April 2026

2025 Annual

EQR Technical Report

Indiana Family and Social Services

Office of Medicaid Policy and Planning

Indiana PathWays for Aging

Final

Office of Medicaid Policy & Planning

Qsource®

Table of Contents

List of Tables

List of Tables

List of Figures

Acknowledgements, Acronyms, and Initialisms[1]

AAP ..... Adults' Access to Preventive/Ambulatory Health Services
AHRQ ..... Agency for Healthcare Research and Quality
AHU ..... Acute Hospital Utilization
ANA ..... Annual Network Adequacy
Anthem ..... Blue Cross Blue Shield Anthem, Managed Care Entity
AON ..... Area of Noncompliance
BH ..... Behavioral Health
BPD ..... Blood Pressure Control for Patients with Diabetes
CA ..... Compliance Assessment
CAHPS® ..... Consumer Assessment of Healthcare Provider and Services
CAP ..... Corrective Action Plan
CAU ..... Comprehensive Assessment and Update
CBP ..... Controlling Blood Pressure
CFR ..... Code of Federal Regulations
CHAT ..... Comprehensive Health Assessment Tool
CHIP ..... Children's Health Insurance Program
CMS ..... Centers for Medicare & Medicaid Services
CPT ..... Current Procedural Terminology
CPU ..... Comprehensive Care Plan Update
CY ..... Calendar Year
DME ..... Durable Medical Equipment
EDQ ..... Enterprise Data Warehouse
EDU ..... Emergency Department Utilization
EDV ..... Electronic Data Verification
EDW ..... Electronic Data Warehouse
EED ..... Eye Exam for Patients with Diabetes
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
ESRI ArcGIS™ ..... Environmental Systems Research Institute, Inc. ArcGISTM
EVV ..... Electronic Visit Verification
FFS ..... Fee-for-Service
FSSA ..... Indiana Family and Social Services Administration
FUA ..... Follow-up After Emergency Department Visit for Drug Abuse or Dependence
FUH ..... Follow-Up After Hospitalization for Mental Illness
FUM .. Follow-Up After Emergency Department Visit for Mental Illness
GD ..... General Dentist
GSD ..... Glycemic Status Assessment for Patients with Diabetes
GYN ..... Gynecologist
HbA1c ..... Hemoglobin A1c
HCBS ..... Home- and Community-Based Services
HEDIS® ..... Healthcare Effectiveness Data and Information Set, a registered trademark of the National Committee for Quality Assurance (NCQA)
HNS ..... Health Needs Screening
Humana ..... Humana Healthy Horizons, Managed Care Entity
ICP ..... Individualized Care Plan
ID ..... Identification
IET ..... Initiation and Engagement of Alcohol and Other Drugs
IMD ..... Institution for Mental Disease
ISCA/ISCAT ..... Information Systems Capability Assessment Tool
KED ..... Kidney Health Evaluation for Patients with Diabetes
LTSS ..... Long-Term Services and Supports

[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.*

MCE ..... Managed Care Entity
MCP ..... Managed Care Plan
MLTSS ..... Managed Long-Term Services and Supports
MMIS ..... Medicaid Management Information System
MRR ..... Medical Record Review
MY ..... Measurement Year
N ..... Number of Encounters
NA ..... Not Applicable
NABD ..... Notice of Adverse Benefit Decisions
NCQA ..... National Committee for Quality Assurance
NDC ..... National Drug Code
NF ..... Nursing Facility
NFLOC ..... Nursing Facility Level of Care
NPI ..... National Provider Identifier
NQ ..... Not Required
NR ..... Not Reported
OMPP ..... Office of Medicaid Policy and Planning
P&P ..... Policy and Procedure
PathWays ..... Indiana's PathWays to Aging Waiver Program
PCP ..... Primary Care Provider/Physician
PCR ..... Plan All-Cause Readmissions
PDF ..... Portable Document Format
PDSA ..... Plan-Do-Study-Act
PIP ..... Performance Improvement Project
PMP ..... Primary Medical Provider
PMV ..... Performance Measure Validation
QI ..... Quality Improvement
Qsource® ..... EQRO, a registered trademark
Roadmap ..... Record of Administration, Data Management and Processes
SAA ..... Adherence to Antipsychotic Medications for Individuals with Schizophrenia
SCP ..... Shared Care Plan with PCP
SMC ..... Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia
SMD ..... Diabetes Monitoring for Persons with Diabetes and Schizophrenia
SMI ..... Serious Mental Illness
SNF ..... Skilled Nursing Facility
SPU ..... Special Population Unit
SQL ..... Structured Query Language
SSD ..... Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications
SUD ..... Substance Use Disorder
TBD ..... To Be Determined
UB ..... Uniform Bill
UHC ..... UnitedHealthcare Community Plan, Managed Care Entity
UM ..... Utilization Management

Overview

In accordance with Title 42 *Code of Federal Regulations* (CFR) § 438.364, Qsource has produced this *2025 Annual External Quality Review Organization (EQRO) Technical Report* to summarize the quality, timeliness, and accessibility of care furnished to members in the Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) Indiana PathWays for Aging (hereafter referred to as PathWays) program by the Managed Care Entities (MCEs). Indiana's MCEs for PathWays include Blue Cross Blue Shield Anthem (hereafter referred to as Anthem), Humana Healthy Horizons (hereafter referred to as Humana), and UnitedHealthcare Community Plan (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' 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, member data for each MCE, OMPP's quality improvement initiative descriptions, 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 new PathWays program, began on July 1, 2024, is aimed towards Hoosiers aged 60 or older who receive Medicaid or dual Medicaid/Medicare benefits. This program gives the qualifying member access to a care and services coordinator that helps the member receive the individualized care they need to remain independent in their own homes for as long as possible and age with dignity. This program expands Indiana's Medicaid services, as well as their goal to safeguard distinct, susceptible populations throughout the state.

Three MCEs are contracted with the state of Indiana for the PathWays program:

- Anthem;
- Humana; and
- UHC.

