ▪ Endocrinologists ▪ Gastroenterologists ▪ Hematologists ▪ Inpatient Psychiatric Facilities ▪ Nephrologists ▪ Oncologists ▪ Ophthalmologists ▪ Oral Surgeons ▪ Orthodontists ▪ Otolaryngologists ▪ PMPs-Physicians	Low

Table 56. MY 2023 Recommendations Addressed in MY 2024

MY 2023 Recommendations	MY 2024 Results	Degree to Which Plan Addressed Recommendation(s)
▪ Home Health Providers ▪ Inpatient Psychiatric Facilities ▪ Orthodontists ▪ Otolaryngologists ♦ HCC Program ▪ Oral Surgeons ▪ Diagnostic Testing ▪ DME ▪ Endocrinologists ▪ Dentists ▪ Home Health Providers ▪ Orthodontists ▪ Otolaryngologists	▪ Pulmonologists ▪ Radiation Oncologists ▪ Rheumatologists ▪ Speech Therapists ▪ Urologists ♦ HIP Program ▪ Cardiothoracic Surgeons ▪ Cardiovascular Surgeons ▪ Dentists ▪ Diagnostic Testing ▪ DME ▪ Endocrinologists ▪ Hematologists ▪ Inpatient Psychiatric Facilities ▪ Oncologists ▪ Oral Surgeons ▪ Orthodontists ▪ Pulmonologists ▪ Speech Therapists ♦ HCC Program ▪ Cardiothoracic Surgeons ▪ Cardiovascular Surgeons ▪ Dentists ▪ Dermatologists ▪ Diagnostic Testing ▪ DME ▪ Endocrinologists ▪ Gastroenterologists ▪ Hematologists ▪ Inpatient Psychiatric Facilities	

Table 56. MY 2023 Recommendations Addressed in MY 2024

MY 2023 Recommendations	MY 2024 Results	Degree to Which Plan Addressed Recommendation(s)
	▪ Nephrologists ▪ Oncologists ▪ Ophthalmologists ▪ Orthodontists ▪ Otolaryngologists ▪ PMPs-Physicians ▪ Podiatrists ▪ Pulmonologists ▪ Rheumatologists ▪ Speech Therapists	
MHS may want to consider reviewing the length of its appointment wait times for PMP and OB/GYN in the HHW, HIP, and HCC programs. 70.77% of the appointments offered were within the MCE's wait time standards.	MHS's appointment wait times for the HHW, HIP, and HCC programs were in compliance with MCE standards 60.00% of the time.	Low
UHC		
UHC did not meet the provider accessibility standards on the following provider service types: ♦ HCC Program: ▪ Acute Care Hospitals ▪ Oral Surgeons ▪ Diagnostic Testing ▪ DME ▪ Dentists ▪ Home Health Providers ▪ Inpatient Psychiatric Facilities ▪ Occupational Therapists ▪ Orthodontists ▪ Prosthetic Suppliers ▪ Rheumatologists ▪ Speech Therapists	UHC did not meet the provider accessibility standards on the following provider categories: ♦ HCC Program ▪ Dentists ▪ Diagnostic Testing ▪ Interventional Radiologists ▪ Orthodontists ▪ Rheumatologists	Medium

Table 56. MY 2023 Recommendations Addressed in MY 2024

MY 2023 Recommendations	MY 2024 Results	Degree to Which Plan Addressed Recommendation(s)
UHC may want to consider reviewing the length of its appointment wait times in the HCC programs. 77.63% of the appointments offered were within the MCE's wait time standards.	UHC's appointment wait times for the HCC program were in compliance with MCE standards 70.00% of the time.	Low

Conclusions and Recommendations

The MCEs demonstrated a shared strength for the following:

- **Data Collection Procedures:** The MCEs demonstrated consistent and reliable data collection procedures for all state standards.
- **Network Adequacy Methods:** The MCEs demonstrated consistent and reliable network adequacy methods for all state standards.
- **Network Adequacy Results:** The MCEs demonstrated consistent and reliable network adequacy results for all state standards.

Despite these shared strengths, however, all MCEs struggled to maintain provider accessibility standards and wait time compliance.

Anthem

Throughout the 2025 ANA, Anthem met the requirements for provider-to-member ratios on 97.33% of the provider categories and the provider accessibility standards for 98.61% of its members. Anthem increased its percentage of members meeting provider accessibility standards by 0.52 percentage points but decreased in its provider directory service location match rate from 99.60% to 83.98%.

Throughout the Secret Shopper Survey, Anthem increased its wait time compliance from 31.67% to 36.59%. This standard continues to need improvement. Likewise, Anthem should ensure that all contracted providers are properly trained, as the most prevalent reason for the Secret Shoppers to not obtain an appointment was the provider not accepting Medicaid or Anthem's insurance or not accepting new patients.

For these reasons, Qsource offers the following recommendations:

- Anthem should continue to improve its provider-to-member ratios.
- Anthem should continue to improve its provider accessibility standards.
- Anthem should work to increase its provider directory accuracy.

- Anthem should work to increase appointment wait time compliance.
- Anthem should work with its providers to ensure that patient needs are being met properly and they understand they must take Anthem's insurance.

CareSource

Throughout the 2025 ANA, CareSource met the requirements for provider-to-member ratios on 100% of the provider categories and met the provider accessibility standards for 98.59% of its members. This displayed a 2.22 percentage point improvement in accessibility standards from the previous year's ANA. However, CareSource should consider reviewing its provider directory issued to members for completeness and accuracy.

Throughout the Secret Shopper Survey, CareSource improved its wait time compliance from 38.46% to 51.61%. This standard continues to need improvement. Likewise, CareSource should ensure that all contracted providers are properly trained, as the most prevalent reason for the Secret Shoppers to not obtain an appointment was the provider not accepting Medicaid or CareSource's insurance or not accepting new patients.

For these reasons, Qsource offers the following recommendations:

- CareSource should continue to maintain its provider-to-member ratios.
- CareSource should continue to improve its provider accessibility standards.
- CareSource should work to increase its provider directory accuracy.
- CareSource should work to increase appointment wait time compliance.
- CareSource should work with its providers to ensure that patient needs are being met properly and they understand they must take CareSource's insurance.

MDwise

Throughout the 2025 ANA, MDwise met the requirements for provider-to-member ratios on 100% of the provider categories. MDwise also met the provider accessibility standards for 98.21% of its members, an increase of 4.67 percentage points from the previous year's ANA. However, MDwise should consider reviewing its provider directory issued to members for completeness and accuracy.

Throughout the Secret Shopper Survey, MDwise declined in its wait time compliance from 72.00% to 56.82%. This standard continues to need improvement. Likewise, MDwise should ensure that all contracted providers are properly trained, as the most prevalent reason for the Secret Shoppers to not obtain an appointment was the provider not accepting Medicaid or MDwise's insurance or not accepting new patients.

For these reasons, Qsource offers the following recommendations:

- MDwise should continue to improve its provider-to-member ratios.

- MDwise should continue to improve its provider accessibility standards.
- MDwise should work to increase its provider directory accuracy.
- MDwise should work to increase appointment wait time compliance.
- MDwise should work with its providers to ensure that patient needs are being met properly and they understand they must take CareSource's insurance.

MHS

Throughout the 2025 ANA, MHS met the requirements for provider-to-member ratios on 100% of the provider categories. MHS also met the provider accessibility standards for 97.07% of its members, a decrease of 0.83 percentage points from the previous year's ANA. MHS should also consider reviewing its provider directory issued to members for completeness and accuracy.

Throughout the Secret Shopper Survey, MHS decreased its wait time compliance from 70.77% to 60.00%. This standard continues to need improvement. Likewise, MHS should ensure that all contracted providers are properly trained, as the most prevalent reason for the Secret Shoppers to not obtain an appointment was the provider not accepting Medicaid or MHS's insurance or not accepting new patients.

For these reasons, Qsource offers the following recommendations:

- MHS should continue to improve its provider-to-member ratios.
- MHS should continue to improve its provider accessibility standards.
- MHS should work to increase its provider directory accuracy.
- MHS should work to increase appointment wait time compliance.
- MHS should work with its providers to ensure that patient needs are being met properly and they understand they must take MHS's insurance.

UHC

Throughout the 2025 ANA, UHC met the requirements for provider-to-member ratios on 100% of the provider categories. UHC also met the provider accessibility standards for 98.60% of its members, an increase of 7.5 percentage points from the previous year's ANA. However, UHC should consider reviewing its provider directory issued to members for completeness and accuracy.

Throughout the Secret Shopper Survey, UHC decreased its wait time compliance from 77.63% to 70.00%. Likewise, UHC should ensure that all contracted providers are properly trained, as the most prevalent reason for the Secret Shoppers to not obtain an appointment was the provider not accepting Medicaid or UHC's insurance or not accepting new patients.

For these reasons, Qsource offers the following recommendations:

- UHC should continue to improve its provider-to-member ratios.
- UHC should continue to improve its provider accessibility standards.
- UHC should work to increase its provider directory accuracy.
- UHC should work to increase appointment wait time compliance.
- UHC should work with its providers to ensure that patient needs are being met properly and they understand they must take UHC's insurance.

Protocol 9: Conducting Focus Studies of Health Care Quality

Overview

OMPP engaged Qsource to perform the CMS mandatory and optional EQR activities. Qsource engaged Myers and Stauffer to assist in the EQR, which included designing and conducting Indiana's Protocol 9 activities, evaluating MCE clinical and non-clinical performance. For Protocol 9, OMPP selected two focus study topic areas for MY 2024:

- MCE Performance in Depression Screening and Timely Follow-Up
- MCE High Risk Diabetes Care Management and Care Coordination Strategies

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

Study 1 Background

Depression is one of the most commonly diagnosed mental illnesses among adult Medicaid beneficiaries, affecting an estimated 4 million individuals in 2021. Medicaid is the largest payer of mental health services in the United States with more than one in three (35%) adult Medicaid beneficiaries diagnosed with a mental illness. In 2019, Medicaid allocated more than $58 billion on mental health care and an additional $17 billion to substance use care, in part because Medicaid costs are more than doubled in patients with mental illness.

Playing a part in the growing mental health crisis in America is the fact that, as of 2021, nearly 130 million individuals resided in a federally designated mental health care Health Professional Shortage Areas. This means less than one third of the United States' population has adequate access to mental health professionals. Less than 40% of states have the mental health care workforce necessary to meet the needs of their population. Furthermore, fragmented care coordination often results in patients receiving disjointed or inconsistent treatment, which can lead to poorer health outcomes. These barriers are particularly damaging to underserved populations, where delayed or absent care contributes to the worsening of symptoms and increases the long-term costs of untreated mental illness.

Early identification is crucial, as untreated depression can severely impact an individual's quality of life, and is linked to substance abuse, chronic disease, and increased risk of suicide. Early identification of mental health disorders enables timely treatment, reducing the risk of the condition becoming more severe. To identify a diagnosis of depression, individuals must

be screened for depressive symptoms. Depression screening is the process of systematically identifying individuals who may be experiencing depressive symptoms using standardized tools. Commonly used standardized depression screening tools include the Patient Health Questionnaire (PHQ)-2 and PHQ-9. A positive depression screen indicates a patient may be experiencing symptoms consistent with depression and warrants further evaluation or intervention.

Follow-up after a positive screen involves a range of actions, including diagnostic assessment, referral to behavioral health services, initiation of treatment, or ongoing monitoring and support to ensure continuity of care. Timely follow-up ensures individuals who screen positive are connected to appropriate care, addressing critical behavioral health care needs. Depression screening and timely follow-up are essential for early identification and intervention, which can significantly improve patient outcomes, reduce the severity and duration of depressive episodes, and prevent associated complications such as suicide, substance use, and chronic disease.

Health plans play a critical role in ensuring follow-up is conducted and specified timeframes are met. Health plans are required to adhere to quality standards that often include performance measures related to behavioral health. NCQA manages and maintains HEDIS®, which is the mechanism by which evidence-based treatments are regularly measured. For MY 2023, the HEDIS® Depression Screening and Follow-up for Adolescents and Adults (DSF-E) measure defines timely follow-up care within 30 days after a positive depression screen. CMS also measured depression screening and follow-up as part of the Adult and Child Core Sets with the measure segmented by age stratification. While HEDIS® had two measures specifically for depression screening and follow-up in the prenatal and postpartum populations in MY 2023, CMS only began including these measures as part of the Core Set for the prenatal and postpartum populations in MY 2024. The relevant measures are as follows:

- NCQA Measure: Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
- NCQA Measure: Prenatal Depression Screening and Follow-Up (PND-E)
- NCQA Measure: Postpartum Depression Screening and Follow-Up (PPD-E)
- CMS Measure: Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF) – Child Core Set
- CMS Measure: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF) – Adult Core Set

These measures assess performance of depression screening and timely follow-up among the Medicaid population. The aim of this focus study is to evaluate depression screening and follow-up practices across MCEs, identify protocols in place at the MCE-level, and understand the barriers and enablers influencing screening and follow-up.

Study 1 Purpose and Objectives

Focus Study 1 evaluated and compared MCE performance in depression screening and timely follow-up, during MY 2024. Specifically, the objectives of the study were to address the following questions for MY 2024:

1. How do MCEs compare in completion of depression screenings?
2. How does the rate of timely follow-up after a positive depression screen compare across MCEs?
3. What current depression screening and follow-up protocols/practices exist and what are the barriers and enablers to follow-up, at each MCE?

Technical Methods of Data Collection and Analysis

The study evaluated the five MCEs approach to depression screening and follow-up across the Indiana Medicaid IHCPs during MY 2024. A mixed methods study design was used to collect quantitative and qualitative data to address the study objectives. MCEs were requested to (1) complete a 34-question self-report survey about MCE-level protocols, measure performance, and perceived enablers and barriers related to depression screening and follow-up; (2) submit report *0514 Care and Complex Case Management Report – Physical and Behavioral Health Conditions of Interest*; (3) submit patient-level data used to compile the Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) HEDIS® measure; (4) submit MCE-level policies and procedures related to depression screening and follow-up; and (5) submit a process map outlining the completion of depression screening for members. A minimum submission review (MSR) was performed to ensure all requested information was received, accessible, and relevant. When issues occurred, the MCE was contacted to submit updated information through a Request for Information (RFI) process. Complete data were organized and analyzed by study objective and are presented in the findings section of the report. This study was conducted in accordance with the 2023 CMS External Quality Review Protocols Guide.

Findings

All MCEs had formal depression screening and follow-up after a positive screen policies and protocols in MY 2024, with all MCEs integrating protocols at the organizational level. While all MCEs report having pregnant- or postpartum-specific depression screening protocols, implementation by each MCE varied. All MCEs had standardized referral processes to care management after a positive screen, consistent follow-up and monitoring, and immediate action protocols for crisis situations. However, while implementation of processes for screening were very similar (e.g. tools used, setting administered), implementation of processes, such as how follow-up was

completed or the tools used to trigger care, following a positive screen differed across MCEs.

When evaluating screening and follow-up performance, while generally aligned with national Medicaid HMO rates, screening rates were low among MCEs, indicating a need for improvement across the board. However, among those who were screened, follow-up rates were significantly higher, also in alignment with national Medicaid HMO rates. Overall, MCE performance was relatively consistent across programs. This suggests that an MCE's overall approach to depression care is likely consistent across different health programs. Notably, there was alignment among barriers and enablers for depression screening and follow-up. Specifically, patient attitudes, referral processes, and Electronic Health Record (EHR) integration were highlighted as key factors, each presenting distinct challenges and opportunities that should be addressed to facilitate early detection and timely intervention of depression.

Finally, general guidelines/requirements, incentives, and performance measures for depression screening and follow-up were generally absent from MCE contracts.

Strengths, Weaknesses, and Conclusions

To improve depression screening rates, it is vital for OMPP to understand the enablers and barriers that affect routine screening, or lack thereof, to identify members with depression. MCEs were asked to identify their top five enablers and barriers from a list of provided options. Barrier options included: lack of integrated EHR system or prompt to identify patients who need to be screened, lack of time during visits, lack of training or guidelines on screening requirements, patient language or literacy barriers, patient refusal, provider attitudes, provider availability, reimbursement concerns, and screening modalities allowed to be utilized. Enabler options included: cultural competence tools, EHR integration, patient-provider relationship, patient willingness, standardized protocols, team-based care models, and training for providers. MCEs also had the opportunity to specify barriers and enablers not listed.

While survey responses were mixed, the top enablers and barriers identified by MCEs are provided in Figure 115 and Figure 116 below.

Figure 115. Enablers to Depression Screening

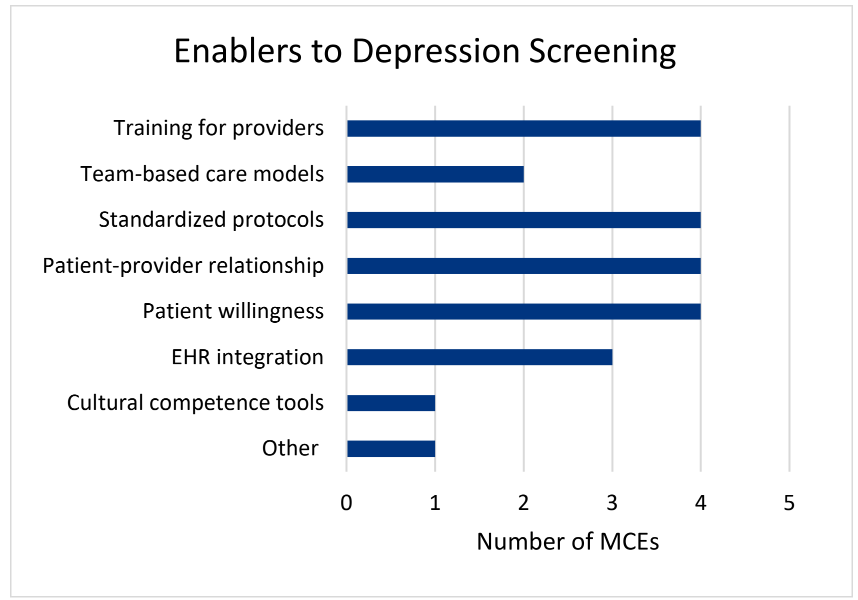
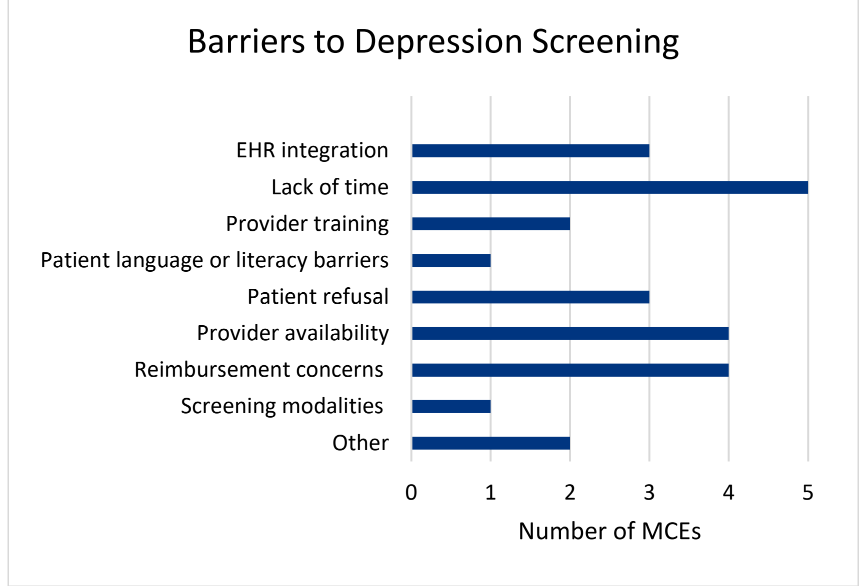


Figure 116. Barriers to Depression Screening



Notably, enablers and barriers related to patient attitudes and EHR integration emerged as critical factors, acting as both significant enablers and barriers. Additionally, accessibility and efficiency of care were highlighted as major concerns, with MCEs citing time constraints and provider availability as key barriers to depression screening. Addressing these issues could be pivotal in improving depression screening rates.

Similarly, MCEs were asked to identify their top five enablers and barriers to timely follow-up after a positive depression screening. MCEs were asked to select from a list of options, including inadequate referral process, lack of an integrated EHR system, limited follow-up resources/resource availability, member engagement/no show rates, patient language or literacy barriers, provider availability, reimbursement concerns, and socioeconomic factors. MCEs also had the opportunity to specify barriers not listed. The top barriers and enablers are presented in the figure below.

Figure 117. Enablers to Timely Follow-Up

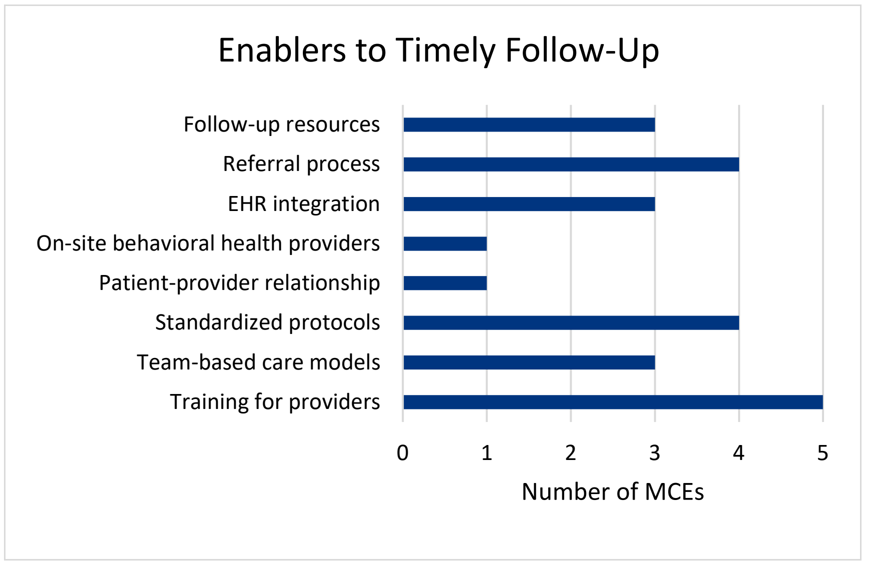
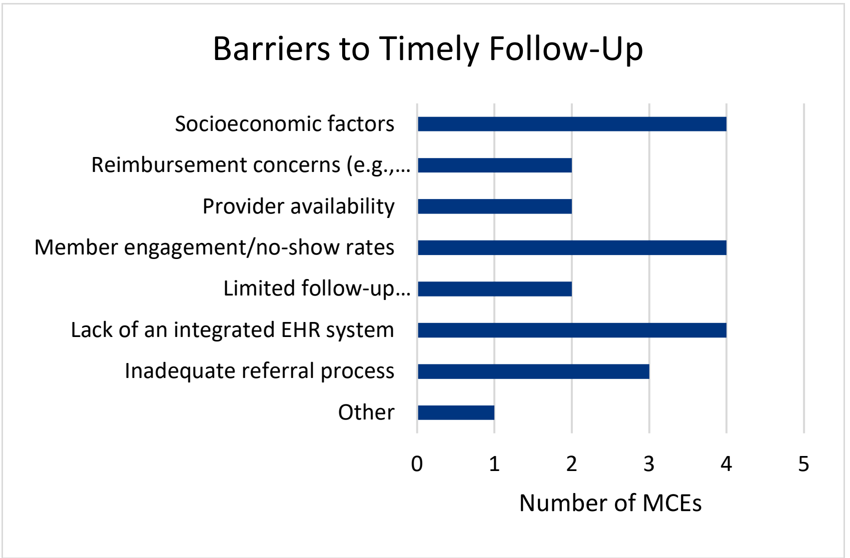


Figure 118. Barriers to Timely Follow-Up



While the specific enablers and barriers varied significantly among MCEs, there was noticeable alignment regarding those related to referral processes. Additionally, training for providers was ranked in the top five enablers by all MCEs, with standardized protocols being the highest ranked enabler to follow-up among MCEs.

Conclusions

All MCEs have formal depression screening and follow-up after a positive screen policies and protocols, with all MCEs integrating protocols at the organizational level. While all MCEs report having pregnant or postpartum specific depression screening protocols, implementation by each MCE varied, and generally did not align with the American College of Obstetricians and Gynecologists' screening recommendations for screening pregnant and postpartum members.

All MCEs used the Health Needs Screening (HNS) for new members and had standardized referral processes to care management after a positive screen, consistent follow-up and monitoring, and immediate action protocols for crisis situations. To conduct screenings, MCEs generally used the same depression screening tools. Perinatal or postpartum visits, annual well visits, and chronic care management visits were the most common settings for administering depression screenings, with screenings being primarily administered either in-person,

by phone, or via the patient portal outside of an office visit. While implementation of processes for screening were very similar, implementation of processes following a positive screen differed across MCEs (e.g. how follow-up was completed or the tools used to trigger care).

Key infrastructure components related to screening and follow-up at the MCE and MCE-to-Provider level were also assessed. Responses by MCEs on training for providers, data sharing capabilities, and review and evaluation processes differed. Responses indicated MCEs are in different places from an infrastructure perspective, as some offer training to their provider network, most but not all have data sharing systems in place, all had care management programs to address depression, and most but not all regularly reviewed and evaluated follow-up data.

When evaluating screening and follow-up performance, while generally aligned with national rates, screening rates were low among MCEs, indicating a need for improvement. However, among those who were screened, follow-up rates were significantly higher, also in alignment with national rates. Overall, MCE performance was relatively consistent across programs. This suggests that an MCE's overall approach to depression care is likely consistent across different health programs.

Notably, there was alignment among barriers and enablers for depression screening and follow-up. Specifically, patient attitudes, referral processes, and EHR integration were highlighted as key factors, each presenting distinct challenges and opportunities that should be addressed to facilitate early detection and timely intervention for depression management.

Finally, general guidelines/requirements, incentives, and performance measures for depression screening and follow-up were missing from MCE contracts, except for one contract.

Recommendations

- Establish OMPP-specific depression screening and follow-up goals and targets, clearly defining activities and timeframes based on measure specifications;
- Develop policies that strengthen use of evidence-based depression screening protocols, inclusive of tools, methods, and frequency for conducting screenings;
- Encourage and support enhancing MCE and Provider infrastructure to aid in the sharing of depression screening and follow-up data;
- Promote regular review of screening and follow-up data by MCEs to identify opportunities to improve rates;
- Consider including depression screening and follow-up measures in the Pay-for-Outcomes (P4O) Program; and
- Consider offering incentives related to depression screening and follow-up in MCE contracts, encouraging or mandating provider training as a component to earn the incentive(s).

Study 2 Background

Diabetes is a major health concern. A study forecasting prevalence based on major risk factors projects U.S. diabetes prevalence will reach 55 million people by 2030, roughly 43% higher than the current prevalence of 38.4 million[2]. The growing burden of diabetes has prompted national efforts to adopt more coordinated care models that enhance patient engagement and strengthen provider support through health plan collaboration.

The Americans with Disabilities Act (ADA) 2025 Standards of Medical Care in Diabetes reflect the continued shift toward more coordinated care. Updated guidelines endorse team-based care as the standard for diabetes management. The ADA also emphasizes strategies that empower patients to take an active role in their care, improve access and ease of care delivery, and expand care teams to enhance patient support. For instance, the ADA recommends Diabetes self-management education and support (DSMES) for all people with diabetes or at minimum when not meeting treatment goals. The goal of DSMES is to equip individuals with the knowledge and skills needed to make informed choices, manage their own care, address challenges, and work closely with their healthcare team to achieve improved health outcomes. Furthermore, the ADA also indicates the importance of offering both in-person and virtual care options, enabling convenient and frequent contact based on patient needs. The use of digital tools such as mobile applications for self-monitoring and continuous glucose monitoring systems are promoted as they improve patients' ability to track their glycemic status and make lifestyle adjustments. Also highlighted in ADA standards is the importance of assessing SDOHs such as food insecurity, and social support, as critical inputs into treatment plans. Lastly, a core element of the ADA's updated framework is the integration of a multidisciplinary care team that extends beyond the traditional patient-physician relationship. The inclusion of care coordinators, care managers, and disease management specialists is promoted. Each team member contributes self-management support, facilitates more consistent engagement with the patient, and plays a key role in coordinating services. This collaborative structure is designed to meet patients where they are and strengthen the overall continuity of care.

Shifts towards these updated standards are seen in alternative payment models, such as Patient-Centered Medical Homes (PCMHs). According to the Kaiser Family Foundation analysis of state Medicaid budgets, in fiscal year 2023 at least 24 states reported that a portion of their Medicaid members are served through a PCMH. The ADA highlights care models such as the PCMH for their potential to improve diabetes outcomes,

[2] Rowley, W. R., Bezold, C., Arikan, Y., Byrne, E., & Krohe, S. (2017). Diabetes 2030: Insights from yesterday, today, and future trends. *Population Health Management, 20*(1), 6–12. https://doi.org/10.1089/pop.2015.0181.

emphasizing team-based chronic disease management and patient education and support. A critical component of a PCMH practice includes care management, "which has already been shown to be among the most effective quality improvement strategies for glycemic control". Within PCMHs, care management teams are tasked with identifying high-risk patients—such as those with poorly controlled HbA1c levels or multiple comorbidities—and delivering individualized interventions. Care managers coordinate specialist referrals, schedule follow-ups, reconcile medications, and ensure the member has access to transportation, food, or other SDOH resources. Complementing these efforts, disease management programs provide condition-specific education, conduct routine outreach, and monitor patient progress over time. Functioning as a unified entity, the PCMH model provides an opportunity to deliver more seamless and patient-centered care by integrating all components of the care team within the same organization.

Similar to the PCMH model, efforts to enhance care coordination are also emerging in more traditional care settings. Evidence shows that introducing structured, team-based approaches in primary care and hospital environments can significantly improve outcomes for people with type 2 diabetes. Team-based care involves a team of multidisciplinary healthcare professionals working together to provide patient-centered care. Multidisciplinary teams include nurses, pharmacists, dietitians, and diabetes care specialists, working alongside physicians to provide routine monitoring, self-management education, medication adjustments, and lifestyle counseling. These interventions have been associated with meaningful improvements, including an average HbA1c reduction of 0.5% and better blood pressure and lipid control.

OMPP has implemented a comprehensive diabetes strategic plan for 2022–2026, inclusive of goals to enhance provider awareness and expand access to diabetes self-management resources. In 2025, the state aimed to improve healthcare provider knowledge of Indiana Medicaid's coverage for diabetes self-management technologies, such as continuous glucose monitors and insulin pumps. Similarly, in 2025, Indiana planned to increase the number of accredited DSMES programs across the state by 10%. Key strategies to achieve these goals include assessing Medicaid coverage for DSMES programs to ensure alignment with national standards and confirming that DSMES providers are included in, and reimbursed by, Medicaid managed care networks. Additional strategies include developing guidance for providers to increase awareness and utilization of the Indiana Medicaid Preferred Diabetes Supply List and clarifying steps for coverage of supplies not currently listed; and recommending improvements to Indiana Medicaid coverage policies to optimize access and care delivery.

In the 2024-2027 Quality Strategy, OMPP embedded diabetes related objectives within two of the "5 Pillars of Well Being": (1) Behavioral Health; and (2) Chronic Conditions. As part of the behavioral health goal, aiming to "improve health outcomes through preventive care and behavioral health condition

management", OMPP requires the Diabetes Monitoring for Persons with Diabetes and Schizophrenia (SMD) HEDIS® measure be monitored across all health programs, to improve health screenings and follow-up. Additionally, as part of the chronic conditions goal, to "improve the health of members with chronic conditions", OMPP requires three HEDIS® measures be monitored to "improve health and reduce complications for members diagnosed with diabetes". The three HEDIS® measures include: (1) HbA1c Testing; (2) Hemoglobin A1c Control for Patients with Diabetes: Poor Control, and (3) Hemoglobin A1c Control for Patients with Diabetes. MCEs are required to report the above metrics across all health programs, annually.

Moreover, OMPP leverages programs to promote health outcomes. Contracted MCEs are required to participate in a Pay-for-Outcomes program, which focuses on incentivizing progress toward goals outlined in the Five Pillars of Well-Being framework. OMPP works closely with MCEs to select goals and performance measures to track program outcomes per Indiana health program. Benchmarks are reviewed annually and may be adjusted based on national standards or technical specification updates. The diabetes measure, HBD – Hemoglobin A1c Control for Patients with Diabetes, is incorporated into HIP and HCC P4O program. Each measurement year, OMPP withholds a designated percentage of approved capitation payments from MCEs, which may be earned back based on performance against selected measures.

In addition to the P4O program, MCEs are required to develop and implement a Provider Incentive Program, which is a performance-based provider incentive program between the MCE and its providers. MCEs are given flexibility with the design and payment methodology used so long as it is within one of the OMPP-determined focus areas: (1) tobacco cessation; (2) substance use disorder treatment; (3) chronic disease management; or (4) employment related incentives, and complies with regulations outlined in Section 1876(i)(8) of the Social Security Act and federal regulations 42 CFR 438.10(f)(3), 42 CFR 422.208, and 42 CFR 422.210. Prior to implementation, the MCE must obtain OMPP approval of the program design.

In 2024, CareSource, Anthem, MDwise, and MHS launched diabetes-related Provider Incentive Programs. These Provider Incentive Programs focus on improving glycemic control and reducing complications among members with diabetes through enhanced care coordination and proactive outreach. CareSource and Anthem emphasized provider engagement and member education to support better diabetes self-management and clinical follow-up. MDwise focused on increasing enrollment of diabetic members into disease and case management programs by identifying high-risk individuals through health screenings and automatically referring them to care coordination services. Similarly, MHS used targeted data analytics to identify members in need of follow-up care and ensure consistent HbA1c monitoring. Across all four Provider Incentive Programs, common strategies include member identification through

claims or health risk assessments, referrals to care or case management, routine HbA1c screening, individualized goal-setting, and ongoing tracking of clinical outcomes.

Lastly, OMPP outlines diabetes care expectations though MCE contracts. MCEs are required to support care planning and care coordination for members with chronic conditions, including diabetes, through structured care and disease management programs. These programs must include proactive member outreach, individualized care planning, coordination across providers, and regular follow-up to support glycemic control and prevent complications. MCEs are also responsible for ensuring timely access to necessary diabetes-related services such as lab testing and glucose monitors.

Study 2 Purpose and Objectives

Focus Study 2 evaluated and compared the MCEs' high-risk diabetes care management and care coordination strategies.

Specifically, the objectives of the study were to address the following questions for MY 2024:

- For MY 2024, how do MCEs' rates of members HbA1c levels and members with poorly controlled HbA1c levels compare?
- For MY 2024, how do MCEs' rates of members with poorly controlled HbA1c levels enrolled in care management programs compare?
- How do MCEs compare in their strategies to assist providers in identifying and resolving cases of persistently high HbA1c levels (i.e. members with poor control)?
- What approaches are MCEs using to target members not adherent to care regiments, how is disease management involved in these approaches, and what barriers and enablers exist to enhance member engagement?

Technical Methods of Data Collection and Analysis

The study evaluated the five MCEs approach to high-risk diabetes care management and care coordination strategies across the Indiana Medicaid Managed Care programs, excluding Indiana Pathways for Aging, during MY 2024. A mixed methods study design was used to collect quantitative and qualitative data to address the study objectives. MCEs were requested to (1) complete a 26 question self-report survey about MCE-level diabetes care management and disease management programs, patient outreach policies and provider supports; (2) submit report *0515: Disease Management Report - Physician and Behavioral Health Conditions of Interest*; (3) submit MCE-level policies and procedures related to outreach protocols for engaging non-adherent members with diabetes; and (4) submit a report of all care management participants from MY 2024. An MSR was performed to ensure all requested information was received, accessible, and relevant.

When issues occurred, the MCE was contacted to submit updated information through an RFI process. Complete data were organized and analyzed by study objective and are presented in the findings section of the report. This study was conducted in accordance with the 2023 CMS External Quality Review Protocols Guide.

Findings

MCE-Reported MY 2024 Diabetes Outcomes

Within the document request, MCEs were asked to self-report numerators, denominators, and rates related to the Glycemic Status Assessment for Patients with Diabetes (GSD) HEDIS® measure, for each IHCP the MCE participates in. Specifically, MCEs were asked to provide data on: (1) percent of adult members aged 18-75 years with diabetes whose HbA1C <8% during MY 2024; (2) percent of adult members with diabetes whose HbA1C was >9% during MY 2024; and (3) percent of all adult members with diabetes out of all members aged 18-75 during MY 2024. All MCE-reported measure outcomes, excluding MDwise due to data discrepancy issues, are provided in **Table 57**.

Table 57. MCE Reported Diabetes Outcomes by Program for MY 2024

Program	Measure	Anthem	CareSource	MHS*	UHC
HCC	A1C < 8%	40.8%	-	27.6%	24.6%
	A1C > 9%	53.0%	-	68.9%	72.2%
	Total % Diabetes	10.5%	-	12.9%	6.1%
HHW	A1C < 8%	37.6%	47.7%	24.8%	-
	A1C > 9%	55.9%	45.5%	74.3%	-
	Total % Diabetes	0.08%	0.61%	0.83%	-
HIP	A1C < 8%	42.9%	37.1%	30.0%	-
	A1C > 9%	51.5%	56.8%	66.2%	-
	Total % Diabetes	8.3%	4.8%	6.1%	-

**MHS excluded pregnant members – other MCEs adhered to HEDIS® specifications.*

Notably, all MCEs reported greater than 50% of members with diabetes as "poorly controlled" for all programs, with the exception of CareSource's HHW members. Additionally, rates calculated for the percentage of total diabetes in the HHW program for Anthem, CareSource, and MHS were very low due to a small, reported number of adult members with diabetes compared to total adult members. Anthem reported 245 diabetic members out of nearly 300,000 total members, CareSource reported 44 diabetic members out of approximately 7,200 total members, and MHS reported 101 diabetic members out of nearly 12,200 total members. Future evaluations should consider in-depth reviews into these reported rates to understand if members are missing in the counts and/or why the total number of diabetic members is reportedly so low.

MCEs were also asked to provide three patient-level data universes, one that was used to compile the Glycemic Status Assessment for Patients with Diabetes (GSD) HEDIS® measure, one for the Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD) HEDIS® measure, and one for the Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) HEDIS® measure, inclusive of each IHCP the MCE participates in. Patients included in the submitted data universes were used to create the subsample Myers and Stauffer extracted from the Medicaid Management Information System (MMIS) for claims encounter analyses. Because this subsample was created based on the three HEDIS® measures, these analyses are limited by the eligible population criteria for these measures. Notably, for two of the measures (GSD and SMD) members must have diabetes to be included; this requirement does affect the analysis outcomes.

Further, the number of patients provided in the data universes varied across MCEs, with Anthem providing the largest sample, followed by MDwise, MHS, CareSource, and UHC. Some of the variance is due to the number of IHCPs an MCE participates in. The total member counts and member counts by health program for each MCE are provided **Table 58**.

Table 58. MCE Total Member Counts by Health Program

MCE	Program	Member Count
Anthem	HCC	6,924
	HHW	401
	HIP	32,831
	Total	40,156
CareSource	HHW	73
	HIP	5,361
	Total	5,434
MDwise	HHW	301
	HIP	14,568
	Total	14,778
MHS	HCC	2,983
	HHW	199
	HIP	10,399

Table 58. MCE Total Member Counts by Health Program		
MCE	**Program**	**Member Count**
	Total	13,581
UHC	HCC/Total	545

Across the MCE subsample populations, the diabetes prevalence was at least 70% for all MCEs except UHC, with most diabetic members enrolled in either the HIP or HCC programs. Given that the sample population was drawn from the data universe, high rates of diabetes are expected. When assessing the percentage of members in each program diagnosed with diabetes, greater than 50% of members in each IHCP across all MCEs from the subsample were diabetic. Future in-depth analyses could assess how each MCE's diabetes population compares relative to its total membership.

Across each MCE subsample population, a sizable portion of members did not have a clear HbA1c glucose test result attached to their claims. In this subsample, the majority of members had 'good control' followed by 'poor control' status. However, determining accurate trends when large proportions of the data are unknown is not possible. Future studies should consider evaluating diabetes control status by health program, using larger sample sizes vs using the subsample, and addressing coding limitations, given the increased health risk with higher HbA1c levels and the high percentages of poorly controlled members reported by the MCEs. Additionally, future evaluations should review data for those classified as "prediabetic" as well as assess the "between status" groups in greater depth, given both groups are at risk of transitioning into glycemic status categories that are more harmful to their health. Assessing the "between status" could be of utmost importance given these members are no longer in good control and mitigating the risk of moving to poor control can have great impacts on health outcomes.

MCE-Reported MY 2024 Schizophrenia Population Diabetes Outcomes

Within the document request, MCEs were asked to report numerators, denominators, and rates related to the Diabetes Screening for People with Schizophrenia or Biploar Disorder Who Are Using Antipsychotic Medications (SSD) and the Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) HEDIS® measures, for each program the MCE participates in. Specifically, MCEs were asked to provide data on:

1. SSD measure outcomes reported to HEDIS®;
2. SMD measure outcomes reported to HEDIS®;
3. Members aged 18-75 with only schizophrenia or schizoaffective disorder during MY 2024;
4. Members aged 18-75 with only schizophrenia or schizoaffective disorder screened for diabetes during MY 2024;
5. Members aged 18-75 with diabetes and schizophrenia or schizoaffective disorder relative to total members with diabetes during MY 2024;

6. Members aged 18-75 with diabetes whose most recent glycemic status or glucose management indicator was > 9%, who also had schizophrenia or schizoaffective disorder relative to total diabetic members with glycemic status > 9% during MY 2024.