Members

Calendar Year (CY) 2024 was the first year for the PathWays program, having started on July 1, 2024. According to the March 2025 FSSA narrative on the monthly Medicaid financial report for December 2024, OMPP stated that, with the launch of the PathWays Program, enrollment of 116,785 individuals shifted from Medicaid fee-for-service and Hoosier Care Connect to the new PathWays managed care program. The year-to-date average monthly enrollment for PathWays from its inception through December 2024 is 116,971. The following table presents enrollment for 2024 since the inception of the program by month.

Table 1. Total Members by Month

	July-24	August-24	September-24	October-24	November-24	December-24
Anthem	44,428	44,740	44,898	45,121	44,821	45,003
Humana	35,441	35,331	35,326	35,347	35,085	35,098
UHC	36,762	36,942	36,947	36,973	36,709	36,854
Total	**116,631**	**117,013**	**117,171**	**117,441**	**116,615**	**116,955**

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

1. Quality – Monitor quality improvement measures and strive to maintain high standards.
    a. Improve health outcomes.
    b. Encourage quality, continuity, and appropriateness of medical care.
2. Prevention – Foster access to primary and preventive care services with a family focus.
    a. Promote primary and preventive care.
    b. Foster personal responsibility and healthy lifestyles.
3. Cost – Ensure cost-effective medical coverage.
    a. Deliver cost-effective coverage.
    b. Ensure the appropriate use of health care services.
    c. Ensure utilization management best practices.

4. Coordination/Integration – Encourage the organization of patient activities to ensure appropriate care.
    a. Integrate physical and Behavioral Health (BH) services.
    b. Emphasize communication and collaboration with network providers.

OMPP Strategic Objectives for Quality Improvement

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

The initiatives are at the forefront of planning and implementation of this Quality Strategy. Ongoing monitoring will provide OMPP with quality-related data for future monitoring and planning. To this end, OMPP established the Five Pillars of Well Being, based off 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. Please note that the second pillar listed below is not applicable to the PathWays program members due to demographics; however, all Pillars are listed below for understanding of OMPP's initiatives.

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.

Table 2 presents the strategic initiatives for each MCE, as well as past achievement results against the OMPP-established goals. Because 2024 was the first year that the PathWays program was active, any measure relating to the Healthcare Effectiveness Data and Information Set (HEDIS®) data was waived for the calendar year, as were many performance measures. These waived measures are listed in the table as Not Reported. Reported measures will be considered baseline data for future comparisons. Likewise, goals will be identified for the measures relative to the baseline year; therefore, all goals are listed as To be Determined (TBD).

Table 2. PathWays Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Baseline
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 of Care and Access to Care	HEDIS® measure using administrative data	Anthem Humana UHC	TBD*	Not reported
Measure: Follow-Up After Hospitalization for Mental Illness (FUH) 7-Day and 30-Day Follow-Up **Domain:** Quality of Care and Access to Care	HEDIS® measure using administrative data	Anthem Humana UHC	TBD	Not reported
Measure: Follow-Up After Emergency Department Visit for Mental Illness (FUM) 7-Day and 30-Day Follow-Up **Domain:** Quality of Care and Access to Care	HEDIS® measure using administrative data	Anthem Humana UHC	TBD	Not reported
Measure: Initiation and Engagement of Alcohol and Other Drug (IET) Total **Domain:** Timeliness of Care and Access to Care	HEDIS® measure using administrative data	Anthem Humana UHC	TBD	Not reported
Measure: Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	HEDIS® measure using administrative data	Anthem Humana	TBD	Not reported

Table 2. PathWays Quality Strategy Initiatives				
Measure and Domain	**Methodology**	**MCE**	**Goal**	**Baseline**
Domain: Timeliness of Care and Access to Care		UHC		
Measure: Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SSD) **Domain:** Quality of Care and Access to Care	HEDIS® measure using administrative data	Anthem	TBD	Not Reported
		Humana		
		UHC		
Measure: Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia (SMC) **Domain:** Quality of Care and Access to Care	HEDIS® measure using administrative data	Anthem	TBD	Not Reported
		Humana		
		UHC		
Measure: Diabetes Monitoring for Persons with Diabetes and Schizophrenia (SMD) **Domain:** Quality of Care and Access to Care	HEDIS® measure using administrative data	Anthem	TBD	Not Reported
		Humana		
		UHC		
Goal 3: Improve Oral Health and Prevent Oral Disease				
Measure: Dentists and Oral Surgeons Network Adequacy **Domain:** Quality of Care and Access to Care	OMPP-chosen performance measure using administrative data	Anthem	TBD	2.17%
		Humana		76.09%
		UHC		14.13%
Goal 4: Improve the Health of Members with Chronic Conditions				
Measure: Glycemic Status Assessment for Patients with Diabetes (GSD) **Domain:** Timeliness of Care and Access to Care	HEDIS® measure using administrative data	Anthem	TBD	Not Reported
		Humana		
		UHC		
Measure: Blood Pressure Control for Patients with Diabetes (BPD)	HEDIS® measure using administrative data	Anthem	TBD	Not Reported
		Humana		

Table 2. PathWays Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Baseline
Domain: Quality of Care, Timeliness of Care, and Access to Care		UHC		
Measure: Eye Exam for Patients with Diabetes (EED) **Domain:** Quality of Care, Timeliness of Care, and Access to Care	HEDIS® measure using administrative data	Anthem Humana UHC	TBD	Not Reported
Measure: Kidney Health Evaluation for Patients with Diabetes (KED) **Domain:** Quality of Care, Timeliness of Care, and Access to Care	HEDIS® measure using administrative data	Anthem Humana UHC	TBD	Not Reported
Measure: Controlling Blood Pressure (CBP) **Domain:** Quality of Care, Timeliness of Care, and Access to Care	HEDIS® measure using administrative data	Anthem Humana UHC	TBD	Not Reported
Measure: Adults' Access to Preventive/Ambulatory Health Services (AAP) **Domain:** Quality of Care, Timeliness of Care, and Access to Care	HEDIS® measure using administrative data	Anthem Humana UHC	TBD	Not Reported
Measure: Acute Hospital Utilization (AHU) **Domain:** Quality of Care, Timeliness of Care, and Access to Care	HEDIS® measure using administrative data	Anthem Humana UHC	TBD	Not Reported
Measure: Emergency Department Utilization (EDU) **Domain:** Timeliness of Care and Access to Care	HEDIS® measure using administrative data	Anthem Humana UHC	TBD	Not Reported

Table 2. PathWays Quality Strategy Initiatives				
Measure and Domain	**Methodology**	**MCE**	**Goal**	**Baseline**
Goal 5: Improve Care Coordination Across the Entire Service Continuum				
Measure: Plan All-Cause Readmissions (PCR) **Domain:** Timeliness of Care and Access to Care	HEDIS® measure using administrative data	Anthem	TBD	Not Reported
		Humana		
		UHC		
Measure: Managed Long-Term Services and Supports (MLTSS)-1 Medicaid Managed Long-Term Services and Supports Comprehensive Assessment and Update **Domain:** Quality of Care	CMS-chosen performance measure using administrative data	Anthem	TBD	Not Reported
		Humana		
		UHC		
Measure: MLTSS-2 Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update **Domain:** Access to Care	CMS-chosen performance measure using administrative data	Anthem	TBD	Not Reported
		Humana		
		UHC		
Measure: MLTSS-3 Medicaid Managed Long-Term Services and Supports Shared Care Plan with Primary Care Provider **Domain:** Quality of Care and Access to Care	CMS-chosen performance measure using administrative data	Anthem	TBD	Not Reported
		Humana		
		UHC		
Measure: MLTSS-4 Medicaid Managed Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge **Domain:** Quality of Care and Access to Care	CMS-chosen performance measure using administrative data	Anthem	TBD	Not Reported
		Humana		
		UHC		
Measure: MLTSS-5 Screening, Risk Assessment, and Plan of Care to Prevent Future Falls **Domain:** Quality of Care and Access to Care	CMS-chosen performance measure using administrative data	Anthem	TBD	Not Reported
		Humana		
		UHC		

Table 2. PathWays Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	Goal	Baseline
Measure: MLTSS-6 Medicaid Managed Long-Term Services and Supports Admission to a Facility from the Community **Domain:** Access to Care	CMS-chosen performance measure using administrative data	Anthem	TBD	Not Reported
		Humana		
		UHC		
Measure: MLTSS-7 Medicaid Managed Long-Term Services and Supports Minimizing Facility Length of Stay **Domain:** Access to Care	CMS-chosen performance measure using administrative data	Anthem	TBD	Not Reported
		Humana		
		UHC		
Measure: MLTSS-8 Medicaid Managed Long-Term Services and Supports Successful Transition after Long-Term Facility Stay **Domain:** Quality of Care and Access to Care	CMS-chosen performance measure using administrative data	Anthem	TBD	Not Reported
		Humana		
		UHC		
Measure: Completion of Initial Health Needs Screening Within 30 Days or 90 Days of MCE Enrollment Based on Care Program; Comprehensive Health Assessment Tool (CHAT) and Health Needs Screening (HNS) **Domain:** Quality of Care, Timeliness of Care, and Access to Care	OMPP-chosen performance measure using administrative data	Anthem	TBD	CHAT: 0.00%
				HNS: 4.66%
		Humana		CHAT: 4.94%
				HNS: 5.44%
		UHC		CHAT: 0.00%
				HNS: 2.56%
Measure: Participants Who Report Knowing Who Their MCE Care Manager Is **Domain:** Quality of Care, Timeliness of Care, and Access to Care	OMPP-chosen performance measure using administrative data	Anthem	TBD	Not Reported
		Humana		
		UHC		
Measure: Participants who, in the Last 3 Months,	OMPP-chosen	Anthem	TBD	Not Reported

Table 2. PathWays Quality Strategy Initiatives				
Measure and Domain	**Methodology**	**MCE**	**Goal**	**Baseline**
Reported that Their Service Plan Included Most or all of the Things that are Important to Them **Domain:** Quality of Care and Access to Care	performance measure using administrative data	Humana		
		UHC		
Measure: Service Coordinators Who Have Successfully Completed Person-Centered Planning Competency Training Within 90 Days of Hire **Domain:** Quality of Care, Timeliness of Care, and Access to Care	OMPP-chosen performance measure using administrative data	Anthem	TBD	99.00%
		Humana		106%†
		UHC		100%
Measure: Care Management Individualized Care Plan Developed and Implemented Within 90 Days of MCE Effective Date for Members with Care Management Level of Service **Domain:** Access to Care	OMPP-chosen performance measure using administrative data	Anthem	TBD	0.15%
		Humana		1.96%
		UHC		3.38%
Measure: Care Management Individualized Care Plan Developed and Implemented Within 60 Days of MCE Effective Date for Members with Complex Care Management Level of Service **Domain:** Access to Care	OMPP-chosen performance measure using administrative data	Anthem	TBD	1.21%
		Humana		1.83%
		UHC		3.48%

**To Be Determined (TBD).*

†Per the MCE, this percentage is due to some service coordinators completing the training modules who were active for less than 60 days.

Quality Strategy Evaluation and Conclusion

The Quality Strategy Initiatives positively indicate appropriate methods to gauge and track improvement across OMPP's managed care services. Measures are in place to guide growth and service standards at specific, set points in time. These initiatives will allow OMPP and the MCEs to consistently track progress and utilize the results to improve the timeliness of care, the access to care, and the quality of care provided to members. However, because 2024 was the first year that the PathWays

program was active, many of the Quality Strategy Initiatives were unable to be analyzed due to a lack of data availability. Therefore, Qsource cannot offer more specific evaluation or conclusions.

EQR Activities

As outlined in Title 42 *Code of Federal Regulations,* Section 438, Part 358 (42 § 438.358), incorporated by 42 CFR § 457.1250, there are four mandated and six optional EQR activities. In addition, a state agency can assign other responsibilities to its designated EQRO. This section summarizes the activities that Qsource performed for OMPP in Measurement Year (MY) 2024, 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 3**.