The additional MCE-reported measures were requested in order to only assess the schizophrenic population, since the SSD HEDIS® measure includes bipolar disorder as well. All MCE-reported measure outcomes are provided in the tables below, with HEDIS® reported measures in **Table 59** and the additional MCE-reported measures in **Table 60**.

Table 59. MCE HEDIS® Reported Schizophrenia Population Diabetes Outcomes by Program for MY 2024

Program	HEDIS® Measure	Anthem	CareSource	MDwise	MHS*	UHC
HCC	SSD	83.2%	-	-	81.9%	82.4%
	SMD	78.6%	-	-	76.6%	56.0%
HHW	SSD	81.4%	87.5%	74.2%	85.1%	-
	SMD	100%	0%	100%	0%	-
HIP	SSD	83.7%	83.5%	80.9%	83.4%	-
	SMD	76.3%	72.7%	68%	65.7%	-

**MHS excluded pregnant members – other MCEs adhered to HEDIS® specifications.*

All MCE programs HEDIS® reported measures indicated greater than 80% of bipolar and schizophrenic members were screened for diabetes, with the exception of MDwise's HHW program (74.2%). Further, schizophrenic members with diabetes were monitored at rates ranging from 56% (UHC) to 100% (n=1, MDwise), with most MCEs monitoring between 65% and 79% of these members.

Table 60. MCE Reported Schizophrenia Population Diabetes Outcomes by Program for MY 2024

Program	Measure	Anthem	CareSource	MDwise	MHS*	UHC
HCC	Schizophrenia Screen	54.5%	-	-	76.6%	41.2%
	Schizophrenia Diabetes	9.4%	-	-	10.5%	3.0%
	Schizophrenia A1C >9%	9.7%	-	-	10.1%	1.3%
HHW	Schizophrenia Screen	60.0%	47.3%	100%	0%	-
	Schizophrenia Diabetes	0.41%	2.2%	0.61%	0%	-

Table 60. MCE Reported Schizophrenia Population Diabetes Outcomes by Program for MY 2024

Program	Measure	Anthem	CareSource	MDwise	MHS*	UHC
	Schizophrenia A1C >9%	0%	0.61%	0%	0%	-
HIP	Schizophrenia Screen	51.3%	70.5%	68%	65.7%	-
	Schizophrenia Diabetes	1.3%	1.6%	1.3%	1.3%	-
	Schizophrenia A1C >9%	12.7%	4.8%	0.81%	1.2%	-

**MHS excluded pregnant members per MSLC instruction – other MCEs adhered to HEDIS specifications.*

When reviewing the additional schizophrenia population measures reported by MCEs, it is important to note the MCEs had to pull and calculate these data themselves, and there are slight differences in the methods each used to complete the request. Overall, the percentage of members with schizophrenia or schizoaffective disorder, only, compared to the combined population of schizophrenia and bipolar, appears to decrease for all MCEs and programs except MDwise HHW (41.2% - 76.6%). Current measures assessed the percent of schizophrenic members with diabetes and poorly controlled diabetes to the total diabetic population and total poorly controlled diabetic population, respectively. Rates of diabetes ranged from 0.41% - 10.5%, and rates of poorly controlled diabetes ranged from 0.61% - 12.7%. The low percentages in comparison to the MCEs reported general diabetes and poorly controlled percentages and percentages reported in the literature indicate future studies should review these rates relative to the schizophrenic population.

Because the literature indicates patients with schizophrenia experience higher rates of diabetes compared to the general population, additional analyses were conducted to examine diabetes health outcomes within the MCEs schizophrenia population using the MCE subsample described previously. Proportions of the schizophrenic population within each MCE sample were low with four MCEs at or below 5% and UHC at 13.4%. Schizophrenic population sample sizes ranged widely across MCEs, as expected given total member count variations, with Anthem having the largest sample followed by MDwise and MHS. While UHC has the smallest sample sizes, it had the largest proportion of members with schizophrenia. The percentage of schizophrenic members enrolled in the IHCPs ranged by health program with 10% or more of members in the HCC programs being diagnosed with schizophrenia, while 10% or less of both HHW and HIP were diagnosed with schizophrenia. Future studies could further evaluate the proportion of the schizophrenic population among MCEs total membership and perform more in-depth analyses within the

schizophrenic population at both the MCE and health program level.

Care Management and Patient Engagement

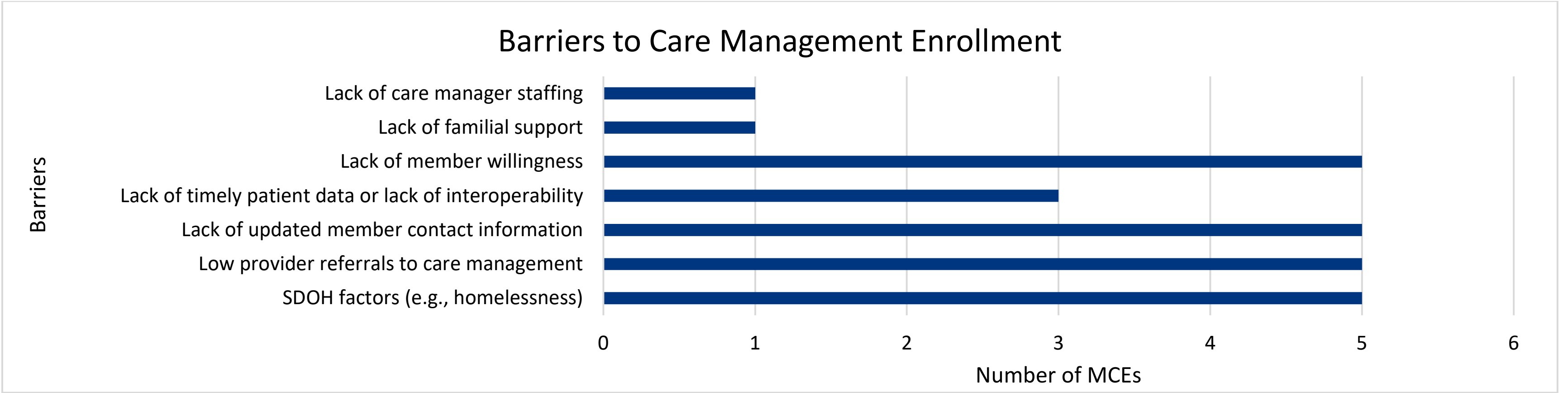
Although at least 60% of each MCE's subsample population had diabetes, the proportion of members enrolled in care management in MY 2024 varied significantly across MCEs. Anthem and MDwise had the largest total MCE sample population sizes but substantially fewer number of members enrolled in care management compared to CareSource and UHC. Notably, Anthem and MDwise also had the highest proportions of diabetic members within their sample populations, at least 74%, while UHC had the lowest proportion at 60%. The number of members with poorly controlled diabetes enrolled in care management was very low for all MCEs, therefore the proportions of poorly controlled members enrolled in care management relative to total members enrolled in care management were very low for all MCEs as well (2.92%-4.89%).

From the MCE subsample data, the proportion of members with poorly controlled diabetes relative to the total population of poorly controlled diabetic per MCE was assessed. Anthem had the largest population of members with poorly controlled diabetes (2,117 members) but the second lowest number of poorly controlled members enrolled in care management (6 members). MDwise had a similar pattern, with 423 members with poorly controlled diabetes but only 5 enrolled in care management in MY 2024. Conversely MHS had the second largest population with poor control (572 members) with roughly 50% of members (284 members) enrolled in care management in MY 2024. The potentially low rates of care management enrollment pose an opportunity for improvement; future studies should use a larger sample size and potentially other data sources to confirm low rates.

Care management and disease management are programs required by OMPP as part of MCE contracts. Given that each of Indiana's health programs serve different populations, requirements vary by contract. Overall, OMPP has established guidelines requiring that all members be screened within 90 days of enrollment. The initial screening is intended to determine the need for care management, disease management, or complex case management. Following screening, MCEs are required to assign members to a care level and develop a care plan tailored to each member's needs.

As part of the high-risk diabetes survey, MCEs were asked to rank their top five barriers to care management enrollment from a list of options including: the enrollment process, care manager staffing, member familial support, member educational materials, member willingness, timely patient data or lack of interoperability, updated member contact information, low provider referrals, and SDOH factors. Respondents could also specify additional barriers not listed. Subsequently, MCEs were asked to indicate the strategies used to reduce the identified barriers. The barriers reported by MCEs are presented in Figure 119 below.

Figure 119. MCE Reported Barriers to Care Management Enrollment



Among the barriers identified by MCEs, the most frequently cited were SDOH factors, low provider referrals to care management, lack of updated member contact information, and lack of member willingness. However, most of the reported barrier reduction strategies focused on obtaining accurate contact information through additional data sources such as claims, Health Information Exchange (HIE) data, pharmacy records, or home visits. Few strategies targeting the other major barriers were discussed. To encourage member willingness, Anthem reported using member incentives tied to care management participation, and both Anthem and MDwise cited the use of motivational interviewing to engage members. Only one MCE (MDwise) described a strategy to address SDOH barriers, and one MCE (MHS) noted addressing provider engagement through site visits.

Although not unanimously noted as a barrier among MCEs, Anthem, MHS, and MDwise cited lack of timely patient data or lack of interoperability as a barrier to care management enrollment. MCEs noted predictive modeling as an approach to support identification of members who may benefit from care management programs. Timely member data and improved interoperability may be an opportunity to help these systems work more effectively. MCEs did not report strategies to reduce this barrier.

To further understand patient engagement, the high-risk diabetes survey included questions in which MCEs were asked to rank their top five barriers and enablers to member engagement from a list of options. Options for barriers included SDOH factors, behavioral health challenges, homelessness, lack of member willingness, lack of updated member contact information, and limited member awareness or understanding. Options for

enablers included care management, disease management, familial support, home visits, member incentive programs, member mobile apps, SDOH support, and transportation assistance.

Conclusions

The total percentage of members with diabetes for HCC and HIP, reported by MCEs, ranged from 4.8%-12.9%, while the rate for the HHW program was very low. Further, all MCEs reported greater than 50% of their members with diabetes were diagnosed as 'poorly controlled' for all health programs, with the exception of CareSource's HHW members. Additionally, all MCE programs' HEDIS® measures indicated greater than 80% of bipolar or schizophrenic members were screened for diabetes, with the exception of MDwise's HHW program, and that schizophrenic members with diabetes were monitored at rates generally between 65% and 79%.

Per MCE claims data subsample, most MCEs' member enrollment in care management was low, particularly for members with poorly controlled diabetes, highlighting opportunities for improvement. Marion, Lake, and St. Joseph counties consistently showed the highest prevalence of diabetes, comorbid schizophrenia, and poorly controlled diabetes, warranting further analysis and consideration for targeted interventions.

There were minimal differences observed between MCE care management programs; all programs met OMPP requirements. MCE disease management enrollment processes and intervention strategies varied more. While most MCEs reported no differences amongst the care management program design or services for schizophrenic members, three MCEs indicated differences among disease management programs. Evaluating different implementation strategies relative to member outcomes could offer additional insights into successful strategies to employ with these high-risk populations.

Alignment was noted in enablers and barriers to member engagement, with SDOH support identified as both the most significant enabler and a major barrier. Differences emerged in how MCEs monitor and flag negative A1c progression. While most MCEs reported quarterly monitoring, timelines were often unclear, and data sharing practices with providers varied in timeliness and approach. Provider engagement was generally reported on a quarterly basis, with interoperability cited as both an enabler and an opportunity to increase engagement frequency. Supporting infrastructure for A1c monitoring and data sharing could promote greater consistency across MCEs.

Recommendations

- Encourage MCEs to enhance efforts to align care management enrollment, particularly for members with poorly controlled diabetes;
- Encourage MCEs to invest in strategies that enable increased care management participation such as SDOH-focused initiatives, member incentives, and provider engagement;
- Encourage MCEs to introduce targeted interventions in high prevalence counties such as Marion, Lake, and St. Joseph;
- Consider policies/practices to encourage regular review of diabetes outcomes data, outlining minimum standards for frequency and timeliness of data sharing;
- Encourage MCEs to increase the frequency of provider engagement for high-risk diabetic members, with greater emphasis on data sharing and increased interoperability to support collaboration;
- Promote opportunities for member engagement strategies, including remote monitoring and diabetes self-management education and support programs;
- Support the expansion of provider incentives focused on diabetes outcomes and coordination.

2025 EQR Conclusions

Qsource conducted mandatory EQR activities for the OMPP program for MY 2024. 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.

PIP Validation

One of OMPP's goals is to continuously monitor quality improvement measures and strive to maintain high standards to improve the health of enrollees. OMPP contractually requires the MCEs to complete PIPs yearly. Analysis of each PIP revealed that the MCEs demonstrated an understanding of the improvement process by providing descriptions of the barriers and interventions, 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 PIPs regarding missing or incomplete information, which compromised Qsource's ability to evaluate and draw conclusions from the results and the validity of the study. MCEs used a Qsource developed PIP Summary Form (with accompanying PIP Summary Form Completion Instructions) and a PIP Validation Tool to standardize the process by which each MCE delivers PIP information to OMPP and Qsource. OMPP received PIP information and data quarterly for assessment, and this information was turned over to Qsource on an annual basis for further analysis and assessment. To facilitate ongoing improvement through technical assistance and education, Qsource and OMPP are administering CAPs to the MCEs based on the AONs found within the PIPs starting in MY 2025. These CAPs will facilitate growth in the plans and allow OMPP to continue to monitor the MCEs' PIPs as part of its Quality Strategy to ensure quality, timeliness, and access to care for its enrollees. Qsource further recommends that the MCEs ensure that they submit all pertinent PIP information to both OMPP and Qsource.

PMV

PMV is designed to assess the accuracy of reported quality and performance measures and determine the extent to which the reported rates follow the measure specifications and reporting requirements. Qsource validated processes and systems to determine the MCEs' ability to produce accurate, complete, and timely performance measure reporting. Qsource defined the scope of the validation to include OMPP-required metrics in administrative performance measures and HEDIS® performance measures. This validation included source data, reporting frequency, and format of those measures. In addition to

document review, Qsource's audit included a request to review each MCE's ISCA, to ensure that each MCE maintained a health information system that can accurately and completely collect, analyze, integrate, and report data on member and provider characteristics, and on services furnished to members.

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. No deficiencies were noted in the MCEs' processes for data collection.

There were a number of weaknesses found within the reporting of the performance measures themselves, however. Qsource and OMPP will work with the MCEs to develop better methods of compliance so that the MCEs can continue to administer quality and timely care for their members.

CA

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

Four of the five MCEs participated in both the 2021 and 2024 EQR Compliance Assessments; the exception being UHC, who was not a contracted MCE during the 2021 EQR performance period.

All MCEs achieved a High Confidence rating for overall Compliance Standards and File Review scores in the 2024 EQR, indicating an average of 90.00% or greater number of elements were met. It was noted that 14 of the 16 Standards evaluated for 2024 CA achieved a 100% compliance score across all MCEs; Compliance Standard categories that exhibited less than 100% compliance in terms of performance include Grievance and Appeals Systems and Disenrollment Requirements and Limitations. Additionally, the Grievances and Appeals file review categories reflect the lowest compliance ratings received among the MCEs' File Review scores for the 2024 CA. The MCEs included evidence of internal adjustments implemented to rectify all elements identified as noncompliant and portrayed

active quality assurances to mitigate current and future maintained compliance. Qsource recommends the continued alignment of CFR Compliance Standards with OMPP quality metrics to assess MCE process updates.

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. This work is followed up on through the use of the Secret Shopper Survey, where surveyors check appointment availability and wait times in the guise of a member to ensure that members are receiving the care that the providers claim. 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.

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. Additionally, the MCEs should ensure that providers accept insurance through the MCEs, as this was one of the biggest barriers to receiving a new patient appointment, as found through the Secret Shopper Survey.

Conducting Focus Studies for Health Care Quality

To address each goal within OMPP's Quality Strategy, OMPP makes use of the optional Protocol 9. These Focus Studies address critical aspects of reducing costs, utilization, and member satisfaction within the Medicaid managed care realm by conducting health care related focus studies that typically evaluate a specific service area (clinical or nonclinical) during a single year. For 2025, OMPP selected two focus study areas: MCE Performance in Depression Screening and Timely Follow-Up and MCE High Risk Diabetes Care Management and Care Coordination Strategies.

Overall, the results of both focus studies demonstrated that all five MCEs have similar strategies for depression screening and enrollment of members in care management programs. All five MCEs met OMPP requirements and list similar barriers to success. However, in both focus studies, all MCEs showed areas for improvement. In both cases, EHR integration was highlighted as a key factor, as well as patient attitude and the

referral process. Evaluating implementation strategies and cross-MCE support for implementation could benefit programs from both studies. Identified recommendations included establishing OMPP-specific goals for implementation of follow-up goals and data sharing processes/practices, encouraging the frequency of provider engagement, and investment in strategies that are SDOH-focused.

Appendix A | PIP Validation Findings

Table A-1 includes the full PIP title, study population, study variables and performance measures, improvement strategies, and measurement results for the MCEs. The overall validation status, type of PIP, performance summary, and strengths and weaknesses are provided in the PIP section of the report for each MCE. Note that the table contains information directly from the MCEs.

Table A-1. 2025 PIP Details for MCEs	
Anthem: *Improving Diabetes Management* (Clinical)	
Study Population	The PIP population included all members aged 18-75 covered under Anthem Medicaid HIP, HCC, and HHW, diagnosed with Type 1 or Type 2 diabetes, and included in the HEDIS® Glycemic Status Assessment measure per applicable HEDIS® Technical Specifications.
Study Variables and Performance Measures	**Performance Measure 1:** Glycemic Status Assessment <8% – The percentage of members 18-75 years as of December 31 of the measurement year with diabetes (type 1 or type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI] was at <8%.
	Performance Measure 2: Inpatient Admissions for Diabetes Short-Term Complications – Short-term Complications of Diabetes measure (refined to include only HEDIS® HBD/GSD measure eligible members) hospitalized for a principal diagnosis of diabetes with short-term complications, such as ketoacidosis, hyperosmolarity, or coma. Hospitalizations are defined as inpatient admissions lasting over 24 hours with specified diagnosis codes.
Improvement Strategies	**Improvement Strategy 1:** VBP Incentive – Strengthens collaborative quality efforts between the Anthem Providers Success Team and PCPs in value-based incentive agreements. With 53% of Anthem's Medicaid members in these provider groups, this strategy adopts a holistic, patient-centered approach. It emphasizes advanced data analytics to identify gaps, benchmark performance, and develop improvement strategies. The focus is on quality planning, continuous monitoring, and regular impact assessments, quickly resolving provider obstacles with health plan support. Additionally, it promotes clear, consistent communication among all stakeholders to ensure active engagement of the entire care team, including members and patients.
	Improvement Strategy 2: High Emergency Department Utilizer Program – Identifying members having Emergency Room (ER) overutilization and implementing appropriate interventions to connect members with appropriate outpatient providers and services to decrease unnecessary ER utilization is the goal of the ER High Utilizer Program. The program aims to provide care coordination support to these members to help members receive the most appropriate care in the right setting and at the right time.
	Improvement Strategy 3: High Touch Member Outreach Program – This strategy involves prioritizing face-to-face visits for members in critical situations: urgent referrals, unmet needs due to SDOH, unreachable cases in care coordination, upcoming loss of eligibility, and excessive emergency room visits without recent wellness checks. Anthem's CHWs play a key role by educating members, reviewing HEDIS® care gaps, assessing SDOH needs, and

Table A-1. 2025 PIP Details for MCEs	
	facilitating community resource referrals. CHWs also assist with appointment scheduling and connect members to primary care providers and case management, helping them navigate the health plan and system effectively.
	Improvement Strategy 4: HbA1c Home Test Kit Mailing Program – This targeted intervention entailed mailing test kits to members identified with lower HBD/GSD rates and infrequent or no HbA1c testing, according to Anthem records, in specific Indiana counties identified as high risk according to the original 2022 PIP diabetes complication hospital admissions analysis.
Measurement Results	**Performance Measure 1:** Glycemic Status Assessment < 8% Goal: 44.25%; Benchmark: 44.25% MY 2024 Rate: HIP – 39.59%; HHW – 36.10%; HCC – 37.63%
	Performance Measure 2: Inpatient Admissions for Diabetes Short-term Complications per 1000 Goal: 11.20; Benchmark: 5% reduction from Baseline MY 2024 Rate: HIP – 11.24; HHW – 25.00; HCC – 12.09
Anthem: *Triple Care Triumph: Harnessing SDOH Driven Wellness in Diabetes, Asthma, and Cardio Health* (Nonclinical)	
Study Population	The PIP population includes all members aged 5-85 covered under Anthem Medicaid HIP, HCC, and HHW, diagnosed with asthma, diabetes, or cardiovascular disease, and included in the HEDIS® Asthma Medication Ratio (AMR), Controlling High Blood Pressure (CBP), and/or Hemoglobin A1c Control <8 for Patients with Diabetes (HBD)/Glycemic Status Assessment (GSD) measures per applicable measurement year HEDIS® Technical Specifications.
Study Variables and Performance Measures	**Performance Measure 1:** Asthma Medication Ratio (AMR) HEDIS® measure – The percentage of Medicaid members ages 5-64 as of December 31 of the measurement year who have been identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
	Performance Measure 2: Glycemic Status (HbA1c or GMI) <8 – The percentage of Anthem Medicaid Plan-wide (HCC, HHW, HIP) members ages 18-75 years as of December 31 of the measurement year with Diabetes (type 1 or type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI] was at <8% during the measurement year.
	Performance Measure 3: Controlling High Blood Pressure (CBP) – The percentage of Medicaid members 18-85 years who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year. The final BP of the measurement year is captured.
Improvement Strategies	**Improvement Strategy 1:** SDOH Provider Incentive Program – Educate and engage providers to perform SDOH assessments on patients and refer patients to appropriate Community Resources for SDOH needs identified for food, housing, or transportation.