Table 3. EQR Activities Conducted in 2025

Protocol #	Activity Name	Mandatory or Optional	Measurement Period
1	***Validation of Performance Improvement Projects***	Mandatory	July 2024 – June 2025
2	***Validation of Performance Measures***	Mandatory	July 2024 – December 2024
3	***Review of Compliance with Medicaid and CHIP Managed Care Regulations***	Mandatory	July 2024 – December 2024
4	***Validation of Network Adequacy***	Mandatory	Varied (See Below)
	Geographic Network Adequacy Analysis and Validation		As of July 2025
	Member-to Provider Ratio Analysis		As of July 2025
	Secret Shopper Survey		As of July 2025
5	***Encounter Data Validation***	Optional	October 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 has chosen to review all applicable standards every three years. Protocol 3 was performed in 2025, 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 member 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 members. 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 and Encounter Data Validation to determine if the MCEs met these quality performance measure targets.

Timeliness of Care

For quality care to be effective, it must be delivered promptly. Thus, various standards for timely care were monitored through MCE compliance with federal and state regulations. All program PIPs validated by Qsource addressed the timeliness of care for enrollees: *Home- and Community-Based Services (HCBS) Service Delivery, Care Coordination,* and *HCBS Service Planning*. Qsource's validation of performance measures evaluated timeliness measures determined by OMPP. Additionally, Qsource's validation of encounter data evaluated, among other things, the timeliness and accuracy of the data.

Access to Care

Access to care is equally critical for member 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 members' access to care met requirements, and a Secret Shopper Survey was completed to ensure the members' access matched the listed availability. 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 5: Encounter Data Validation (EDV)

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 care provided by the MCEs. This report includes the following results of these activities:

1. A brief description of the data collection, aggregation, and analyses for each of the EQR compliance activities;
2. A summary of findings from each review;
3. Strengths and weaknesses demonstrated by each MCE in providing healthcare services to members;
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 MCEs, where appropriate, consistent with CMS EQR Protocol guidance.

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

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

The appendices provide additional EQR activity information:

- Appendix A | PIP Validation Findings
- Appendix B | 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, EQRO 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

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 the PathWays program members. Qsource's *Annual PIP Validation Reports* present validation findings by MCE.

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 interventions and remeasurement, significant and sustained improvement in clinical and nonclinical care areas that are expected to favor health outcomes and member 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 member 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 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. 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 Not Applicable (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 findings.

Table 4 lists the nine PIP steps used for assessing the PIP methodology.

Table 4. 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 5 presents the rating criteria used for PIP validation based on the CMS EQR Protocol's suggested rating scale.

Table 5. 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 assessed were met.

Table 5. PIP Validation Rating Criteria	
Rating	**Criteria**
Rating 2	
High Confidence	The PIP achieved statistically significant 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. Qsource received the MCEs' PIP Summary Forms on July 14, 2025, and assessed them for the following PIP topics, as found in **Table 6**.

The MCEs were assigned three PIP topics. Qsource received and validated PIP Summary Forms for the following PIP topics:

Table 6. PIP Topics			
PIP Topic	**Anthem**	**Humana**	**UHC**
Care Coordination	X	X	X
HCBS Service Delivery	X	X	X

Table 6. PIP Topics			
PIP Topic	Anthem	Humana	UHC
HCBS Service Planning	X	X	X

Table 7 displays the PIP names, as chosen by the MCEs, the PIPs' EQR validation status, and what measurement year the PIP is in.

Table 7. PIP Validation Status and Measurement Year			
MCE	PIP Title	Validation Status	Measurement Year
Anthem	*Care Coordination*	Validated	Baseline Year
	HCBS Service Delivery	Validated	Baseline Year
	HCBS Service Planning	Validated	Baseline Year
Humana	*Care Coordination*	Validated	Baseline Year
	HCBS Service Delivery	Validated	Baseline Year
	HCBS Service Planning	Validated	Baseline Year
UHC	*Improving Care Coordination for Indiana PathWays for Aging HCBS Members*	Validated	Baseline Year
	HCBS Service Delivery	Validated	Baseline Year
	Increasing Member Participation in HCBS Service Planning	Validated	Baseline Year

Each MCE tailored their chosen PIP topics to focus on their specific member populations with tailored aim statements. Table 8 displays the population and aim statements for each of the MCEs' PIP topics.

Table 8. PIP Aim Statements and Populations

MCE	PIP Title	Aim Statement	PIP Population
Anthem	*Care Coordination*	Does care and service coordination training, provider education and outreach, tracking of service plan content and timeliness and delivery of technical assistance lead to improved care coordination as evidenced by the Person Centered- Support Plan (Service plan) being shared with the Primary Medical Provider/Primary Care Provider (PMP/PCP) within 30 days of service plan development for Medicaid members eligible for Home and Community Based Services (HCBS) in the Indiana PathWays for Aging Program as evidenced by improving long-term services and supports (LTSS)-Shared Care Plan (SCP) rates during each 12 month remeasurement year? Measurable goal to be set in collaboration with OMPP as baseline data becomes available from all MCES participating in state-defined PIP. The baseline year will be 1/1/25-12/31/25, this submission is pre-baseline year.	All members who are eligible for HCBS services
	HCBS Service Delivery	Does Person Centered Training for coordinators, training on documentation requirements, and auditing with technical assistance for coordinators increase the percentage of Medicaid HCBS PathWays members with new Nursing Facility Level of Care (NFLOC) determination of eligibility for HCBS who have their first LTSS service delivered within 20 days of receiving the member's NFLOC determination notification from the State-designated entity in each 12 month remeasurement year? Does tracking of HCBS Provider connectivity for Electronic Visit Verification (EVV) services and technical Assistance to providers increase the number of HCBS providers serving Indiana PathWays for Aging Members, who have established informational system capacity to enable them to meet reporting specifications as evidenced by a 5% year over year improvement the number of providers with 90% or better EVV compliance in each 12 month remeasurement year?	All HCBS members with new NFLOC determination as indicated from State 834 enrollment files and all HCBS Providers under provider type 05 (Home Health) and 32 (Waiver)
	HCBS Service Planning	Does Person Centered Training for coordinators, training on documentation requirements, and auditing with technical assistance for coordinators, increase the percentage of members eligible for HCBS reporting that their service plan included most or all things that are important to them during each 12-month remeasurement year?	All Anthem, Medicaid-only, PathWays members who are eligible for HCBS services and follow the Agency for Healthcare Research and Quality (AHRQ) Consumer Assessment of