Table A-1. 2025 PIP Details for MCEs	
	Improvement Strategy 2: VRI Remote Condition Monitoring Program – The VRI remote condition monitoring program is designed to empower members in managing asthma, hypertension, or diabetes by supporting their health management in a comfortable and private setting. Members are equipped with devices that allow them to self-monitor their health from the convenience of their homes. Each day, members take their readings or utilize devices which track rescue and controller inhaler medication use, which are automatically transmitted to VRI's secure monitoring platform. If any readings fall outside the typical range, VRI proactively reaches out to the member. Any confirmed concerns related to these readings are communicated to the member's physician or a higher level of care as needed. VRI follows up with members within 24-36 hours to ensure their condition is stable and addresses any new or worsening symptoms. Additionally, VRI forwards any further needs through Anthem Case Management (CM) to ensure comprehensive support.
	Improvement Strategy 3: Provider Quality Collaboration & Support – Anthem's quality collaboration with contracted providers is driven by a comprehensive approach that combines patient-centered care and robust data analytics. This provider engagement strategy leverages sophisticated analytics to identify care gaps, benchmark performance, and develop effective improvement plans. It emphasizes quality planning, continuous monitoring, and impact assessment, while promptly addressing obstacles with health plan support. Additionally, it fosters clear communication among all stakeholders, ensuring active involvement of the entire care team, including patients, in their healthcare journey.
Measurement Results	**Performance Measure 1**: Asthma Medication Ratio (AMR) Goal: 70.56%; Benchmark: 70.56% MY 2024 Rate: HIP – 60.61%; HHW – 71.64%; HCC – 63.38%
	Performance Measure 2: Glycemic Status Assessment (GSD) Goal: 44.25%; Benchmark: 44.25% MY 2024 Rate: HIP – 39.59%; HHW – 36.10%; HCC – 37.63%
	Performance Measure 3: Controlling High Blood Pressure (CBP) Goal: 72.75%; Benchmark 72.75% MY 2024 Rate: HIP – 70.80%; HHW – 73.02%; HCC – 70.56%
CareSource: ***Improve Access to Annual Kidney Health Evaluation for Members Diagnosed with Diabetes*** **(Clinical)**	
Study Population	The PIP population included the entire population enrolled in HHW or HIP, assigned to the MCE during the enrollment period (January 1 to December 31 of the MY), aged 18-85 years, had a diagnosis of type 1 or 2 diabetes during the MY or the year prior to the MY, and were identified as needing annual kidney health evaluation in accordance with the HEDIS® technical specifications.
Study Variables and Performance Measures	**Performance Measure 1:** HEDIS® KED for Patients with Diabetes – Kidney Health Evaluation for Patients with Diabetes based (KED) HEDIS® technical specification captured monthly and annually through NCQA-certified CareAnalyzer software used to submit HEDIS® results to the NCQA.
Improvement Strategies	**Improvement Strategy 1:** CareSource will deliver a targeted provider education campaign to improve the rate of

Table A-1. 2025 PIP Details for MCEs	
	provider adoption and member access to the recommended annual kidney health evaluation. Targeted education will include a review of the clinical standards and recommendations and address common barriers among providers and members. One-on-one provider meetings will be conducted by and the shared responsibility of the Quality improvement Specialist and Community Health Liaisons (CHL). Providers will receive a minimum of two annual one-on-one meetings highlighting the clinical standards accompanied with a member gap list and provider specific rates. Providers unwilling or unable to complete the two recommended annual one-on-one meetings will receive educational materials and upon confirmation of a secure platform will receive a member gap roster for review.
Measurement Results	**Performance Measure 1:** HEDIS® KED for Patients with Diabetes Goal: HHW – 33.00%, HIP – 45.11%; Benchmark: HHW/HIP – Not Applicable MY 2024 Rate: HHW – 27.91%; HIP – 41.64%
CareSource: *Improve Birth Outcomes for Pregnant Members at Risk for Preeclampsia* (Clinical)	
Study Population	The PIP population is defined as the entire population of pregnant members with live births occurring within the MY identified with one or more of the following risk factors associated with preeclampsia: diagnosis of Hypertension, Diabetes, Obesity, Renal Disease, maternal age 35 or greater, and member reported race as Black or African American.
Study Variables and Performance Measures	**Performance Measure 1:** Preterm Birth Rate for Members At-Risk for Preeclampsia – Preterm births occurring less than 37 weeks gestation for identified members at-risk for preeclampsia derived from use of administrative data captured through provider submitted claims and member enrollment history.
Improvement Strategies	**Improvement Strategy 1:** CareSource will form a Preeclampsia Interdisciplinary Review Team (PIRT) to act as a surveillance hub driving evidence-based care for pregnant members at-risk for preeclampsia through systematic case review. The purpose of the systematic case review is to facilitate evidence-based clinical decision-making to improve birth outcomes, and the quality of care delivered. Through this systematic approach, CareSource will enhance surveillance and interdisciplinary collaboration and coordinated care to pregnant members with a diagnosis of hypertension, diabetes, obesity, renal disease, maternal age less than 19 years and greater than 35 years, and members with a reported race as Black or African American.
Measurement Results	**Performance Measure 1:** Preterm Birth Rate for Members At-Risk for Preeclampsia Goal: 2% Reduction to Baseline; Benchmark: Not Applicable MY 2024 Rate: HHW – 22.89%; HIP – 27.72%
CareSource: *Improve Member Satisfaction and Reported Perception of the Health Plan* (Nonclinical)	
Study Population	The PIP population is the entire population enrolled in HHW or HIP.
Study Variables and	**Performance Measure 1:** CAHPS® Adult Survey Rating of Health – Annual Member reported satisfaction and Rating of Health Plan. The annual performance measure will be extracted from the CAHPS Adult survey for HIP

Table A-1. 2025 PIP Details for MCEs	
Performance Measures	respondents. The Rating of Health Plan measure assesses and determines the level of overall member reported satisfaction with health plan services.
	Performance Measure 2: Rate Dissatisfaction with Plan Grievances per 1,000 Members
Improvement Strategies	**Improvement Strategy 1:** Standardized Staff Training on Enhanced Benefits and Rewards – CareSource will implement a standardized staff training tool to facilitate member awareness and engagement in enhanced benefits during inbound and outbound member calls.
Measurement Results	**Performance Measure 1:** CAHPS® Adult Survey Rating of Health Goal HHW – 73.76%; HIP – 64.05%; Benchmark HHW/HIP – 64.71% MY 2024 Rate: HHW – 70.88%; HIP – 61.50%
	Performance Measure 2: Rate Dissatisfaction with Plan Grievances per 1,000 Members Goal HHW – 0.76; HIP – 2.96; Benchmark HHW/HIP – Not Applicable MY 2024 Rate: HHW – 0.79; HIP – 3.07
MDwise: *Disease Management: Diabetes Care* (Clinical)	
Study Population	The PIP population is defined as MDwise members aged 18-64, with continuous enrollment of at least 180 days, with no gaps in enrollment of more than 45 days, who have an identified diagnosis of diabetes (type 1 or type 2).
Study Variables and Performance Measures	**Performance Measure 1:** Glycemic Status Assessment for Patients with Diabetes (GSD)
Improvement Strategies	**Improvement Strategy 1:** Increase member enrollment in MDwise's care management chronic disease management program INcontrol.
	Improvement Strategy 2: Engage diabetic members via educational SMS text campaign.
Measurement Results	**Performance Measure 1:** Glycemic Status Assessment for Patients with Diabetes (GSD) Goal: 44.25%; Benchmark: 44.25% MY 2024 Rate: HHW – 45.12%; HIP – 56.45%
MDwise: *Post-Partum Care* (Clinical)	
Study Population	The PIP population is defined as all MDwise members who have delivered a baby, in any setting, from October 8th the year prior, to October 7th of the current year with continuous enrollment from 43 days pre-birth to 60 days post-birth.
Study Variables and	**Performance Measure 1:** Prenatal and Post-Partum Care (PPC) – Postpartum Visits HEDIS® measure – The percentage of live deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Table A-1. 2025 PIP Details for MCEs	
Performance Measures	
Improvement Strategies	**Improvement Strategy 1:** Increase case management outreach to members who are identified as pregnant.
Measurement Results	**Performance Measure 1:** PPC – Postpartum Visits Goal: 83.33%; Benchmark: 82.00% MY 2024 Rate: HHW – 83.46%; HIP – 81.00%
MDwise: *Member Satisfaction* (Nonclinical)	
Study Population	The PIP population is defined as MDwise members, of any age, with continuous enrollment in the plan of at least 180 days with no gaps in enrollment of more than 45 days, with any diagnosis or procedures given in the measurement year.
Study Variables and Performance Measures	**Performance Measure 1:** Number of Member Grievances
	Performance Measure 2: CAHPS® Child Rating of Health Plan – The percentage of members surveyed through the CAHPS® survey that scored the question, "Rating of Health Plan" (8, 9, 10) as an 8, 9, or 10 on a Likert scale from 1 to 10 where 1 is indicated as the lowest rating and 10 is indicated as the highest rating.
Improvement Strategies	**Improvement Strategy 1:** Utilize MDwise Quality Outreach Representatives to engage members with MDwise via telephone.
	Improvement Strategy 2: Utilize mailers and postcards to engage members with MDwise.
	Improvement Strategy 3: Utilize text message campaigns to engage members with MDwise.
Measurement Results	**Performance Measure 1:** Number of Member Grievances Goal: 2.45 per 1,000 members; Benchmark: 2.46 per 1,000 members MY 2024 Rate: HHW – 2.72 per 1,000 members; HIP – 2.72 per 1,000 members
	Performance Measure 2: CAHPS® Rating of Health Plan Goal: HHW – 88.9%; HIP – 80.5%; Benchmark: HHW – 91.18%; HIP – 69.48% MY 2024 Rate: HHW – 91.4%; HIP – 71.7%
MHS: *Improving Diabetes Management* (Clinical)	
Study Population	The PIP population included all adult members between 18-64 years of age with a diagnosis of diabetes (types 1 or 2) that are continuously enrolled with no more than one gap in enrollment of up to 45 days in the MY, require a retinal eye exam, and have adequately controlled blood pressure readings (<140/90 mm HG).
Study Variables and	**Performance Measure 1:** Blood Pressure Control for Patients with Diabetes (BPD) – The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90

Table A-1. 2025 PIP Details for MCEs	
Performance Measures	mm Hg) during the MY.
	Performance Measure 2: Eye Exam for Patients with Diabetes (EED) – The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.
Improvement Strategies	**Improvement Strategy 1:** Expand provider education strategy focusing on the BPD and the EED measures targeting outreach with providers, who have MHS Medicaid members with diabetes and the members who do not have controlled blood pressure reading or a retinal eye exam. Expansion of provider education will include communication delivered in various modes and topics related to the measures, such as but not limited to: ♦ Provider emails; ♦ Provider blogs; ♦ Provider office visits; and ♦ Campaign to promote how to help a member obtain a blood pressure monitor.
Measurement Results	**Performance Measure 1:** Blood Pressure Control for Patients with Diabetes (BPD) Goal: 50th percentile; Benchmark: Not Applicable MY 2024 Rate: HHW – 40.71%; HIP – 40.71%; HCC – 40.71%
	Performance Measure 2: Eye Exam for Patients with Diabetes (EED) Goal: 66th percentile; Benchmark: Not Applicable MY 2024 Rate: HHW – 48.65%; HIP – 48.65%; HCC – 48.65%
MHS: *Reduction in Maternal and Infant Mortality* (Clinical)	
Study Population	The PIP population was defined as all pregnant members enrolled during the MY as identified through a completed Notification of Pregnancy form.
Study Variables and Performance Measures	**Performance Measure 1:** Pregnant members who are enrolled in Start Smart for Your Baby (SSFB) program – The percentage of members identified as high-risk for pregnancy complications, premature delivery, and at risk for low birth weight who enrolled in the SSFB program.
	Performance Measure 2: Reduce hospital admissions for high-risk OB members – The percentage of pregnant members admitted to the hospital with a pregnancy related complication of hypertension, diabetes, or preterm labor.
Improvement Strategies	**Improvement Strategy 1:** MHS Care Coordinators outreach to all members with a pregnancy diagnosis and offer enrollment into the SSFB program. If members are unreachable or refuse program, then outreach to the member continues and education is sent to the member until delivery.
Measurement Results	**Performance Measure 1:** Pregnant members who are enrolled in Start Smart for Your Baby (SSFB) program Goal:

Table A-1. 2025 PIP Details for MCEs	
	20.00%; Benchmark: Not Applicable MY 2024 Rate: HHW – 27.8%; HIP – 27.8%; HCC – 27.8%
	Performance Measure 2: Reduce hospital admissions for high-risk OB members Goal: 12.6%; Benchmark: Not Applicable MY 2024 Rate: HHW – 15.9%; HIP – 15.9%; HCC – 15.9%
MHS: *Member Experience* (Nonclinical)	
Study Population	A random sample of members in HHW, HIP, and HCC.
Study Variables and Performance Measures	**Performance Measure 1:** HEDIS® CAHPS® measure Rating of Health Plan – Adult – Monitoring the satisfaction of adult HIP, HHW, and HCC members, specifically the CAHPS® summary rate tied to the HEDIS® CAHPS® survey composite of Rating of Health Plan.
	Performance Measure 2: HEDIS® CAHPS® measure Rating of Health Plan – Child – Monitoring the satisfaction of HHW and HCC members, specifically the CAHPS® summary rate tied to the HEDIS® CAHPS® survey composite of Rating of Health Plan.
Improvement Strategies	**Improvement Strategy 1:** To monitor real-time member satisfaction with the MHS call center and identify barriers hindering member satisfaction, the plan will implement a post-call survey. A random sample of members will receive an SMS text-based customer service survey within one day of their call to MHS Member Services, unless they have received the survey within the past 30 days. Members who do not have a mobile phone number on file with the plan will not receive the survey.
Measurement Results	**Performance Measure 1:** HEDIS® CAHPS® measure Rating of Health Plan – Adult Goal: 82.9%; Benchmark: 80.9% MY 2024 Rate: HHW – 71.4%; HIP – 79.3%; HCC – 77.6%
	Performance Measure 2: HEDIS® CAHPS® Measure Rating of Health Plans – Child Goal: 91.3%; Benchmark: 89.3% MY 2024 Rate: HHW – 87.9%; HIP – Not Reported (the age group for this performance measure does not apply to HIP); HCC – 84.7%
UHC: *Improving Glycemic Status Assessment Rates for Patients with Diabetes (GSD)* (Clinical)	
Study Population	The PIP population was defined as all members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the MY: Glycemic Status <8.0%, or Glycemic Status >9.0%.
Study Variables and	**Performance Measure 1:** HEDIS® measure Glycemic Status Assessment for Patients with Diabetes (GSD).

Table A-1. 2025 PIP Details for MCEs	
Performance Measures	
Improvement Strategies	**Improvement Strategy 1:** Optum Rx Medication Therapy Management Program (MTM) – Data, interventions and monitoring focused on optimizing drug therapy, improving adherence, reducing risk for interactions and closing gaps in care. Key services comprising the MTM Program are annual Comprehensive Medication Reviews (CMR) and daily Targeted Medication Reviews (TMR). This intervention consists of calls to members identified including for diabetes with applicable disease states – eight or more chronic meds and over three or more disease states (members can opt out). Recommendations go to the provider regardless of member engagement (based on conversations with the member). This includes a medication action plan.
	Improvement Strategy 2: Centralized Vendor Program (mPulse) – mPulse is a UHC Community and State National Program. For UHC Community Plan Indiana, diabetes is a focus measure. The focus is on IN members with an identified care gap closure by outreaching to members based on their communication preference. Three methods of outreach: text (SMS), interactive voice response, and email.
	Improvement Strategy 3: Livongo is an evidence-based platform for remote monitoring and chronic condition management. The platform includes live (telephonic) coaching and 24/7 monitoring as well as AI/App engagement and outreach. UHCCP will engage for diabetes and hypertension management. Goals include managing healthy activities, diet, medication adherence, regular testing (e.g., blood glucose, blood pressure) and reminders about important doctor visits such as A1C testing, diabetic retinal eye exams, kidney testing and wound management. This program will be piloted for certain diabetic members with hypertension in our population who are not being care managed.
	Improvement Strategy 4: Community Partnerships – Community partnerships are utilized to leverage member and provider education regarding diabetes best practices and member self-care.
Measurement Results	**Performance Measure 1:** HEDIS® measure Glycemic Status Assessment for Patients with Diabetes (GSD) Goal: To be Determined; Benchmark: To be Determined MY 2024 Rate: HCC – <8%: 51.24%; >9%: 42.24%
UHC: *Improving Member Satisfaction with the Health Plan's Member Services* (Nonclinical)	
Study Population	The PIP population is defined as all UHC HCC members ages 18 and over who completed the Adult Medicaid Satisfaction CAHPS® Survey in the MY.
Study Variables and Performance Measures	**Performance Measure 1:** Scores from CAHPS® Survey with answers of "Usually" or "Always" to question numbers 24 and 25.
Improvement Strategies	**Improvement Strategy 1:** Interventions currently in place will be reviewed for continuance, enhancement, modification, and/or termination.

Table A-1. 2025 PIP Details for MCEs	
	Improvement Strategy 2: Member services call center audits are conducted by the Member Services supervisory staff on a frequent and ongoing basis. Results of the audits are reviewed with the respective call center staff and any action steps are taken with the identified staff member where needed improvement is identified. Further detailed information related to the history of the member call center audits can be found in Improvement Strategy 1 above. As of Q2 for Remeasurement 1, the local member services supervisory staff are no longer conducting the call center audits. These audits have been transferred to the national member services team. Despite the transfer, the process has not changed. Audit results are funneled down to the local health plan member services supervisory staff who conduct any needed action steps with identified local member services call center staff.
	Improvement Strategy 3: Member escalation refers to the process of guiding team members on how to escalate the incident management process. It is a written procedure that outlines the upward flow of alerts and responsibility within an organization and ensures the necessary parties are brought on board at the appropriate time in an incident's lifecycle. Escalation management is also used to handle customer issues that can't be resolved during a customer's initial interaction with a support team member. It involves advancing a customer's concern to higher levels of expertise or authority until the issue has been resolved.
Measurement Results	**Performance Measure 1:** Scores from CAHPS® Survey with answers of "Usually" or "Always" to question numbers 24 and 25 Goal: #24 – 86.27%; #25 – 95.73%; Benchmark: #24 – 85.89%; #25 – 95.33% MY 2024 Rate: HCC – #24 Not Reported; #25 Not Reported

Appendix B | ANA Analysis Methodology and Ratios

Excluded Source Data Records

Table B-1 through Table B-5 summarizes the MCEs' member and provider records that were excluded from analysis.