Table 8. PIP Aim Statements and Populations

MCE	PIP Title	Aim Statement	PIP Population
		Does tracking of service plan content, timeliness, delivery of technical assistance, and training on documentation requirements increase percentage of service plans completed within 60 days from enrollment and within 365 days for annual renewals during each 12-month remeasurement year? Does training on comprehensive assessment documentation requirements and audits and technical assistance for coordinators increase the number of members receiving HCBS who had comprehensive assessments documented within 90 days of enrollment and within 365 days during each 12-month remeasurement year?	Healthcare Provider and Services (CAHPS®) and National Committee for Quality Assurance (NCQA) Healthcare Effective Data and Information Set (HEDIS®) sampling methodology
Humana	*HCBS Service Delivery*	Does mandatory MCE reporting of service delivery timeliness result in an increased percentage of PathWays new HCBS members receiving their HCBS services within 20 business days of date of notification of the state from the baseline year (January 1st, 2025- December 31st, 2025) and through the subsequent remeasurement years (2026 and 2027)? The exception to HCBS services provided within 20 days are home modification and vehicle modification. A measurable goal will be determined after collecting baseline data and collaborating with OMPP. Does providing technical assistance to providers increase the likelihood of meeting the states EVV reporting specifications and exceeding 90% reporting levels from the baseline year (January 1st, 2025- December 31st, 2025) and through the subsequent remeasurement years (2026 and 2027)? A measurable goal will be determined after collecting baseline data and collaborating with OMPP.	All members who were newly waivered for HCBS after joining the MCE under the PathWays waiver
	Care Coordination	Does Care and Service Coordinator training and related supports to facilitate the sharing of LTSS care plans (service plans) result in an increased percentage of the Humana Healthy Horizons of Indiana HCBS waiver member's LTSS care plan (service plan) being shared with the Primary Care Physician on member's care team within 30 days of care plan development from the baseline year (January 1st, 2025- December 31st, 2025) and through the subsequent	All members eligible for a HCBS waiver and within the population for the HEDIS® LTSS measure LTSS-Special Population Units (SPU)

Table 8. PIP Aim Statements and Populations

MCE	PIP Title	Aim Statement	PIP Population
		remeasurement years (2026 and 2027)? A measurable goal will be determined after collecting baseline data and collaborating with OMPP.	
	HCBS Service Planning	Does training for Care and Service Coordinators on person-centered service planning as well as training for Care and Service Coordinators on service planning documentation requirements result in an increased percentage of PathWays service plans among HCBS waiver members where their service plan included most or all the things important to them from the baseline year (January 1st, 2025 - December 31st, 2025) and through the subsequent remeasurement years (2026 and 2027)? A measurable goal will be determined after collecting baseline data and collaborating with OMPP. Does Care and Service Coordinator training on service planning documentation requirements as well as tracking of service plan content and timeliness result in an increased percentage of PathWays HCBS waiver member's initial LTSS care plan (service plans) completed within defined timelines from the baseline year (January 1st, 2025- December 31st, 2025) and through the subsequent remeasurement years (2026 and 2027)? A measurable goal will be determined after collecting baseline data and collaborating with OMPP. Does Care and Service Coordinator training on Comprehensive Health Assessment Tool (CHAT) documentation requirements as well as tracking of CHAT content and timeliness of HCBS members result in an increased rate of PathWays HCBS waiver members' initial completed comprehensive LTSS assessment within 90 days of enrollment from the baseline year (January 1st, 2025 - December 31st, 2025) and through the subsequent remeasurement years (2026 and 2027)? A measurable goal will be determined after collecting baseline data and collaborating with OMPP.	All members eligible for a HCBS waiver and within the population for the HEDIS® LTSS measures LTSS-Comprehensive Assessment and Update (CAU) and LTSS-Comprehensive Care Plan Update (CPU)
UHC	*Improving Care Coordination for Indiana PathWays for*	Will targeted interventions increase the percentage of care plans shared with PMPs and other documented medical care practitioners identified in the member's care plan within 30 days of the care plan	MLTSS participants, aged 18 and older, with a person-centered care plan submitted to their PMP or

Table 8. PIP Aim Statements and Populations			
MCE	**PIP Title**	**Aim Statement**	**PIP Population**
	Aging HCBS Members	development for HCBS members in the PathWays for Aging program year over year?	other medical care provider within 30 days of its development
	HCBS Service Delivery	Do targeted service delivery interventions for the UnitedHealthcare Community Plan Indiana HCBS members increase the number of HCBS providers who have established information system capacity to enable them to meet the state's EVV reporting specifications as well as increase the percent of providers who exceed 90% reporting levels and increase the percent of new HCBS members whose first HCBS service is delivered within 20 days of Service Plan completion year over year?	All members in the PathWays HCBS program
	Increasing Member Participation in HCBS Service Planning	Will targeted internal UHC Community Plan Indiana interventions increase the adherence rates for HEDIS® LTSS-CAU, LTSS-CPU, and HCBS CAHPS® for the Medicaid only HCBS members year over year? Specifically, the health plan aims to increase the following: ♦ Member participation in HCBS Service Planning (HCBS CAHPS® Survey) ♦ Timeliness of the Service Plan (HEDIS® LTSS-CPU) ♦ The rate of completed Comprehensive Assessments (HEDIS® LTSS-CAU)	All MLTSS participants who have documentation of a comprehensive assessment and fit the description of the LTSS-Comprehensive Assessment and Update (CAU) and LTSS-Comprehensive Care Plan and Update (CPU) HEDIS® measures

Interventions

Table 9 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. No interventions were listed by the MCEs due to all PIPs being in their baseline year.

Table 9. MY 2024 PIP Interventions			
MCE	**PIP Title**	**Interventions**	**Domain of Care**
Anthem	*Care Coordination*	None Listed	

Table 9. MY 2024 PIP Interventions			
MCE	**PIP Title**	**Interventions**	**Domain of Care**
	HCBS Service Delivery	None Listed	
	HCBS Service Planning	None Listed	
Humana	*HCBS Service Delivery*	None Listed	
	Care Coordination	None Listed	
	HCBS Service Planning	None Listed	
UHC	*HCBS Service Delivery*	None Listed	
	Increasing Member Participation in HCBS Service Planning	None Listed	
	Improving Care Coordination for Indiana PathWays for Aging HCBS Members	None Listed	

Performance Measures and Measurement Scores

Table 10 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 10. PIP Performance Measures						
MCE	**PIP Title**	**Performance Measure**	**Goal**	**Benchmark**	**MY 2024 Rate**	**Statistical Significance**
Anthem	*Care Coordination*	The percentage of LTSS members with a care plan that was transmitted to their PCP or other documented medical care practitioner identified by the member within 30 days of its development.	NA*	TBD†	NA	NA

Table 10. PIP Performance Measures

MCE	PIP Title	Performance Measure	Goal	Benchmark	MY 2024 Rate	Statistical Significance
	HCBS Service Delivery	Electronic Visit Verification (EVV) Compliance	90% compliance	TBD	NA	NA
		Service Delivery Timeliness	NA	TBD	NA	NA
	HCBS Service Planning	Members who reported that their service plan included most or all of the things that are important to them in the HCBS CAHPS®	NA	TBD	NA	NA
		Comprehensive Care Plan and Update	NA	TBD	NA	NA
		Comprehensive Assessment and Update	NA	TBD	NA	NA
Humana	*HCBS Service Delivery*	Timely Service Delivery	NA	TBD	NA	NA
		Electronic Visit Verification	NA	TBD	NA	NA
	Care Coordination	Sharing Care Plan with PCP (LTSS-SCP)	NA	TBD	NA	NA
	HCBS Service Planning	Members who reported that their service plan included most or all of the things that are important to them in the HCBS CAHPS®	NA	TBD	NA	NA
		Service Plan Timeliness (LTSS-CPU)	NA	TBD	NA	NA
		Comprehensive Assessment and Update (LTSS-CAU)	NA	TBD	NA	NA
UHC	*Improving Care Coordination for Indiana PathWays for Aging HCBS Members*	Care Plan Coordination	NA	TBD	NA	NA
	HCBS Service Delivery	Timeliness of Service Delivery	NA	TBD	NA	NA
		Improve the State's Capacity to Collect	NA	TBD	NA	NA

Table 10. PIP Performance Measures						
MCE	**PIP Title**	**Performance Measure**	**Goal**	**Benchmark**	**MY 2024 Rate**	**Statistical Significance**
		Service Delivery Data				
	Increasing Member Participation in HCBS Service Planning	Comprehensive Assessment and Update – HEDIS® LTSS-CAU	NA	TBD	NA	NA
		LTSS Comprehensive Care Plan and Update – HEDIS® LTSS-CPU	NA	TBD	NA	NA
		Increase Member Participation in HCBS Service Planning	NA	TBD	NA	NA

**Not Applicable*

†To be determined: the MCE stated that these rates will be determined after the baseline year has been completed.

Validation Results MY 2024 PIPs

Table 11 presents each PIP's name, elements met and applicable, overall validation score, and validation ratings.

For the PIP review, two of the nine PIPs received a Low Confidence validation rating, and the other seven PIPs received a No Confidence validation rating for Validation Rating 1; all nine of the PIPs received a NA validation rating for Validation Rating 2 due to all PIPs being in their baseline year.

Table 11. PIP Score and Validation Rating						
MCE	**PIP Title**	**Elements**		**Overall Score**	**Validation Rating 1**	**Validation Rating 2**
		Met	**Applicable**			
Anthem	*Care Coordination*	26	36	72.22%	Low Confidence	NA*
	HCBS Service Delivery	27	37	72.97%	Low Confidence	NA
	HCBS Service Planning	26	41	63.41%	No Confidence	NA

Table 11. PIP Score and Validation Rating

MCE	PIP Title	Elements		Overall Score	Validation Rating 1	Validation Rating 2
		Met	Applicable			
Humana	*HCBS Service Delivery*	25	37	67.57%	No Confidence	NA
	Care Coordination	18	36	50.00%	No Confidence	NA
	HCBS Service Planning	27	40	67.50%	No Confidence	NA
UHC	*Improving Care Coordination for Indiana PathWays for Aging HCBS Members*	21	39	53.85%	No Confidence	NA
	HCBS Service Delivery	5	42	11.90%	No Confidence	NA
	Increasing Member Participation in HCBS Service Planning	9	41	21.95%	No Confidence	NA

**Not Applicable.*

Anthem's *Care Coordination* PIP was validated by the EQRO during its Baseline Year and received a Validation Rating 1 of Low 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 10/11 elements (90.91%), the Data Collection methodology received a score of 15/16 elements (93.75%), and the Data Analysis and Interpretation Methodology received a score of 1/9 elements (11.11%) for an overall score of 72.22%. Similarly, Anthem's *HCBS Service Delivery* PIP was also validated during its Baseline Year and received a Validation Rating 1 of Low 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 11/12 elements (91.67%), the Data Collection methodology received a score of 15/16 elements (93.75%), and the Data Analysis and Interpretation Methodology received a score of 1/9 elements (11.11%) for an overall score of 72.97%. Anthem's final PIP, *HCBS Service Planning*, was 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 10/12 elements (83.33%), the Data Collection methodology received a score of 15/20 elements (75.00%), and the Data Analysis and Interpretation Methodology received a score of 1/9 elements (11.11%) for an overall score of 63.41%. All three of Anthem's

PIPs received a Validation Rating 2 of NA due to the PIPs being in their Baseline Year.