Anthem

From the member records submitted by Anthem, most of the records excluded from the analysis were members with out-of-state residence. The resulting count of members included in the analysis by program were as follows:

- HHW – 301,718 members
- HIP – 318,251 members
- HCC – 44,791 members

From the provider records submitted by Anthem, most of the records excluded from the analysis contained provider type/provider specialty combinations that were not applicable for the analysis. The resulting count of providers included in the analysis by program were as follows:

- HHW – 151,957 provider service locations
- HIP – 149,702 provider service locations
- HCC – 92,147 provider service locations

Table B-1. Source Records Excluded from Analysis – Anthem

Data Source	Health Programs			
Member Records	**HHW**	**HIP**	**HCC**	**All Programs**
Total Records Submitted	305,055	322,176	45,553	672,784
Total Records Excluded from Analysis	3,337	3,925	762	8,024
Duplicate record	-	-	-	-
Not Medicaid eligible*	58	7	12	77
Invalid address	373	443	79	895
Out-of-state residence	2,906	3,475	671	7,052

Table B-1. Source Records Excluded from Analysis – Anthem				
Data Source	**Health Programs**			
Provider Records	**HHW**	**HIP**	**HCC**	**All Programs**
Total Records Submitted	199,417	197,245	201,548	598,210
Total Records Excluded from Analysis	47,460	47,543	109,401	204,404
Duplicate provider service location	29	32	2	63
Not Applicable Provider Type/Specialty combinations	46,934	47,013	109,139	203,086
Not Medicaid eligible*	101	103	27	231
Invalid address	396	395	233	1,024
Located more than 60 miles outside of Indiana	-	-	-	-

**"Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) identification (ID) against state records. The record was flagged as "Not Medicaid eligible" if the MMIS ID was not found, or if the member/provider was not actively enrolled on the snapshot date (October 1, 2024).*

CareSource

From the member records submitted by CareSource, most of the records excluded from the analysis were members with out-of-state residence. The resulting count of members included in the analysis by program were as follows:

- HHW – 76,452 members
- HIP – 81,486 members

From the provider records submitted by CareSource, most of the records excluded from the analysis contained provider type/provider specialty combinations that were not applicable for the analysis. The resulting count of providers included in the analysis by program were as follows:

- HHW – 173,446 provider service locations
- HIP – 170,057 provider service locations

Table B-2. Source Records Excluded from Analysis – CareSource			
Data Source	**Health Programs**		
Member Records	**HHW**	**HIP**	**All Programs**
Total Records Submitted	77,772	82,985	160,757
Total Records Excluded from Analysis	1,150	1,347	2,497
Duplicate record	-	-	-
Not Medicaid eligible*	2	4	6
Invalid address	84	132	216
Out-of-state residence	1,064	1,211	2,275
Provider Records	**HHW**	**HIP**	**All Programs**
Total Records Submitted	194,034	191,012	385,046
Total Records Excluded from Analysis	20,588	20,955	41,543
Duplicate provider service location	-	-	-
Not Applicable Provider Type/Specialty combinations	13,849	14,455	28,304
Not Medicaid eligible*	72	75	147
Invalid address	978	735	1,713
Located more than 60 miles outside of Indiana	5,689	5,690	11,379

**"Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against state records. The record was flagged as "Not Medicaid eligible" if the MMIS ID was not found, or if the member/provider was not actively enrolled on the snapshot date (October 1, 2024).*

MDwise

From the member records submitted by MDwise, most of the records excluded from the analysis were members with out-of-state residence. The resulting count of members included in the analysis by program were as follows:

- HHW – 193,803 members
- HIP – 154,552 members

From the provider records submitted by MDwise, most of the HHW records excluded from the analysis were providers with invalid addresses or providers located more than 60 miles outside of Indiana. Most of the HIP records excluded from the analysis contained

provider type/provider specialty combinations that were not applicable for the analysis. The resulting count of providers included in the analysis by program were as follows:

- HHW – 227,673 provider service locations
- HIP – 227,950 provider service locations

Table B-3. Source Records Excluded from Analysis – MDwise

Data Source	Health Programs		
Member Records	**HHW**	**HIP**	**All Programs**
Total Records Submitted	195,170	156,910	352,080
Total Records Excluded from Analysis	1,367	2,358	3,725
Duplicate record	-	-	-
Not Medicaid eligible*	9	975	984
Invalid address	262	228	490
Out-of-state residence	1,096	1,155	2,251
Provider Records	**HHW**	**HIP**	**All Programs**
Total Records Submitted	229,447	265,811	495,258
Total Records Excluded from Analysis	1,774	37,861	39,635
Duplicate provider service location	1	173	174
Not Applicable Provider Type/Specialty combinations	-	35,906	35,906
Not Medicaid eligible*	179	178	357
Invalid address	826	833	1,659
Located more than 60 miles outside of Indiana	768	771	1,539

** Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against state records. The record was flagged as "Not Medicaid eligible" if the MMIS ID was not found, or if the member/provider was not actively enrolled on the snapshot date (October 1, 2024).*

MHS

From the member records submitted by MHS, most of the records excluded from the analysis were members with out-of-state residence. The resulting count of members included in the analysis by program were as follows:

- HHW – 172,071 members
- HIP – 129,105 members
- HCC – 27,954 members

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

- HHW – 29,091 provider service locations
- HIP – 29,300 provider service locations
- HCC – 28,935 provider service locations

Table B-4. Source Records Excluded from Analysis – MHS

Data Source	Health Programs			
Member Records	**HHW**	**HIP**	**HCC**	**All Programs**
Total Records Submitted	172,753	129,823	28,283	330,859
Total Records Excluded from Analysis	682	718	329	1,729
Duplicate record	-	-	-	-
Not Medicaid eligible*	15	45	9	69
Invalid address	223	195	44	462
Out-of-state residence	444	478	276	1,198
Provider Records	**HHW**	**HIP**	**HCC**	**All Programs**
Total Records Submitted	29,952	30,168	29,783	89,903
Total Records Excluded from Analysis	861	868	848	2,577
Duplicate provider service location	1	1	1	3
Not Applicable Provider Type/Specialty combinations	-	-	-	-
Not Medicaid eligible*	1	1	1	3
Invalid address	162	167	142	471

Table B-4. Source Records Excluded from Analysis – MHS				
Data Source	**Health Programs**			
Located more than 60 miles outside of Indiana	697	699	704	2,100

"Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against state records. The record was flagged as "Not Medicaid eligible" if the MMIS ID was not found, or if the member/provider was not actively enrolled on the snapshot date (October 1, 2024).

UHC

From the member records submitted by UHC, most of the records excluded from the analysis were members with out-of-state residence. The resulting count of members included in the analysis by program were as follows:

- HCC – 5,680 members

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

- HCC – 137,542 provider service locations

Table B-5. Source Records Excluded from Analysis – UHC	
Data Source	**Health Program**
Member Records	**HCC**
Total Records Submitted	5,846
Total Records Excluded from Analysis	166
Duplicate record	-
Not Medicaid eligible*	-
Invalid address	11
Out-of-state residence	155
Provider Records	**HCC**
Total Records Submitted	138,768
Total Records Excluded from Analysis	1,226
Duplicate provider service location	656

Table B-5. Source Records Excluded from Analysis – UHC	
Data Source	**Health Program**
Not Applicable Provider Type/Specialty combinations	-
Not Medicaid eligible*	164
Invalid address	95
Located more than 60 miles outside of Indiana	311

"Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against state records. The record was flagged as "Not Medicaid eligible" if the MMIS ID was not found, or if the member/provider was not actively enrolled on the snapshot date (October 1, 2024).

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, 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 category, e.g., Anesthesiologist) and one county when assessing Report 0902 was as follows:

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

Provider to Member Ratios

Table B-6 through Table B-10 are the detailed reports of provider to member ratios for all provider categories having ratio requirements by IHCP program.

Table B-6. Provider to Member Ratios – Anthem

Category	HHW	HIP	HCC	Provider Network Standard	Percent that Met Target
Anesthesiology	1:186	1:200	1:27	1:5000	100%
Behavioral Health Providers	1:375	1:393	1:55	1:1000	100%
Cardiology	1:314	1:350	1:46	1:5000	100%
Dentists	1:266	1:286	1:39	1:2000	100%
Dermatology	1:1,464	1:1,487	1:216	1:5000	100%
DME	1:1,639	1:1,729	1:242	1:5000	100%
Endocrinology	1:1,885	1:1,989	1:279	1:5000	100%
Gastroenterology	1:545	1:616	1:81	1:5000	100%
General Surgery	1:296	1:314	1:44	1:5000	100%
Infectious Disease	1:1,587	1:1,701	1:235	1:5000	100%
Nephrology	1:819	1:884	1:121	1:5000	100%
OB/GYNs	1:222	1:235	1:32	1:2000	100%
Occupational Therapists*	1:277	1:306	1:41	1:5000	100%
Oncology	1:637	1:733	1:95	1:5000	100%
Ophthalmology	1:867	1:862	1:128	1:5000	100%

Table B-6. Provider to Member Ratios – Anthem

Category	HHW	HIP	HCC	Provider Network Standard	Percent that Met Target
Orthopedic Surgery	1:344	1:371	1:51	1:5000	100%
Otolaryngology	1:897	1:988	1:132	1:5000	100%
Physical Therapists*	1:131	1:135	1:19	1:5000	100%
PMPs	1:12	1:13	1:7	1:1000	100%
Prosthetic Suppliers	1:25,143	1:26,520	1:3,732	1:5000	33.33%
Psychiatry	1:384	1:414	1:57	1:5000	100%
Pulmonology	1:554	1:613	1:82	1:5000	100%
Rheumatology	1:3,110	1:3,280	1:461	1:5000	100%
Speech Therapists*	1:383	1:445	1:56	1:5000	100%
Urology	1:771	1:830	1:115	1:5000	100%

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

Table B-7. Provider to Member Ratios – CareSource

Category	HHW	HIP	Provider Network Standard	Percent that Met Target
Anesthesiology	1:151	1:188	1:5,000	100%
Behavioral Health Providers	1:24	1:25	1:1,000	100%
Cardiology	1:93	1:104	1:5,000	100%

Table B-7. Provider to Member Ratios – CareSource				
Category	HHW	HIP	Provider Network Standard	Percent that Met Target
Dentists	1:92	1:98	1:2,000	100%
Dermatology	1:562	1:636	1:5,000	100%
DME	1:349	1:373	1:5,000	100%
Endocrinology	1:431	1:485	1:5,000	100%
Gastroenterology	1:161	1:186	1:5,000	100%
General Surgery	1:98	1:107	1:5,000	100%
Infectious Disease	1:367	1:411	1:5,000	100%
Nephrology	1:295	1:327	1:5,000	100%
OB/GYNs	1:77	1:83	1:2,000	100%
Occupational Therapists*	1:210	1:225	1:5,000	100%
Oncology	1:166	1:193	1:5,000	100%
Ophthalmology	1:338	1:380	1:5,000	100%
Orthopedic Surgery	1:134	1:145	1:5,000	100%
Otolaryngology	1:322	1:360	1:5,000	100%
Physical Therapists*	1:63	1:68	1:5,000	100%
PMPs	1:4	1:4	1:1,000	100%
Prosthetic Suppliers	1:2,066	1:1,987	1:5,000	100%
Psychiatry	1:100	1:112	1:5,000	100%

Table B-7. Provider to Member Ratios – CareSource

Category	HHW	HIP	Provider Network Standard	Percent that Met Target
Pulmonology	1:174	1:194	1:5,000	100%
Rheumatology	1:910	1:1,006	1:5,000	100%
Speech Therapists*	1:288	1:313	1:5,000	100%
Urology	1:300	1:327	1:5,000	100%

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

Table B-8. Provider to Member Ratios – MDwise

Category	HHW	HIP	Provider Network Standard	Percent that Met Target
Anesthesiology	1:102	1:80	1:5000	100%
Behavioral Health Providers	1:184	1:147	1:1000	100%
Cardiology	1:198	1:159	1:5000	100%
Dentists	1:144	1:115	1:2000	100%
Dermatology	1:797	1:638	1:5000	100%
DME	1:1,364	1:1,080	1:5000	100%
Endocrinology	1:1,160	1:925	1:5000	100%
Gastroenterology	1:323	1:255	1:5000	100%
General Surgery	1:189	1:150	1:5000	100%

Table B-8. Provider to Member Ratios – MDwise

Category	HHW	HIP	Provider Network Standard	Percent that Met Target
Infectious Disease	1:1,082	1:844	1:5000	100%
Nephrology	1:547	1:439	1:5000	100%
OB/GYNs	1:137	1:109	1:2000	100%
Occupational Therapists*	1:234	1:187	1:5000	100%
Oncology	1:493	1:405	1:5000	100%
Ophthalmology	1:472	1:378	1:5000	100%
Orthopedic Surgery	1:249	1:199	1:5000	100%
Otolaryngology	1:558	1:445	1:5000	100%
Physical Therapists*	1:93	1:74	1:5000	100%
PMPs	1:8	1:6	1:1000	100%
Prosthetic Suppliers	1:950	1:757	1:5000	100%
Psychiatry	1:245	1:194	1:5000	100%
Pulmonology	1:339	1:276	1:5000	100%
Rheumatology	1:1,502	1:1,179	1:5000	100%
Speech Therapists*	1:334	1:265	1:5000	100%
Urology	1:457	1:364	1:5000	100%

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

Table B-9. Provider to Member Ratios – MHS					
Category	**HHW**	**HIP**	**HCC**	**Provider Network Standard**	**Percent that Met Target**
Anesthesiology	1:206	1:151	1:31	1:5,000	100%
Behavioral Health Providers	1:350	1:264	1:57	1:1,000	100%
Cardiology	1:446	1:333	1:72	1:5,000	100%
Dentists	1:166	1:125	1:27	1:2,000	100%
Dermatology	1:2,073	1:1,501	1:336	1:5,000	100%
DME	1:1,686	1:1,265	1:274	1:5,000	100%
Endocrinology	1:1,773	1:1,265	1:307	1:5,000	100%
Gastroenterology	1:719	1:516	1:118	1:5,000	100%
General Surgery	1:416	1:298	1:65	1:5,000	100%
Infectious Disease	1:1,686	1:1,265	1:271	1:5,000	100%
Nephrology	1:1,042	1:741	1:161	1:5,000	100%
OB/GYNs	1:274	1:202	1:46	1:2,000	100%
Occupational Therapists*	1:328	1:250	1:53	1:5,000	100%
Oncology	1:792	1:603	1:133	1:5,000	100%
Ophthalmology	1:1,062	1:773	1:167	1:5,000	100%
Orthopedic Surgery	1:409	1:297	1:64	1:5,000	100%
Otolaryngology	1:1,018	1:750	1:152	1:5,000	100%
Physical Therapists*	1:199	1:146	1:31	1:5,000	100%

Table B-9. Provider to Member Ratios – MHS

Category	HHW	HIP	HCC	Provider Network Standard	Percent that Met Target
PMPs	1:70	1:54	1:11	1:1,000	100%
Prosthetic Suppliers	1:4,779	1:3,310	1:798	1:5,000	100%
Psychiatry	1:674	1:494	1:107	1:5,000	100%
Pulmonology	1:804	1:558	1:125	1:5,000	100%
Rheumatology	1:2,867	1:2,151	1:481	1:5,000	100%
Speech Therapists*	1:711	1:568	1:113	1:5,000	100%
Urology	1:961	1:733	1:155	1:5,000	100%

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

Table B-10. Provider to Member Ratios – UHC

Category	HCC	Provider Network Standard	Percent that Met Target
Anesthesiology	1:5	1:5,000	100%
Behavioral Health Providers	1:2	1:1,000	100%
Cardiology	1:9	1:5,000	100%
Dentists	1:5	1:2,000	100%
Dermatology	1:47	1:5,000	100%
DME	1:30	1:5,000	100%

Table B-10. Provider to Member Ratios – UHC

Category	HCC	Provider Network Standard	Percent that Met Target
Endocrinology	1:70	1:5,000	100%
Gastroenterology	1:18	1:5,000	100%
General Surgery	1:8	1:5,000	100%
Infectious Disease	1:76	1:5,000	100%
Nephrology	1:23	1:5,000	100%
OB/GYNs	1:6	1:2,000	100%
Occupational Therapists*	1:20	1:5,000	100%
Oncology	1:24	1:5,000	100%
Ophthalmology	1:18	1:5,000	100%
Orthopedic Surgery	1:10	1:5,000	100%
Otolaryngology	1:25	1:5,000	100%
Physical Therapists*	1:8	1:5,000	100%
PMPs	2:1	1:1,000	100%
Prosthetic Suppliers	1:52	1:5,000	100%
Psychiatry	1:11	1:5,000	100%
Pulmonology	1:16	1:5,000	100%
Rheumatology	1:99	1:5,000	100%
Speech Therapists*	1:32	1:5,000	100%

Table B-10. Provider to Member Ratios – UHC

Category	HCC	Provider Network Standard	Percent that Met Target
Urology	1:20	1:5,000	100%

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

Appendix C | Detailed Analysis of Provider Network Access

Provider Network by County

Table C-1 through **Table C-5** are assessments of the MCEs' reporting of their provider networks. MCEs are contractually required to annually submit to the state a *Report 0902 (Count of Enrolled Providers)* for each program it manages. The 0902 reports were compared to the detailed provider listings submitted for the network adequacy assessment. Counts of providers are presented by county across all provider categories.

In accordance with the MCE Reporting Manual Instructions for Report 0902, each provider enumerated on this report is counted in exactly one provider 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-1. Count of Providers by County – Anthem

County	HHW			HIP			HCC			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
All Counties	**37,735**	**46,018**	**(8,283)**	**37,124**	**44,875**	**(7,751)**	**38,244**	**30,253**	**7,991**	**113,103**	**121,146**	**(8,043)**
Adams	93	91	2	96	93	3	93	79	14	282	263	19
Allen	2,268	3,477	(1,209)	2,275	3,466	(1,191)	2,273	1,977	296	6,816	8,920	(2,104)
Bartholomew	499	501	(2)	497	499	(2)	503	373	130	1,499	1,373	126
Benton	3	2	1	3	2	1	3	2	1	9	6	3
Blackford	31	32	(1)	31	34	(3)	31	24	7	93	90	3
Boone	358	240	118	345	230	115	361	195	166	1,064	665	399
Brown	130	7	123	130	7	123	131	8	123	391	22	369
Carroll	42	9	33	42	8	34	42	32	10	126	49	77

Table C-1. Count of Providers by County – Anthem												
County	HHW			HIP			HCC			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Cass	149	111	38	154	110	44	151	75	76	454	296	158
Clark	615	642	(27)	618	635	(17)	618	513	105	1,851	1,790	61
Clay	44	33	11	43	31	12	45	37	8	132	101	31
Clinton	94	86	8	96	81	15	95	71	24	285	238	47
Crawford	22	4	18	21	4	17	22	5	17	65	13	52
Daviess	117	148	(31)	116	135	(19)	118	94	24	351	377	(26)
Dearborn	162	213	(51)	152	212	(60)	168	158	10	482	583	(101)
Decatur	139	76	63	140	75	65	141	64	77	420	215	205
Dekalb	90	91	(1)	95	88	7	90	65	25	275	244	31
Delaware	649	645	4	652	666	(14)	655	474	181	1,956	1,785	171
Dubois	215	208	7	219	211	8	225	163	62	659	582	77
Elkhart	573	730	(157)	614	768	(154)	584	428	156	1,771	1,926	(155)
Fayette	59	49	10	60	49	11	60	43	17	179	141	38
Floyd	381	505	(124)	372	494	(122)	397	310	87	1,150	1,309	(159)
Fountain	11	11	0	11	10	1	11	12	(1)	33	33	0
Franklin	141	56	85	142	60	82	142	61	81	425	177	248
Fulton	67	54	13	67	56	11	68	51	17	202	161	41
Gibson	101	64	37	102	59	43	103	60	43	306	183	123
Grant	295	249	46	296	261	35	300	221	79	891	731	160

Table C-1. Count of Providers by County – Anthem												
County	HHW			HIP			HCC			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Greene	73	62	11	74	63	11	74	52	22	221	177	44
Hamilton	2,165	2,027	138	2,122	2,014	108	2,192	1,506	686	6,479	5,547	932
Hancock	397	306	91	399	309	90	402	214	188	1,198	829	369
Harrison	102	102	0	103	104	(1)	103	89	14	308	295	13
Hendricks	1,009	996	13	986	950	36	1,026	719	307	3,021	2,665	356
Henry	293	163	130	292	158	134	294	166	128	879	487	392
Howard	484	467	17	489	456	33	486	363	123	1,459	1,286	173
Huntington	73	65	8	74	67	7	76	49	27	223	181	42
Jackson	170	190	(20)	188	177	11	174	115	59	532	482	50
Jasper	102	85	17	102	85	17	103	60	43	307	230	77
Jay	66	74	(8)	67	74	(7)	66	58	8	199	206	(7)
Jefferson	165	122	43	167	126	41	167	107	60	499	355	144
Jennings	61	46	15	62	51	11	61	48	13	184	145	39
Johnson	854	1,024	(170)	863	1,007	(144)	873	752	121	2,590	2,783	(193)
Knox	316	299	17	324	323	1	319	224	95	959	846	113
Kosciusko	199	226	(27)	203	226	(23)	200	171	29	602	623	(21)
Lagrange	42	64	(22)	43	69	(26)	42	23	19	127	156	(29)
Lake	2,365	3,075	(710)	2,366	3,131	(765)	2,399	2,183	216	7,130	8,389	(1,259)
Laporte	522	410	112	531	428	103	538	341	197	1,591	1,179	412