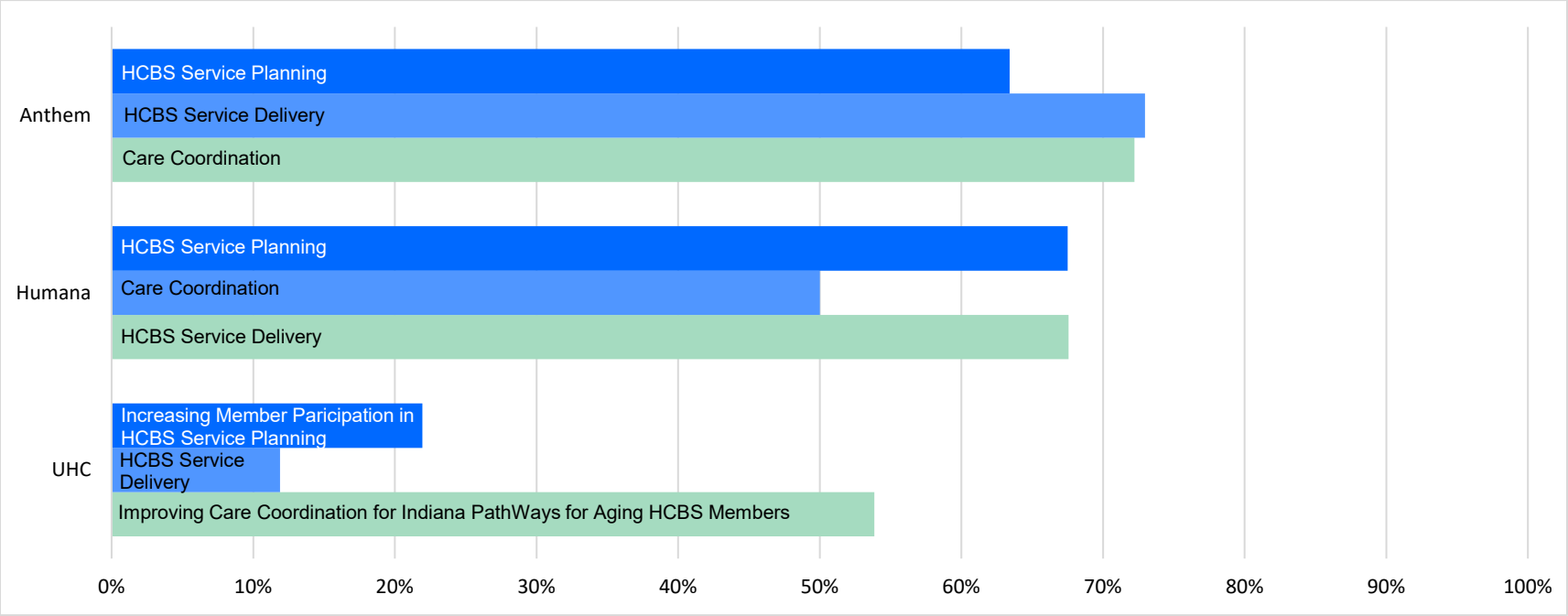
Humana's *HCBS Service Delivery* PIP was validated by the EQRO during its Baseline Year and received a Validation Rating 1 of No Confidence based on the PIP's lack of adherence to acceptable methodology in each phase of the PIP. The PIP's Design Methodology received a score of 10/12 elements (83.33%), the Data Collection methodology received a score of 14/16 elements (87.50%), and the Data Analysis and Interpretation Methodology received a score of 1/9 elements (11.11%) for an overall score of 67.57%. Similarly, Humana's *Care Coordination* 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 5/8 elements (62.50%), the Data Collection methodology received a score of 12/19 elements (63.16%), and the Data Analysis and Interpretation Methodology received a score of 1/9 elements (11.11%) for an overall score of 50.00%. Additionally, Humana's *HCBS Service Planning* PIP was 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 10/11 elements (90.91%), the Data Collection methodology received a score of 16/20 elements (80.00%), and the Data Analysis and Interpretation Methodology received a score of 1/9 elements (11.11%) for an overall score of 67.50%. All three of Humana's PIPs received a Validation Rating 2 of NA due to the PIPs being in their Baseline Year.

UHC's *Improving Care Coordination for Indiana PathWays for Aging HCBS Members* 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 9/11 elements (81.82%), the Data Collection methodology received a score of 12/18 elements (66.67%), and the Data Analysis and Interpretation Methodology received a score of 0/10 elements (0.00%) for an overall score of 53.85%. Similarly, UHC's *HCBS Service Delivery* 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 2/12 elements (16.67%), the Data Collection methodology received a score of 3/20 elements (15.00%), and the Data Analysis and Interpretation Methodology received a score of 0/10 elements (0.00%) for an overall score of 11.90%. UHC's *Increasing Member Participation in HCBS Service Planning* PIP, the third validated PIP, was 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 4/11 elements (36.36%), the

Data Collection methodology received a score of 5/20 elements (25.00%), and the Data Analysis and Interpretation Methodology received a score of 0/10 elements (0.00%) for an overall score of 21.95%. All three 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

Table 12 presents strengths and Table 13 presents weaknesses identified for each MCE during the QIP validation. 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. 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. 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 2. PIP Strengths

PIP	PIP Type	PIP Steps	Strengths	Domain of Care
Anthem				
Care Coordination	No strengths identified.			
HCBS Service Delivery	No strengths identified.			
HCBS Service Planning	No strengths identified.			
Humana				
HCBS Service Delivery	No strengths identified.			
Care Coordination	No strengths identified.			
HCBS Service Planning	No strengths identified.			
UHC				
Improving Care Coordination for Indiana PathWays for Aging HCBS Members	No strengths identified.			
HCBS Service Delivery	No strengths identified.			
Increasing Member Participation in HCBS Service Planning	No strengths identified.			