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

County	HHW			HIP			HCC			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Lawrence	255	234	21	247	224	23	258	191	67	760	649	111
Madison	502	544	(42)	501	565	(64)	510	374	136	1,513	1,483	30
Marion	5,567	8,793	(3,226)	5,508	8,844	(3,336)	5,632	5,158	474	16,707	22,795	(6,088)
Marshall	146	109	37	152	115	37	154	80	74	452	304	148
Martin	46	38	8	47	36	11	46	37	9	139	111	28
Miami	92	73	19	92	85	7	94	59	35	278	217	61
Monroe	857	944	(87)	860	958	(98)	864	639	225	2,581	2,541	40
Montgomery	215	115	100	224	119	105	265	103	162	704	337	367
Morgan	216	186	30	209	181	28	220	136	84	645	503	142
Newton	18	14	4	18	16	2	18	17	1	54	47	7
Noble	62	37	25	70	46	24	64	32	32	196	115	81
Ohio	4	3	1	4	3	1	4	3	1	12	9	3
Orange	82	50	32	74	52	22	82	50	32	238	152	86
Out of State	5,265	8,717	(3,452)	4,665	7,481	(2,816)	5,303	4,794	509	15,233	20,992	(5,759)
Owen	14	17	(3)	14	17	(3)	14	12	2	42	46	(4)
Parke	77	15	62	77	17	60	80	19	61	234	51	183
Perry	79	72	7	81	70	11	80	58	22	240	200	40
Pike	22	9	13	22	10	12	22	12	10	66	31	35
Porter	736	744	(8)	720	674	46	754	574	180	2,210	1,992	218

Table C-1. Count of Providers by County – Anthem												
County	HHW			HIP			HCC			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Posey	22	20	2	22	20	2	22	19	3	66	59	7
Pulaski	35	20	15	35	23	12	37	22	15	107	65	42
Putnam	103	77	26	103	82	21	103	84	19	309	243	66
Randolph	46	41	5	46	43	3	46	37	9	138	121	17
Ripley	63	88	(25)	59	78	(19)	64	65	(1)	186	231	(45)
Rush	130	56	74	130	58	72	131	47	84	391	161	230
Scott	150	67	83	150	70	80	150	70	80	450	207	243
Shelby	239	153	86	241	157	84	242	117	125	722	427	295
Spencer	38	24	14	39	25	14	38	24	14	115	73	42
St. Joseph	1,347	1,793	(446)	1,386	1,793	(407)	1,365	1,164	201	4,098	4,750	(652)
Starke	105	51	54	105	48	57	108	45	63	318	144	174
Steuben	114	104	10	117	101	16	118	80	38	349	285	64
Sullivan	37	31	6	37	32	5	38	33	5	112	96	16
Switzerland	4	5	(1)	4	5	(1)	4	3	1	12	13	(1)
Tippecanoe	811	1,042	(231)	787	1,028	(241)	817	685	132	2,415	2,755	(340)
Tipton	92	31	61	91	36	55	95	30	65	278	97	181
Union	7	7	0	7	7	0	7	6	1	21	20	1
Vanderburgh	1,128	1,512	(384)	1,126	1,517	(391)	1,146	983	163	3,400	4,012	(612)
Vermillion	96	24	72	98	31	67	96	18	78	290	73	217

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

County	HHW			HIP			HCC			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Vigo	837	895	(58)	843	897	(54)	844	713	131	2,524	2,505	19
Wabash	92	50	42	95	49	46	93	55	38	280	154	126
Warren	19	13	6	20	15	5	19	10	9	58	38	20
Warrick	494	428	66	489	428	61	500	317	183	1,483	1,173	310
Washington	62	37	25	60	35	25	61	40	21	183	112	71
Wayne	359	437	(78)	357	451	(94)	364	285	79	1,080	1,173	(93)
Wells	63	54	9	63	57	6	65	46	19	191	157	34
White	88	65	23	89	70	19	89	34	55	266	169	97
Whitley	93	42	51	96	44	52	93	38	55	282	124	158

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

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
All Counties	**87,333**	**34,577**	**52,756**	**86,338**	**33,297**	**53,041**	**173,671**	**67,874**	**105,797**
Adams	426	86	340	426	81	345	852	167	685
Allen	4,395	2,584	1,811	4,398	2,620	1,778	8,793	5,204	3,589
Bartholomew	1,222	277	945	1,218	299	919	2,440	576	1,864
Benton	64	1	63	64	1	63	128	2	126

Table C-2. Count of Providers by County – CareSource									
County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Blackford	342	34	308	342	31	311	684	65	619
Boone	989	126	863	991	137	854	1,980	263	1,717
Brown	221	10	211	221	9	212	442	19	423
Carroll	156	9	147	156	8	148	312	17	295
Cass	374	76	298	374	77	297	748	153	595
Clark	1,627	472	1,155	1,630	466	1,164	3,257	938	2,319
Clay	123	25	98	123	27	96	246	52	194
Clinton	535	90	445	535	69	466	1,070	159	911
Crawford	66	6	60	66	9	57	132	15	117
Daviess	539	112	427	539	113	426	1,078	225	853
Dearborn	459	85	374	458	82	376	917	167	750
Decatur	463	76	387	458	73	385	921	149	772
Dekalb	754	77	677	750	68	682	1,504	145	1,359
Delaware	1,836	537	1,299	1,839	550	1,289	3,675	1,087	2,588
Dubois	611	235	376	613	233	380	1,224	468	756
Elkhart	1,177	492	685	1,179	504	675	2,356	996	1,360
Fayette	277	38	239	277	39	238	554	77	477
Floyd	1,264	255	1,009	1,267	254	1,013	2,531	509	2,022
Fountain	201	12	189	201	14	187	402	26	376

Table C-2. Count of Providers by County – CareSource									
County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Franklin	197	72	125	188	56	132	385	128	257
Fulton	317	51	266	317	52	265	634	103	531
Gibson	356	45	311	356	42	314	712	87	625
Grant	928	220	708	929	218	711	1,857	438	1,419
Greene	178	57	121	178	55	123	356	112	244
Hamilton	4,717	1,446	3,271	4,721	1,479	3,242	9,438	2,925	6,513
Hancock	873	220	653	870	218	652	1,743	438	1,305
Harrison	541	68	473	543	70	473	1,084	138	946
Hendricks	2,795	607	2,188	2,797	538	2,259	5,592	1,145	4,447
Henry	768	126	642	769	125	644	1,537	251	1,286
Howard	1,526	368	1,158	1,527	374	1,153	3,053	742	2,311
Huntington	682	85	597	678	94	584	1,360	179	1,181
Jackson	627	158	469	628	124	504	1,255	282	973
Jasper	305	57	248	305	57	248	610	114	496
Jay	512	56	456	512	54	458	1,024	110	914
Jefferson	486	98	388	488	94	394	974	192	782
Jennings	358	42	316	358	37	321	716	79	637
Johnson	2,272	591	1,681	2,275	607	1,668	4,547	1,198	3,349
Knox	575	235	340	576	246	330	1,151	481	670

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

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Kosciusko	1,049	159	890	1,049	161	888	2,098	320	1,778
Lagrange	253	39	214	252	38	214	505	77	428
Lake	3,137	2,138	999	3,158	2,155	1,003	6,295	4,293	2,002
Laporte	924	279	645	935	296	639	1,859	575	1,284
Lawrence	843	100	743	845	97	748	1,688	197	1,491
Madison	1,797	369	1,428	1,797	427	1,370	3,594	796	2,798
Marion	10,019	7,667	2,352	10,027	7,600	2,427	20,046	15,267	4,779
Marshall	376	107	269	376	106	270	752	213	539
Martin	104	20	84	104	21	83	208	41	167
Miami	354	44	310	355	50	305	709	94	615
Monroe	2,216	647	1,569	2,216	636	1,580	4,432	1,283	3,149
Montgomery	519	73	446	536	85	451	1,055	158	897
Morgan	1,512	148	1,364	1,514	163	1,351	3,026	311	2,715
Newton	36	9	27	36	9	27	72	18	54
Noble	650	72	578	645	71	574	1,295	143	1,152
Ohio	17	2	15	17	2	15	34	4	30
Orange	477	50	427	477	48	429	954	98	856
Out of State	7,323	6,713	610	6,346	5,399	947	13,669	12,112	1,557
Owen	262	11	251	262	12	250	524	23	501

Table C-2. Count of Providers by County – CareSource									
County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Parke	157	14	143	157	14	143	314	28	286
Perry	260	47	213	260	44	216	520	91	429
Pike	90	13	77	90	16	74	180	29	151
Porter	1,280	431	849	1,291	400	891	2,571	831	1,740
Posey	218	17	201	218	17	201	436	34	402
Pulaski	94	20	74	94	23	71	188	43	145
Putnam	317	74	243	317	76	241	634	150	484
Randolph	206	44	162	206	43	163	412	87	325
Ripley	103	64	39	99	72	27	202	136	66
Rush	189	38	151	189	37	152	378	75	303
Scott	665	51	614	665	58	607	1,330	109	1,221
Shelby	850	139	711	850	135	715	1,700	274	1,426
Spencer	187	22	165	187	22	165	374	44	330
St. Joseph	1,990	981	1,009	1,995	980	1,015	3,985	1,961	2,024
Starke	161	44	117	161	43	118	322	87	235
Steuben	432	101	331	432	95	337	864	196	668
Sullivan	79	30	49	80	33	47	159	63	96
Switzerland	32	8	24	32	9	23	64	17	47
Tippecanoe	1,959	700	1,259	1,974	698	1,276	3,933	1,398	2,535

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

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Tipton	465	25	440	465	24	441	930	49	881
Union	35	5	30	35	6	29	70	11	59
Vanderburgh	2,147	1,091	1,056	2,149	1,091	1,058	4,296	2,182	2,114
Vermillion	261	12	249	263	10	253	524	22	502
Vigo	1,460	643	817	1,468	649	819	2,928	1,292	1,636
Wabash	633	49	584	634	63	571	1,267	112	1,155
Warren	78	12	66	78	12	66	156	24	132
Warrick	1,277	378	899	1,279	373	906	2,556	751	1,805
Washington	259	33	226	259	42	217	518	75	443
Wayne	1,190	403	787	1,190	403	787	2,380	806	1,574
Wells	298	30	268	301	32	269	599	62	537
White	417	47	370	417	47	370	834	94	740
Whitley	542	47	495	416	50	366	958	97	861

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

County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
All Counties	40,470	47,860	(7,390)	40,821	47,763	(6,942)	81,291	95,623	(14,332)

Table C-3. Count of Providers by County – MDwise									
County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Adams	169	86	83	179	90	89	348	176	172
Allen	2,211	3,501	(1,290)	2,112	3,512	(1,400)	4,323	7,013	(2,690)
Bartholomew	545	497	48	562	485	77	1,107	982	125
Benton	10	2	8	19	4	15	29	6	23
Blackford	91	31	60	99	43	56	190	74	116
Boone	537	179	358	548	191	357	1,085	370	715
Brown	22	14	8	36	14	22	58	28	30
Carroll	43	12	31	58	12	46	101	24	77
Cass	189	155	34	190	146	44	379	301	78
Clark	676	750	(74)	767	752	15	1,443	1,502	(59)
Clay	65	38	27	64	36	28	129	74	55
Clinton	200	118	82	207	112	95	407	230	177
Crawford	10	4	6	12	5	7	22	9	13
Daviess	161	192	(31)	189	194	(5)	350	386	(36)
Dearborn	258	214	44	254	219	35	512	433	79
Decatur	276	102	174	260	95	165	536	197	339
Dekalb	261	76	185	254	74	180	515	150	365
Delaware	753	841	(88)	749	858	(109)	1,502	1,699	(197)
Dubois	275	237	38	287	234	53	562	471	91

Table C-3. Count of Providers by County – MDwise									
County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Elkhart	582	606	(24)	574	606	(32)	1,156	1,212	(56)
Fayette	89	56	33	105	59	46	194	115	79
Floyd	515	530	(15)	532	534	(2)	1,047	1,064	(17)
Fountain	27	12	15	40	10	30	67	22	45
Franklin	192	69	123	190	70	120	382	139	243
Fulton	82	64	18	81	63	18	163	127	36
Gibson	109	71	38	104	59	45	213	130	83
Grant	468	244	224	517	251	266	985	495	490
Greene	89	76	13	93	78	15	182	154	28
Hamilton	2,957	1,465	1,492	2,932	1,668	1,264	5,889	3,133	2,756
Hancock	266	181	85	279	181	98	545	362	183
Harrison	157	110	47	152	110	42	309	220	89
Hendricks	1,541	1,062	479	1,500	856	644	3,041	1,918	1,123
Henry	293	150	143	265	156	109	558	306	252
Howard	637	463	174	632	457	175	1,269	920	349
Huntington	199	92	107	185	86	99	384	178	206
Jackson	191	178	13	202	172	30	393	350	43
Jasper	218	59	159	225	64	161	443	123	320
Jay	128	63	65	127	56	71	255	119	136

Table C-3. Count of Providers by County – MDwise									
County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Jefferson	183	51	132	191	55	136	374	106	268
Jennings	91	61	30	103	53	50	194	114	80
Johnson	956	708	248	1,005	687	318	1,961	1,395	566
Knox	277	239	38	274	237	37	551	476	75
Kosciusko	343	219	124	343	221	122	686	440	246
Lagrange	167	60	107	174	60	114	341	120	221
Lake	2,180	3,430	(1,250)	2,160	3,450	(1,290)	4,340	6,880	(2,540)
Laporte	453	416	37	455	434	21	908	850	58
Lawrence	196	111	85	205	119	86	401	230	171
Madison	596	335	261	661	344	317	1,257	679	578
Marion	5,676	11,419	(5,743)	5,701	11,531	(5,830)	11,377	22,950	(11,573)
Marshall	165	103	62	160	108	52	325	211	114
Martin	34	34	0	60	30	30	94	64	30
Miami	196	59	137	201	58	143	397	117	280
Monroe	909	740	169	880	881	(1)	1,789	1,621	168
Montgomery	257	85	172	263	86	177	520	171	349
Morgan	503	276	227	510	172	338	1,013	448	565
Newton	19	14	5	19	14	5	38	28	10
Noble	191	77	114	198	58	140	389	135	254

Table C-3. Count of Providers by County – MDwise									
County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Ohio	4	3	1	4	3	1	8	6	2
Orange	144	43	101	154	45	109	298	88	210
Out of State	2,920	9,050	(6,130)	2,961	8,771	(5,810)	5,881	17,821	(11,940)
Owen	48	16	32	71	17	54	119	33	86
Parke	49	16	33	54	16	38	103	32	71
Perry	78	52	26	84	51	33	162	103	59
Pike	22	13	9	45	13	32	67	26	41
Porter	808	581	227	791	558	233	1,599	1,139	460
Posey	32	18	14	29	16	13	61	34	27
Pulaski	51	18	33	51	18	33	102	36	66
Putnam	176	79	97	167	75	92	343	154	189
Randolph	85	47	38	99	41	58	184	88	96
Ripley	52	100	(48)	53	100	(47)	105	200	(95)
Rush	81	51	30	95	46	49	176	97	79
Scott	262	69	193	272	63	209	534	132	402
Shelby	157	130	27	123	134	(11)	280	264	16
Spencer	758	30	728	756	32	724	1,514	62	1,452
St. Joseph	458	1,348	(890)	447	1,370	(923)	905	2,718	(1,813)
Starke	78	65	13	81	62	19	159	127	32

Table C-3. Count of Providers by County – MDwise									
County	HHW			HIP			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Steuben	267	114	153	260	114	146	527	228	299
Sullivan	39	33	6	39	35	4	78	68	10
Switzerland	13	11	2	12	11	1	25	22	3
Tippecanoe	1,028	1,184	(156)	1,026	1,160	(134)	2,054	2,344	(290)
Tipton	190	37	153	189	36	153	379	73	306
Union	18	12	6	23	12	11	41	24	17
Vanderburgh	1,032	1,462	(430)	1,005	1,496	(491)	2,037	2,958	(921)
Vermillion	77	28	49	87	34	53	164	62	102
Vigo	753	1,007	(254)	747	1,018	(271)	1,500	2,025	(525)
Wabash	292	67	225	300	63	237	592	130	462
Warren	72	11	61	73	13	60	145	24	121
Warrick	530	411	119	521	421	100	1,051	832	219
Washington	70	44	26	72	44	28	142	88	54
Wayne	411	526	(115)	451	528	(77)	862	1,054	(192)
Wells	160	44	116	163	42	121	323	86	237
White	163	60	103	171	55	116	334	115	219
Whitley	208	43	165	201	40	161	409	83	326

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

County	HHW			HIP			HCC			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
All Counties	**19,545**	**14,934**	**4,611**	**19,772**	**14,979**	**4,793**	**19,978**	**15,155**	**4,823**	**59,295**	**45,068**	**14,227**
Adams	76	48	28	78	46	32	77	50	27	231	144	87
Allen	1,095	993	102	1,107	995	112	1,165	1,044	121	3,367	3,032	335
Bartholomew	243	152	91	252	155	97	258	162	96	753	469	284
Benton	13	3	10	13	3	10	13	3	10	39	9	30
Blackford	20	5	15	21	6	15	22	6	16	63	17	46
Boone	202	94	108	206	102	104	213	116	97	621	312	309
Brown	27	3	24	26	2	24	27	4	23	80	9	71
Carroll	34	16	18	35	16	19	31	19	12	100	51	49
Cass	82	52	30	83	53	30	83	53	30	248	158	90
Clark	357	308	49	358	294	64	361	298	63	1,076	900	176
Clay	36	21	15	34	18	16	36	19	17	106	58	48
Clinton	74	15	59	76	17	59	76	18	58	226	50	176
Crawford	21	8	13	20	7	13	20	7	13	61	22	39
Daviess	103	52	51	105	50	55	101	47	54	309	149	160
Dearborn	107	63	44	106	59	47	110	63	47	323	185	138
Decatur	94	44	50	90	42	48	96	47	49	280	133	147
Dekalb	70	52	18	69	48	21	69	48	21	208	148	60
Delaware	322	222	100	326	215	111	339	254	85	987	691	296
Dubois	134	112	22	138	117	21	145	126	19	417	355	62

Table C-4. Count of Providers by County – MHS												
County	HHW			HIP			HCC			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Elkhart	398	343	55	384	306	78	413	318	95	1,195	967	228
Fayette	53	24	29	60	31	29	58	32	26	171	87	84
Floyd	265	166	99	265	166	99	272	186	86	802	518	284
Fountain	24	8	16	24	9	15	27	7	20	75	24	51
Franklin	50	31	19	50	32	18	47	27	20	147	90	57
Fulton	52	24	28	57	26	31	50	26	24	159	76	83
Gibson	48	20	28	53	23	30	51	24	27	152	67	85
Grant	173	109	64	167	98	69	179	105	74	519	312	207
Greene	75	41	34	76	40	36	75	39	36	226	120	106
Hamilton	938	846	92	942	837	105	959	818	141	2,839	2,501	338
Hancock	224	150	74	227	152	75	221	151	70	672	453	219
Harrison	83	57	26	83	59	24	84	60	24	250	176	74
Hendricks	582	418	164	554	396	158	578	413	165	1,714	1,227	487
Henry	127	58	69	116	63	53	121	62	59	364	183	181
Howard	319	223	96	326	213	113	332	229	103	977	665	312
Huntington	53	29	24	55	30	25	51	32	19	159	91	68
Jackson	97	59	38	98	59	39	102	64	38	297	182	115
Jasper	55	26	29	59	32	27	56	29	27	170	87	83
Jay	39	16	23	40	14	26	38	13	25	117	43	74

Table C-4. Count of Providers by County – MHS												
County	HHW			HIP			HCC			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Jefferson	81	22	59	84	24	60	83	21	62	248	67	181
Jennings	67	38	29	62	34	28	66	31	35	195	103	92
Johnson	491	362	129	508	371	137	496	367	129	1,495	1,100	395
Knox	165	116	49	165	113	52	161	108	53	491	337	154
Kosciusko	115	86	29	109	79	30	114	91	23	338	256	82
Lagrange	40	20	20	42	24	18	41	23	18	123	67	56
Lake	1,143	914	229	1,192	969	223	1,195	958	237	3,530	2,841	689
Laporte	249	166	83	253	157	96	246	160	86	748	483	265
Lawrence	96	48	48	98	44	54	95	40	55	289	132	157
Madison	332	210	122	320	239	81	320	215	105	972	664	308
Marion	3,027	2,912	115	3,036	2,928	108	3,140	2,983	157	9,203	8,823	380
Marshall	105	67	38	110	77	33	114	66	48	329	210	119
Martin	35	22	13	38	19	19	39	21	18	112	62	50
Miami	68	45	23	70	45	25	68	43	25	206	133	73
Monroe	302	216	86	313	224	89	291	207	84	906	647	259
Montgomery	75	40	35	72	38	34	76	40	36	223	118	105
Morgan	156	70	86	152	70	82	152	70	82	460	210	250
Newton	19	7	12	19	6	13	19	6	13	57	19	38
Noble	47	25	22	50	23	27	48	24	24	145	72	73

Table C-4. Count of Providers by County – MHS												
County	HHW			HIP			HCC			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Ohio	10	4	6	9	5	4	9	5	4	28	14	14
Orange	58	27	31	63	32	31	59	29	30	180	88	92
Owen	30	10	20	30	10	20	30	10	20	90	30	60
Parke	31	14	17	31	13	18	32	15	17	94	42	52
Perry	51	31	20	50	31	19	53	32	21	154	94	60
Pike	19	6	13	19	6	13	18	6	12	56	18	38
Porter	411	277	134	406	270	136	412	275	137	1,229	822	407
Posey	25	10	15	26	11	15	25	12	13	76	33	43
Pulaski	37	17	20	36	16	20	36	15	21	109	48	61
Putnam	73	40	33	70	41	29	69	43	26	212	124	88
Randolph	47	24	23	50	26	24	50	27	23	147	77	70
Ripley	45	30	15	45	31	14	43	31	12	133	92	41
Rush	48	21	27	45	19	26	49	23	26	142	63	79
Scott	70	25	45	71	27	44	69	26	43	210	78	132
Shelby	164	92	72	187	78	109	178	74	104	529	244	285
Spencer	29	14	15	30	15	15	31	16	15	90	45	45
St. Joseph	653	576	77	677	575	102	689	580	109	2,019	1,731	288
Starke	46	24	22	48	26	22	44	25	19	138	75	63
Steuben	73	43	30	77	44	33	75	45	30	225	132	93

Table C-4. Count of Providers by County – MHS												
County	HHW			HIP			HCC			Total		
	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported	MCE Report 0902	Calculated	Over (Under) Reported
Sullivan	26	15	11	25	14	11	25	14	11	76	43	33
Switzerland	14	4	10	14	4	10	13	5	8	41	13	28
Tippecanoe	371	302	69	367	290	77	373	326	47	1,111	918	193
Tipton	45	11	34	44	12	32	49	12	37	138	35	103
Union	14	5	9	14	5	9	14	5	9	42	15	27
Vanderburgh	701	581	120	700	574	126	699	568	131	2,100	1,723	377
Vermillion	39	16	23	40	16	24	39	17	22	118	49	69
Vigo	418	301	117	412	304	108	426	306	120	1,256	911	345
Wabash	63	31	32	60	30	30	57	30	27	180	91	89
Warren	18	8	10	18	8	10	18	9	9	54	25	29
Warrick	297	171	126	303	185	118	291	164	127	891	520	371
Washington	35	21	14	34	17	17	36	18	18	105	56	49
Wayne	235	187	48	239	180	59	246	196	50	720	563	157
Wells	55	36	19	57	34	23	52	33	19	164	103	61
White	33	17	16	33	16	17	28	15	13	94	48	46
Whitley	45	26	19	48	28	20	44	24	20	137	78	59
Out of state	1,838	1,620	218	1,922	1,671	251	1,877	1,631	246	5,637	4,922	715

Table C-5. Count of Providers by County – UHC			
County	HCC		
	MCE Report 0902	Calculated	Over (Under) Reported
All Counties	31,430	30,983	447
Adams	62	67	(5)
Allen	2,542	2,426	116
Bartholomew	375	367	8
Benton	2	2	0
Blackford	24	26	(2)
Boone	120	123	(3)
Brown	7	5	2
Carroll	9	9	0
Cass	103	90	13
Clark	623	519	104
Clay	43	43	0
Clinton	26	72	(46)
Crawford	3	4	(1)
Daviess	125	128	(3)
Dearborn	303	107	196
Decatur	49	50	(1)
Dekalb	58	65	(7)
Delaware	534	551	(17)
Dubois	207	220	(13)

Table C-5. Count of Providers by County – UHC			
County	HCC		
	MCE Report 0902	Calculated	Over (Under) Reported
Elkhart	523	540	(17)
Fayette	45	48	(3)
Floyd	433	402	31
Fountain	14	14	0
Franklin	71	39	32
Fulton	34	31	3
Gibson	36	42	(6)
Grant	215	214	1
Greene	52	54	(2)
Hamilton	1,098	1,390	(292)
Hancock	208	213	(5)
Harrison	77	83	(6)
Hendricks	496	571	(75)
Henry	173	174	(1)
Howard	379	442	(63)
Huntington	51	86	(35)
Jackson	132	149	(17)
Jasper	32	55	(23)
Jay	39	43	(4)
Jefferson	109	104	5

Table C-5. Count of Providers by County – UHC			
County	HCC		
	MCE Report 0902	Calculated	Over (Under) Reported
Jennings	42	42	0
Johnson	592	584	8
Knox	229	226	3
Kosciusko	148	165	(17)
Lagrange	57	63	(6)
Lake	2,420	2,329	91
Laporte	268	273	(5)
Lawrence	84	96	(12)
Madison	522	335	187
Marion	8,879	8,343	536
Marshall	88	101	(13)
Martin	12	10	2
Miami	55	67	(12)
Monroe	735	692	43
Montgomery	63	73	(10)
Morgan	112	143	(31)
Newton	5	6	(1)
Noble	63	58	5
Ohio	2	2	0
Orange	28	29	(1)

Table C-5. Count of Providers by County – UHC			
County	HCC		
	MCE Report 0902	Calculated	Over (Under) Reported
Out of State	1,444	1,845	(401)
Owen	10	11	(1)
Parke	20	13	7
Perry	44	40	4
Pike	13	15	(2)
Porter	336	425	(89)
Posey	12	13	(1)
Pulaski	16	19	(3)
Putnam	66	63	3
Randolph	30	31	(1)
Ripley	32	55	(23)
Rush	26	26	0
Scott	82	64	18
Shelby	155	149	6
Spencer	21	22	(1)
St. Joseph	1,248	1,197	51
Starke	38	40	(2)
Steuben	103	102	1
Sullivan	31	31	0
Switzerland	6	8	(2)

Table C-5. Count of Providers by County – UHC			
County	**HCC**		
	MCE Report 0902	**Calculated**	**Over (Under) Reported**
Tippecanoe	930	887	43
Tipton	22	22	0
Union	5	5	0
Vanderburgh	1,272	1,069	203
Vermillion	17	20	(3)
Vigo	572	528	44
Wabash	59	51	8
Warren	9	8	1
Warrick	396	432	(36)
Washington	29	34	(5)
Wayne	451	442	9
Wells	27	26	1
White	33	48	(15)
Whitley	39	37	2

Provider Network Accessibility by Category

Table C-6 through **Table C-10** are assessments of the MCEs' reporting of their provider network accessibility to their members across all provider categories. MCEs are contractually required to annually submit to the State a *Report 0903 (Member Access to Providers)* for each program it manages. The MCEs' 0903 reports were compared to the provider network accessibility and calculated from the detailed provider and member listings submitted for the network adequacy assessment. Counts of members are presented by provider category.

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

Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
HHW						
Acute Care Hospitals	302,994	301,718	1,276	24	0	24
Anesthesiologists	302,994	301,718	1,276	0	0	0
Behavioral Health Providers	302,994	301,718	1,276	0	0	0
Cardiologists	302,994	301,718	1,276	0	0	0
Cardiothoracic Surgeons	302,994	301,718	1,276	0	0	0
Cardiovascular Surgeons	302,994	301,718	1,276	0	0	0
Dentists	302,994	301,718	1,276	0	0	0
Dermatologists	302,994	301,718	1,276	0	0	0
Diagnostic Testing	302,994	301,718	1,276	0	18,517	(18,517)
Durable Medical Equipment (DME)	302,994	301,718	1,276	0	0	0
Endocrinologists	302,994	301,718	1,276	0	0	0
ESRD Clinic	302,994	301,718	1,276	0	0	0
Gastroenterologists	302,994	301,718	1,276	0	0	0
General Surgeons	302,994	301,718	1,276	0	0	0
Hematologists	302,994	301,718	1,276	0	0	0
Home Health Providers	302,994	301,718	1,276	0	0	0
Infectious Disease Specialists	302,994	301,718	1,276	0	0	0
Inpatient Psychiatric Facilities	302,994	301,718	1,276	0	0	0

Table C-6. Anthem Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Interventional Radiologists	302,994	301,718	1,276	0	0	0
Nephrologists	302,994	301,718	1,276	0	0	0
Neurological Surgeons	302,994	301,718	1,276	0	0	0
Neurologists	302,994	301,718	1,276	0	0	0
Nonhospital based Anesthesiologists	302,994	301,718	1,276	0	23,595	(23,595)
OBGYN	302,994	151,303	151,691	0	0	0
Occupational Therapists	302,994	301,718	1,276	0	0	0
Oncologists	302,994	301,718	1,276	0	0	0
Ophthalmologists	302,994	301,718	1,276	0	0	0
Optometrists	302,994	301,718	1,276	0	0	0
Oral Surgeons	302,994	301,718	1,276	3	2,848	(2,845)
Orthodontists	302,994	301,718	1,276	45,128	95,211	(50,083)
Orthopedic Surgeons	302,994	301,718	1,276	0	0	0
Otolaryngologists	302,994	301,718	1,276	0	0	0
Pathologists	302,994	301,718	1,276	0	0	0
Pharmacy	302,994	301,718	1,276	0	0	0
Physical Therapists	302,994	301,718	1,276	0	0	0
PMPs-Physicians	302,994	301,718	1,276	0	0	0
Prosthetic Suppliers	302,994	301,718	1,276	0	18,307	(18,307)
Psychiatrists	302,994	301,718	1,276	0	0	0

Table C-6. Anthem Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Pulmonologists	302,994	301,718	1,276	0	0	0
Radiation Oncologists	302,994	301,718	1,276	0	46,819	(46,819)
Radiologists	302,994	301,718	1,276	0	0	0
Rheumatologists	302,994	301,718	1,276	0	0	0
Speech Therapists	302,994	301,718	1,276	0	0	0
Urologists	302,994	301,718	1,276	0	0	0
HIP						
Acute Care Hospitals	311,262	318,251	(6,989)	0	0	0
Anesthesiologists	311,262	318,251	(6,989)	0	0	0
Behavioral Health Providers	311,262	318,251	(6,989)	0	0	0
Cardiologists	311,262	318,251	(6,989)	0	0	0
Cardiothoracic Surgeons	311,262	318,251	(6,989)	0	0	0
Cardiovascular Surgeons	311,262	318,251	(6,989)	0	0	0
Dentists	311,262	318,251	(6,989)	0	1	(1)
Dermatologists	311,262	318,251	(6,989)	0	0	0
Diagnostic Testing	311,262	318,251	(6,989)	0	20,053	(20,053)
Durable Medical Equipment (DME)	311,262	318,251	(6,989)	0	0	0
Endocrinologists	311,262	318,251	(6,989)	0	0	0
ESRD Clinic	311,262	318,251	(6,989)	0	0	0
Gastroenterologists	311,262	318,251	(6,989)	0	0	0

Table C-6. Anthem Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
General Surgeons	311,262	318,251	(6,989)	0	0	0
Hematologists	311,262	318,251	(6,989)	0	0	0
Home Health Providers	311,262	318,251	(6,989)	0	0	0
Infectious Disease Specialists	311,262	318,251	(6,989)	0	0	0
Inpatient Psychiatric Facilities	311,262	318,251	(6,989)	0	0	0
Interventional Radiologists	311,262	318,251	(6,989)	0	0	0
Nephrologists	311,262	318,251	(6,989)	0	0	0
Neurological Surgeons	311,262	318,251	(6,989)	0	0	0
Neurologists	311,262	318,251	(6,989)	0	0	0
Nonhospital based Anesthesiologists	311,262	318,251	(6,989)	0	24,504	(24,504)
OBGYN	311,262	187,317	123,945	0	0	0
Occupational Therapists	311,262	318,251	(6,989)	0	0	0
Oncologists	311,262	318,251	(6,989)	0	0	0
Ophthalmologists	311,262	318,251	(6,989)	0	0	0
Optometrists	311,262	318,251	(6,989)	0	0	0
Oral Surgeons	311,262	318,251	(6,989)	0	3,428	(3,428)
Orthodontists	311,262	318,251	(6,989)	49,594	102,028	(52,434)
Orthopedic Surgeons	311,262	318,251	(6,989)	0	0	0
Otolaryngologists	311,262	318,251	(6,989)	0	0	0
Pathologists	311,262	318,251	(6,989)	0	0	0

Table C-6. Anthem Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Pharmacy	311,262	318,251	(6,989)	0	0	0
Physical Therapists	311,262	318,251	(6,989)	0	0	0
PMPs-Physicians	311,262	318,251	(6,989)	0	0	0
Prosthetic Suppliers	311,262	318,251	(6,989)	0	18,616	(18,616)
Psychiatrists	311,262	318,251	(6,989)	0	0	0
Pulmonologists	311,262	318,251	(6,989)	0	0	0
Radiation Oncologists	311,262	318,251	(6,989)	0	1,122	(1,122)
Radiologists	311,262	318,251	(6,989)	0	0	0
Rheumatologists	311,262	318,251	(6,989)	0	0	0
Speech Therapists	311,262	318,251	(6,989)	0	0	0
Urologists	311,262	318,251	(6,989)	0	0	0
HCC						
Acute Care Hospitals	44,047	44,791	(744)	0	0	0
Anesthesiologists	44,047	44,791	(744)	0	0	0
Behavioral Health Providers	44,047	44,791	(744)	0	0	0
Cardiologists	44,047	44,791	(744)	0	0	0
Cardiothoracic Surgeons	44,047	44,791	(744)	0	0	0
Cardiovascular Surgeons	44,047	44,791	(744)	0	0	0
Dentists	44,047	44,791	(744)	0	0	0
Dermatologists	44,047	44,791	(744)	0	0	0

Table C-6. Anthem Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Diagnostic Testing	44,047	44,791	(744)	0	3,342	(3,342)
Durable Medical Equipment (DME)	44,047	44,791	(744)	0	0	0
Endocrinologists	44,047	44,791	(744)	0	0	0
ESRD Clinic	44,047	44,791	(744)	0	0	0
Gastroenterologists	44,047	44,791	(744)	0	0	0
General Surgeons	44,047	44,791	(744)	0	0	0
Hematologists	44,047	44,791	(744)	0	0	0
Home Health Providers	44,047	44,791	(744)	0	0	0
Infectious Disease Specialists	44,047	44,791	(744)	0	0	0
Inpatient Psychiatric Facilities	44,047	44,791	(744)	0	0	0
Interventional Radiologists	44,047	44,791	(744)	0	0	0
Nephrologists	44,047	44,791	(744)	0	0	0
Neurological Surgeons	44,047	44,791	(744)	0	0	0
Neurologists	44,047	44,791	(744)	0	0	0
Nonhospital based Anesthesiologists	44,047	44,791	(744)	0	3,459	(3,459)
OBGYN	44,047	20,696	23,351	0	0	0
Occupational Therapists	44,047	44,791	(744)	0	0	0
Oncologists	44,047	44,791	(744)	0	0	0
Ophthalmologists	44,047	44,791	(744)	0	0	0
Optometrists	44,047	44,791	(744)	0	0	0

Table C-6. Anthem Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Oral Surgeons	44,047	44,791	(744)	0	614	(614)
Orthodontists	44,047	44,791	(744)	7,074	14,975	(7,901)
Orthopedic Surgeons	44,047	44,791	(744)	0	0	0
Otolaryngologists	44,047	44,791	(744)	0	0	0
Pathologists	44,047	44,791	(744)	0	0	0
Pharmacy	44,047	44,791	(744)	0	0	0
Physical Therapists	44,047	44,791	(744)	0	0	0
PMPs-Physicians	44,047	44,791	(744)	0	0	0
Podiatrists	44,047	44,791	(744)	0	0	0
Prosthetic Suppliers	44,047	44,791	(744)	0	2,668	(2,668)
Psychiatrists	44,047	44,791	(744)	0	0	0
Pulmonologists	44,047	44,791	(744)	0	0	0
Radiation Oncologists	44,047	44,791	(744)	0	2,666	(2,666)
Radiologists	44,047	44,791	(744)	0	0	0
Rheumatologists	44,047	44,791	(744)	0	0	0
Speech Therapists	44,047	44,791	(744)	0	0	0
Urologists	44,047	44,791	(744)	0	0	0

Note – Applied Behavior Analysis (ABA) Providers, Addiction Services, and Clinic were not calculated since there was no accessibility requirement.

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

Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
HHW						
Acute Care Hospitals	75,017	76,452	(1,435)	0	0	0
Anesthesiologists	75,017	76,452	(1,435)	0	0	0
Behavioral Health Providers	75,017	76,452	(1,435)	0	0	0
Cardiologists	75,017	76,452	(1,435)	0	0	0
Cardiothoracic Surgeons	75,017	76,452	(1,435)	0	0	0
Cardiovascular Surgeons	75,017	76,452	(1,435)	0	0	0
Dentists	75,017	76,452	(1,435)	41	275	(234)
Dermatologists	75,017	76,452	(1,435)	0	0	0
Diagnostic Testing	75,017	76,452	(1,435)	0	2,296	(2,296)
Durable Medical Equipment (DME)	75,017	76,452	(1,435)	0	0	0
Endocrinologists	75,017	76,452	(1,435)	0	0	0
ESRD Clinic	75,017	76,452	(1,435)	0	0	0
Gastroenterologists	75,017	76,452	(1,435)	0	0	0
General Surgeons	75,017	76,452	(1,435)	0	0	0
Hematologists	75,017	76,452	(1,435)	0	0	0
Home Health Providers	75,017	76,452	(1,435)	0	27,170	(27,170)
Infectious Disease Specialists	75,017	76,452	(1,435)	0	0	0
Inpatient Psychiatric Facilities	75,017	76,452	(1,435)	0	418	(418)
Interventional Radiologists	75,017	76,452	(1,435)	0	125	(125)

Table C-7. CareSource Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Nephrologists	75,017	76,452	(1,435)	0	0	0
Neurological Surgeons	75,017	76,452	(1,435)	0	0	0
Neurologists	75,017	76,452	(1,435)	0	0	0
Nonhospital based Anesthesiologists	75,017	76,452	(1,435)	0	0	0
OBGYN	75,017	38,621	36,396	0	0	0
Occupational Therapists	75,017	76,452	(1,435)	0	0	0
Oncologists	75,017	76,452	(1,435)	0	0	0
Ophthalmologists	75,017	76,452	(1,435)	0	0	0
Optometrists	75,017	76,452	(1,435)	0	0	0
Oral Surgeons	75,017	76,452	(1,435)	16	0	16
Orthodontists	75,017	76,452	(1,435)	20,676	18,073	2,603
Orthopedic Surgeons	75,017	76,452	(1,435)	0	0	0
Otolaryngologists	75,017	76,452	(1,435)	0	0	0
Pathologists	75,017	76,452	(1,435)	0	0	0
Pharmacy	75,017	76,452	(1,435)	0	0	0
Physical Therapists	75,017	76,452	(1,435)	0	0	0
PMPs-Physicians	75,017	76,452	(1,435)	0	0	0
Prosthetic Suppliers	75,017	76,452	(1,435)	0	0	0
Psychiatrists	75,017	76,452	(1,435)	0	0	0
Pulmonologists	75,017	76,452	(1,435)	0	0	0

Table C-7. CareSource Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Radiation Oncologists	75,017	76,452	(1,435)	0	0	0
Radiologists	75,017	76,452	(1,435)	0	0	0
Rheumatologists	75,017	76,452	(1,435)	0	0	0
Speech Therapists	75,017	76,452	(1,435)	0	0	0
Urologists	75,017	76,452	(1,435)	0	0	0
HIP						
Acute Care Hospitals	76,346	81,486	(5,140)	0	0	0
Anesthesiologists	76,346	81,486	(5,140)	0	0	0
Behavioral Health Providers	76,346	81,486	(5,140)	0	0	0
Cardiologists	76,346	81,486	(5,140)	0	0	0
Cardiothoracic Surgeons	76,346	81,486	(5,140)	0	0	0
Cardiovascular Surgeons	76,346	81,486	(5,140)	0	0	0
Dentists	76,346	81,486	(5,140)	38	77	(39)
Dermatologists	76,346	81,486	(5,140)	0	0	0
Diagnostic Testing	76,346	81,486	(5,140)	0	2,444	(2,444)
Durable Medical Equipment (DME)	76,346	81,486	(5,140)	0	0	0
Endocrinologists	76,346	81,486	(5,140)	0	0	0
ESRD Clinic	76,346	81,486	(5,140)	0	0	0
Gastroenterologists	76,346	81,486	(5,140)	0	0	0
General Surgeons	76,346	81,486	(5,140)	0	0	0

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

Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Hematologists	76,346	81,486	(5,140)	0	0	0
Home Health Providers	76,346	81,486	(5,140)	0	25,770	(25,770)
Infectious Disease Specialists	76,346	81,486	(5,140)	0	0	0
Inpatient Psychiatric Facilities	76,346	81,486	(5,140)	0	423	(423)
Interventional Radiologists	76,346	81,486	(5,140)	0	166	(166)
Nephrologists	76,346	81,486	(5,140)	0	0	0
Neurological Surgeons	76,346	81,486	(5,140)	0	0	0
Neurologists	76,346	81,486	(5,140)	0	0	0
Nonhospital based Anesthesiologists	76,346	81,486	(5,140)	0	0	0
OBGYN	76,346	42,492	33,854	0	0	0
Occupational Therapists	76,346	81,486	(5,140)	0	0	0
Oncologists	76,346	81,486	(5,140)	0	0	0
Ophthalmologists	76,346	81,486	(5,140)	0	0	0
Optometrists	76,346	81,486	(5,140)	0	0	0
Oral Surgeons	76,346	81,486	(5,140)	195	587	(392)
Orthodontists	76,346	81,486	(5,140)	23,034	19,001	4,033
Orthopedic Surgeons	76,346	81,486	(5,140)	0	0	0
Otolaryngologists	76,346	81,486	(5,140)	0	0	0
Pathologists	76,346	81,486	(5,140)	0	0	0
Pharmacy	76,346	81,486	(5,140)	0	0	0

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

Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Physical Therapists	76,346	81,486	(5,140)	0	0	0
PMPs-Physicians	76,346	81,486	(5,140)	0	0	0
Prosthetic Suppliers	76,346	81,486	(5,140)	0	0	0
Psychiatrists	76,346	81,486	(5,140)	0	0	0
Pulmonologists	76,346	81,486	(5,140)	0	0	0
Radiation Oncologists	76,346	81,486	(5,140)	0	0	0
Radiologists	76,346	81,486	(5,140)	0	0	0
Rheumatologists	76,346	81,486	(5,140)	0	0	0
Speech Therapists	76,346	81,486	(5,140)	0	0	0
Urologists	76,346	81,486	(5,140)	0	0	0

Note – ABA Providers, Addiction Services, and Clinic were not calculated since there was no accessibility requirement.

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

Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
HHW						
Acute Care Hospitals	194,703	193,803	900	0	0	0
Anesthesiologists	194,703	193,803	900	0	0	0
Behavioral Health Providers	194,703	193,803	900	0	0	0

Table C-8. MDwise Member Access to Providers – Verification of Report 0903						
Category	**Number of Members**			**Members Without Sufficient Access**		
	MCE Report 0903	**Calculated**	**Over (Under) Reported**	**MCE Report 0903**	**Calculated**	**Over (Under) Reported**
Cardiologists	194,703	193,803	900	0	0	0
Cardiothoracic Surgeons	194,703	193,803	900	0	0	0
Cardiovascular Surgeons	194,703	193,803	900	0	0	0
Dentists	194,703	193,803	900	0	137	(137)
Dermatologists	194,703	193,803	900	0	0	0
Diagnostic Testing	194,703	193,803	900	66,461	32,247	34,214
Durable Medical Equipment (DME)	194,703	193,803	900	0	0	0
Endocrinologists	194,703	193,803	900	0	0	0
ESRD Clinic	194,703	193,803	900	4,111	0	4,111
Gastroenterologists	194,703	193,803	900	0	0	0
General Surgeons	194,703	193,803	900	0	0	0
Hematologists	194,703	193,803	900	0	0	0
Home Health Providers	194,703	193,803	900	0	82,865	(82,865)
Infectious Disease Specialists	194,703	193,803	900	0	0	0
Inpatient Psychiatric Facilities	194,703	193,803	900	0	3,353	(3,353)
Interventional Radiologists	194,703	193,803	900	8	0	8
Nephrologists	194,703	193,803	900	0	0	0
Neurological Surgeons	194,703	193,803	900	0	0	0
Neurologists	194,703	193,803	900	0	0	0
Nonhospital based Anesthesiologists	194,703	193,803	900	0	0	0

Table C-8. MDwise Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
OBGYN	194,703	97,008	97,695	183	0	183
Occupational Therapists	194,703	193,803	900	0	0	0
Oncologists	194,703	193,803	900	0	0	0
Ophthalmologists	194,703	193,803	900	0	0	0
Optometrists	194,703	193,803	900	0	0	0
Oral Surgeons	194,703	193,803	900	180	0	180
Orthodontists	194,703	193,803	900	16,454	29,544	(13,090)
Orthopedic Surgeons	194,703	193,803	900	0	0	0
Otolaryngologists	194,703	193,803	900	0	0	0
Pathologists	194,703	193,803	900	0	0	0
Pharmacy	194,703	193,803	900	0	0	0
Physical Therapists	194,703	193,803	900	0	0	0
PMPs-Physicians	194,703	193,803	900	0	0	0
Prosthetic Suppliers	194,703	193,803	900	0	0	0
Psychiatrists	194,703	193,803	900	0	0	0
Pulmonologists	194,703	193,803	900	0	0	0
Radiation Oncologists	194,703	193,803	900	0	0	0
Radiologists	194,703	193,803	900	0	0	0
Rheumatologists	194,703	193,803	900	0	0	0
Speech Therapists	194,703	193,803	900	0	0	0

Table C-8. MDwise Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Urologists	194,703	193,803	900	0	0	0
HIP						
Acute Care Hospitals	160,391	154,552	5,839	0	0	0
Anesthesiologists	160,391	154,552	5,839	0	0	0
Behavioral Health Providers	160,391	154,552	5,839	1	0	1
Cardiologists	160,391	154,552	5,839	0	0	0
Cardiothoracic Surgeons	160,391	154,552	5,839	0	0	0
Cardiovascular Surgeons	160,391	154,552	5,839	0	0	0
Dentists	160,391	154,552	5,839	0	96	(96)
Dermatologists	160,391	154,552	5,839	0	0	0
Diagnostic Testing	160,391	154,552	5,839	56,943	28,205	28,738
Durable Medical Equipment (DME)	160,391	154,552	5,839	0	0	0
Endocrinologists	160,391	154,552	5,839	0	0	0
ESRD Clinic	160,391	154,552	5,839	2,954	0	2,954
Gastroenterologists	160,391	154,552	5,839	0	0	0
General Surgeons	160,391	154,552	5,839	0	0	0
Hematologists	160,391	154,552	5,839	0	0	0
Home Health Providers	160,391	154,552	5,839	0	67,070	(67,070)
Infectious Disease Specialists	160,391	154,552	5,839	0	0	0
Inpatient Psychiatric Facilities	160,391	154,552	5,839	0	2,824	(2,824)

Table C-8. MDwise Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Interventional Radiologists	160,391	154,552	5,839	4	0	4
Nephrologists	160,391	154,552	5,839	0	0	0
Neurological Surgeons	160,391	154,552	5,839	0	0	0
Neurologists	160,391	154,552	5,839	0	0	0
Nonhospital based Anesthesiologists	160,391	154,552	5,839	0	0	0
OBGYN	160,391	95,506	64,885	221	0	221
Occupational Therapists	160,391	154,552	5,839	0	0	0
Oncologists	160,391	154,552	5,839	0	0	0
Ophthalmologists	160,391	154,552	5,839	0	0	0
Optometrists	160,391	154,552	5,839	0	0	0
Oral Surgeons	160,391	154,552	5,839	175	0	175
Orthodontists	160,391	154,552	5,839	16,263	25,525	(9,262)
Orthopedic Surgeons	160,391	154,552	5,839	0	0	0
Otolaryngologists	160,391	154,552	5,839	0	0	0
Pathologists	160,391	154,552	5,839	0	0	0
Pharmacy	160,391	154,552	5,839	5	0	5
Physical Therapists	160,391	154,552	5,839	0	0	0
PMPs-Physicians	160,391	154,552	5,839	0	0	0
Prosthetic Suppliers	160,391	154,552	5,839	0	0	0
Psychiatrists	160,391	154,552	5,839	0	0	0

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

Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Pulmonologists	160,391	154,552	5,839	0	0	0
Radiation Oncologists	160,391	154,552	5,839	0	0	0
Radiologists	160,391	154,552	5,839	0	0	0
Rheumatologists	160,391	154,552	5,839	0	0	0
Speech Therapists	160,391	154,552	5,839	0	0	0
Urologists	160,391	154,552	5,839	0	0	0

Note – ABA Providers, Addiction Services, and Clinic were not calculated since there was no accessibility requirement.

Table C-9. MHS Member Access to Providers – Verification of Report 0903

Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
HHW						
Acute Care Hospitals	174,010	172,071	1,939	0	0	0
Anesthesiologists	174,010	172,071	1,939	0	0	0
Behavioral Health Providers	174,010	172,071	1,939	0	0	0
Cardiologists	174,010	172,071	1,939	0	0	0
Cardiothoracic Surgeons	174,010	172,071	1,939	0	5,099	(5,099)
Cardiovascular Surgeons	174,010	172,071	1,939	0	32,563	(32,563)
Dentists	174,010	172,071	1,939	0	101	(101)

Table C-9. MHS Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Dermatologists	174,010	172,071	1,939	0	117	(117)
Diagnostic Testing	174,010	172,071	1,939	97,267	90,534	6,733
Durable Medical Equipment (DME)	174,010	172,071	1,939	0	47,266	(47,266)
Endocrinologists	174,010	172,071	1,939	0	2,448	(2,448)
ESRD Clinic	174,010	172,071	1,939	0	0	0
Gastroenterologists	174,010	172,071	1,939	0	949	(949)
General Surgeons	174,010	172,071	1,939	0	0	0
Hematologists	174,010	172,071	1,939	0	3,090	(3,090)
Home Health Providers	174,010	172,071	1,939	0	0	0
Infectious Disease Specialists	174,010	172,071	1,939	0	0	0
Inpatient Psychiatric Facilities	174,010	172,071	1,939	0	1,127	(1,127)
Interventional Radiologists	174,010	172,071	1,939	0	0	0
Nephrologists	174,010	172,071	1,939	0	12,182	(12,182)
Neurological Surgeons	174,010	172,071	1,939	0	0	0
Neurologists	174,010	172,071	1,939	0	0	0
Nonhospital based Anesthesiologists	174,010	172,071	1,939	0	0	0
OBGYN	174,010	86,084	87,926	0	0	0
Occupational Therapists	174,010	172,071	1,939	0	0	0
Oncologists	174,010	172,071	1,939	0	2,853	(2,853)
Ophthalmologists	174,010	172,071	1,939	0	11	(11)

Table C-9. MHS Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Optometrists	174,010	172,071	1,939	0	0	0
Oral Surgeons	174,010	172,071	1,939	117	9	108
Orthodontists	174,010	172,071	1,939	50,309	41,317	8,992
Orthopedic Surgeons	174,010	172,071	1,939	0	0	0
Otolaryngologists	174,010	172,071	1,939	0	154	(154)
Pathologists	174,010	172,071	1,939	0	0	0
Pharmacy	174,010	172,071	1,939	0	0	0
Physical Therapists	174,010	172,071	1,939	0	0	0
PMPs-Physicians	174,010	172,071	1,939	0	4	(4)
Prosthetic Suppliers	174,010	172,071	1,939	0	0	0
Psychiatrists	174,010	172,071	1,939	0	0	0
Pulmonologists	174,010	172,071	1,939	0	500	(500)
Radiation Oncologists	174,010	172,071	1,939	0	202	(202)
Radiologists	174,010	172,071	1,939	0	0	0
Rheumatologists	174,010	172,071	1,939	0	2,855	(2,855)
Speech Therapists	174,010	172,071	1,939	0	125	(125)
Urologists	174,010	172,071	1,939	0	1	(1)
HIP						
Acute Care Hospitals	131,142	129,105	2,037	0	0	0
Anesthesiologists	131,142	129,105	2,037	0	0	0

Table C-9. MHS Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Behavioral Health Providers	131,142	129,105	2,037	0	0	0
Cardiologists	131,142	129,105	2,037	0	0	0
Cardiothoracic Surgeons	131,142	129,105	2,037	0	3,913	(3,913)
Cardiovascular Surgeons	131,142	129,105	2,037	0	230	(230)
Dentists	131,142	129,105	2,037	0	63	(63)
Dermatologists	131,142	129,105	2,037	0	0	0
Diagnostic Testing	131,142	129,105	2,037	71,035	63,743	7,292
Durable Medical Equipment (DME)	131,142	129,105	2,037	0	35,327	(35,327)
Endocrinologists	131,142	129,105	2,037	0	248	(248)
ESRD Clinic	131,142	129,105	2,037	0	0	0
Gastroenterologists	131,142	129,105	2,037	0	0	0
General Surgeons	131,142	129,105	2,037	0	0	0
Hematologists	131,142	129,105	2,037	0	6	(6)
Home Health Providers	131,142	129,105	2,037	0	0	0
Infectious Disease Specialists	131,142	129,105	2,037	0	0	0
Inpatient Psychiatric Facilities	131,142	129,105	2,037	0	1,501	(1,501)
Interventional Radiologists	131,142	129,105	2,037	0	0	0
Nephrologists	131,142	129,105	2,037	0	0	0
Neurological Surgeons	131,142	129,105	2,037	0	0	0
Neurologists	131,142	129,105	2,037	0	0	0

Table C-9. MHS Member Access to Providers – Verification of Report 0903

Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Nonhospital based Anesthesiologists	131,142	129,105	2,037	0	0	0
OBGYN	131,142	77,384	53,758	0	0	0
Occupational Therapists	131,142	129,105	2,037	0	0	0
Oncologists	131,142	129,105	2,037	0	6	(6)
Ophthalmologists	131,142	129,105	2,037	0	0	0
Optometrists	131,142	129,105	2,037	0	0	0
Oral Surgeons	131,142	129,105	2,037	132	6	126
Orthodontists	131,142	129,105	2,037	34,494	37,886	(3,392)
Orthopedic Surgeons	131,142	129,105	2,037	0	0	0
Otolaryngologists	131,142	129,105	2,037	0	0	0
Pathologists	131,142	129,105	2,037	0	0	0
Pharmacy	131,142	129,105	2,037	0	0	0
Physical Therapists	131,142	129,105	2,037	0	0	0
PMPs-Physicians	131,142	129,105	2,037	0	0	0
Prosthetic Suppliers	131,142	129,105	2,037	0	0	0
Psychiatrists	131,142	129,105	2,037	0	0	0
Pulmonologists	131,142	129,105	2,037	0	126	(126)
Radiation Oncologists	131,142	129,105	2,037	0	0	0
Radiologists	131,142	129,105	2,037	0	0	0
Rheumatologists	131,142	129,105	2,037	0	0	0

Table C-9. MHS Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Speech Therapists	131,142	129,105	2,037	0	103	(103)
Urologists	131,142	129,105	2,037	0	0	0
HCC						
Acute Care Hospitals	27,841	27,954	(113)	0	0	0
Anesthesiologists	27,841	27,954	(113)	0	0	0
Behavioral Health Providers	27,841	27,954	(113)	0	0	0
Cardiologists	27,841	27,954	(113)	0	0	0
Cardiothoracic Surgeons	27,841	27,954	(113)	0	20	(20)
Cardiovascular Surgeons	27,841	27,954	(113)	0	824	(824)
Dentists	27,841	27,954	(113)	0	10	(10)
Dermatologists	27,841	27,954	(113)	0	1,489	(1,489)
Diagnostic Testing	27,841	27,954	(113)	14,766	13,742	1,024
Durable Medical Equipment (DME)	27,841	27,954	(113)	0	8,017	(8,017)
Endocrinologists	27,841	27,954	(113)	0	381	(381)
ESRD Clinic	27,841	27,954	(113)	0	0	0
Gastroenterologists	27,841	27,954	(113)	0	67	(67)
General Surgeons	27,841	27,954	(113)	0	0	0
Hematologists	27,841	27,954	(113)	0	407	(407)
Home Health Providers	27,841	27,954	(113)	0	0	0
Infectious Disease Specialists	27,841	27,954	(113)	0	0	0

Table C-9. MHS Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Inpatient Psychiatric Facilities	27,841	27,954	(113)	0	2	(2)
Interventional Radiologists	27,841	27,954	(113)	0	0	0
Nephrologists	27,841	27,954	(113)	0	2,065	(2,065)
Neurological Surgeons	27,841	27,954	(113)	0	0	0
Neurologists	27,841	27,954	(113)	0	0	0
Nonhospital based Anesthesiologists	27,841	27,954	(113)	0	0	0
OBGYN	27,841	12,529	15,312	0	0	0
Occupational Therapists	27,841	27,954	(113)	0	0	0
Oncologists	27,841	27,954	(113)	0	398	(398)
Ophthalmologists	27,841	27,954	(113)	0	2	(2)
Optometrists	27,841	27,954	(113)	0	0	0
Oral Surgeons	27,841	27,954	(113)	60	0	60
Orthodontists	27,841	27,954	(113)	6,872	6,650	222
Orthopedic Surgeons	27,841	27,954	(113)	0	0	0
Otolaryngologists	27,841	27,954	(113)	0	9	(9)
Pathologists	27,841	27,954	(113)	0	0	0
Pharmacy	27,841	27,954	(113)	0	0	0
Physical Therapists	27,841	27,954	(113)	0	0	0
PMPs-Physicians	27,841	27,954	(113)	0	2	(2)
Podiatrists	27,841	27,954	(113)	0	9	(9)

Table C-9. MHS Member Access to Providers – Verification of Report 0903						
Category	Number of Members			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Prosthetic Suppliers	27,841	27,954	(113)	0	0	0
Psychiatrists	27,841	27,954	(113)	0	0	0
Pulmonologists	27,841	27,954	(113)	0	211	(211)
Radiation Oncologists	27,841	27,954	(113)	0	0	0
Radiologists	27,841	27,954	(113)	0	0	0
Rheumatologists	27,841	27,954	(113)	0	238	(238)
Speech Therapists	27,841	27,954	(113)	0	26	(26)
Urologists	27,841	27,954	(113)	0	0	0

Note – ABA Providers, Addiction Services, and Clinic were not calculated since there was no accessibility requirement.

Table C-10. UHC Member Access to Providers – Verification of Report 0903						
Category	Number of Members Enrolled			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
HCC						
Acute Care Hospitals	5,726	5,680	46	0	0	0
Anesthesiologists	5,726	5,680	46	0	0	0
Behavioral Health Providers	5,726	5,680	46	0	0	0
Cardiologists	5,726	5,680	46	0	0	0
Cardiothoracic Surgeons	5,726	5,680	46	0	0	0

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

Category	Number of Members Enrolled			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Cardiovascular Surgeons	5,726	5,680	46	0	0	0
Dentists	5,726	5,680	46	2	4	(2)
Dermatologists	5,726	5,680	46	0	0	0
Diagnostic Testing	5,726	5,680	46	1,939	1,503	436
Durable Medical Equipment (DME)	5,726	5,680	46	0	0	0
Endocrinologists	5,726	5,680	46	0	0	0
ESRD Clinic	5,726	5,680	46	0	0	0
Gastroenterologists	5,726	5,680	46	0	0	0
General Surgeons	5,726	5,680	46	0	0	0
Hematologists	5,726	5,680	46	0	0	0
Home Health Providers	5,726	5,680	46	0	0	0
Infectious Disease Specialists	5,726	5,680	46	0	0	0
Inpatient Psychiatric Facilities	5,726	5,680	46	0	0	0
Interventional Radiologists	5,726	5,680	46	0	17	(17)
Nephrologists	5,726	5,680	46	0	0	0
Neurological Surgeons	5,726	5,680	46	0	0	0
Neurologists	5,726	5,680	46	0	0	0
Nonhospital based Anesthesiologists	5,726	5,680	46	0	0	0
OBGYN	5,726	1,583	4,143	0	0	0
Occupational Therapists	5,726	5,680	46	0	0	0

Table C-10. UHC Member Access to Providers – Verification of Report 0903						
Category	Number of Members Enrolled			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Oncologists	5,726	5,680	46	0	0	0
Ophthalmologists	5,726	5,680	46	0	0	0
Optometrists	5,726	5,680	46	0	0	0
Oral Surgeons	5,726	5,680	46	242	0	242
Orthodontists	5,726	5,680	46	1,930	1,992	(62)
Orthopedic Surgeons	5,726	5,680	46	0	0	0
Otolaryngologists	5,726	5,680	46	0	0	0
Pathologists	5,726	5,680	46	0	0	0
Pharmacy	5,726	5,680	46	0	0	0
Physical Therapists	5,726	5,680	46	0	0	0
PMPs-Physicians	5,726	5,680	46	0	0	0
Podiatrists	5,726	5,680	46	0	0	0
Prosthetic Suppliers	5,726	5,680	46	0	0	0
Psychiatrists	5,726	5,680	46	0	0	0
Pulmonologists	5,726	5,680	46	0	0	0
Radiation Oncologists	5,726	5,680	46	0	0	0
Radiologists	5,726	5,680	46	0	0	0
Rheumatologists	5,726	5,680	46	0	6	(6)
Speech Therapists	5,726	5,680	46	0	0	0

Table C-10. UHC Member Access to Providers – Verification of Report 0903						
Category	Number of Members Enrolled			Members Without Sufficient Access		
	MCE Report 0903	Calculated	Over (Under) Reported	MCE Report 0903	Calculated	Over (Under) Reported
Urologists	5,726	5,680	46	0	0	0

Note – ABA Providers, Addiction Services, and Clinic were not calculated since there was no accessibility requirement.