Table 3. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
Anthem				
Care Coordination	Clinical	Step 3: Review the Identified PIP Population	Element 1: Anthem should fully define the population.	Access to Care
		Step 6: Review the Data Collection Procedures	Element 8: Anthem should include an estimated degree of completion for the quarterly administrative data.	Timeliness and Quality of Care
		Step 7: Review the data Analysis and Interpretation of PIP Results	Element 1: Anthem should conduct analysis and interpretation in accordance with the data analysis plan.	Quality of Care
			Element 5: Anthem should identify factors that threaten internal or external validity of findings.	Quality of Care
			Element 7: Anthem should present information on factors that could impact comparability or threaten validity of findings in a concise and easily understood manner.	Quality of Care
		Step 8: Assess the Improvement Strategies	Element 1: Anthem should present strategies that are evidence based.	Quality of Care
			Element 2: Anthem should relate strategies to barriers identified through data analysis and quality improvement processes.	Quality of Care
			Element 3: Anthem should have implemented the plan stage of a rapid-cycle Plan-Do-Study-Act (PDSA).	Quality of Care
			Element 4: Anthem should have strategies that are culturally and linguistically appropriate.	Access to Care
			Element 5: Anthem should have strategies that are reflective of major confounding factors that could have an obvious impact on PIP outcomes.	Quality of Care

Table 3. PIP Weaknesses (AONs)

PIP	PIP Type	PIP Step	Weaknesses	Domain of Care
HCBS Service Delivery	Nonclinical	Step 2: Review the PIP Aim Statement	Element 4: Anthem should have one concise aim statement.	Quality of Care
		Step 5: Review the Selected PIP Variables and Performance Measures	Element 10: Anthem should cite strong evidence that the process being measured is meaningfully associated with outcomes.	Quality of Care
		Step 7: Review the data Analysis and Interpretation of PIP Results	Element 1: Anthem should conduct analysis and interpretation in accordance with the data analysis plan.	Quality of Care
			Element 5: Anthem should Identify factors that threaten internal or external validity of findings.	Quality of Care
			Element 7: Anthem should present information on factors that could impact comparability or threaten validity of findings in a concise and easily understood manner.	Access to Care and Quality of Care
		Step 8: Assess the Improvement Strategies	Element 1: Anthem should present strategies that are evidence based.	Quality of Care
			Element 2: Anthem should relate strategies to barriers identified through data analysis and quality improvement processes.	Quality of Care
			Element 3: Anthem should have implemented the plan stage of a rapid-cycle PDSA.	Quality of Care
			Element 4: Anthem should have strategies that are culturally and linguistically appropriate.	Access to Care
			Element 5: Anthem should have strategies that are reflective of major confounding factors that could have an obvious impact on PIP outcomes.	Quality of Care
HCBS Service Planning	Nonclinical	Step 2: Review the PIP Aim Statement	Element 2: Anthem should clearly specify the PIP population.	Quality of Care

Table 3. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
			Element 4: Anthem should be concise using only one aim statement.	Quality of Care
		Step 5: Review the Selected PIP Variables and Performance Measures	Element 3: Anthem should discuss the resources available to collect data.	Quality of Care
			Element 10: Anthem should present strong evidence that the process being measured is meaningfully associated with outcomes.	Quality of Care
		Step 6: Review the Data Collection Procedures	Element 9: Anthem should describe qualifications of staff responsible for abstracting data.	Quality of Care
			Element 10: Anthem should describe the intra- and inter-rater reliability processes in place.	Quality of Care
			Element 11: Anthem should include guidelines developed for abstraction staff.	Quality of Care
		Step 7: Review the Data Analysis and Interpretation of PIP Results	Element 1: Anthem should conduct analysis and interpretation in accordance with the data analysis plan.	Quality of Care
			Element 5: Anthem should Identify factors that threaten internal or external validity of findings.	Quality of Care
			Element 7: Anthem should present information on factors that could impact comparability or threaten validity of findings in a concise and easily understood manner.	Quality of Care
		Step 8: Assess the Improvement Strategies	Element 1: Anthem should present strategies that are evidence based.	Quality of Care
			Element 2: Anthem should relate strategies to barriers identified through data analysis and quality improvement processes.	Quality of Care
			Element 3: Anthem should have implemented the “plan” stage of a rapid-cycle PDSA.	Quality of Care

Table 3. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
			Element 4: Anthem should have strategies that are culturally and linguistically appropriate.	Access to Care
			Element 5: Anthem should have strategies that are reflective of major confounding factors that could have an obvious impact on PIP outcomes.	Quality of Care
Humana				
HCBS Service Delivery	Clinical	Step 1: Review the Selected PIP Topics	Element 2: Humana should address the CMS Child or Adult Core Set measures.	Access to Care
		Step 2: Review the PIP Aim Statement	Element 4: Humana should have one concise aim statement.	Quality of Care
		Step 5: Review the Selected PIP Variables and Performance Measures	Element 10: Humana should include strong evidence that the process being measured is meaningfully associated with outcomes.	Quality of Care
		Step 6: Review the Data Collection Procedures	Element 1: Humana should include a systematic method for collecting valid and reliable data that represents the PIP population.	Quality of Care
		Step 7: Review the Data Analysis and Interpretation of PIP Results	Element 1: Humana should show data analysis was conducted in accordance with the data analysis plan.	Quality of Care
			Element 5: Humana should identify factors that threaten internal or external validity of findings.	Quality of Care
			Element 7: Humana should present information in a concise and easily understood manner.	Access to Care
		Step 8: Assess the Improvement Strategies	Element 1: Humana should present strategies that are evidence based.	Quality of Care
			Element 2: Humana should relate strategies to barriers identified through data analysis and quality improvement processes.	Quality of Care

Table 3. PIP Weaknesses (AONs)

PIP	PIP Type	PIP Step	Weaknesses	Domain of Care
			Element 4: Humana should have strategies that are culturally and linguistically appropriate.	Access to Care
			Element 5: Humana should have strategies that are reflective of major confounding factors that could have an obvious impact on PIP outcomes.	Quality of Care
		Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred	Element 1: Humana should have discussed the methodology they plan to use for the baseline measurement.	Quality of Care
Care Coordination	Nonclinical	Step 1: Review the Selected PIP Topic	Element 2: Humana should address considerations of the CMS Child or Adult Core Set measures.	Access to Care
		Step 2: Review the PIP Aim Statement	Element 2: Humana should document a consistent population in the aim statement.	Quality of Care
			Element 4: Humana should have a consistent, concise aim statement.	Quality of Care
		Step 5: Review the Selected PIP Variables and Performance Measures	Element 3: Humana should have a performance measure that is appropriate based on the availability of data and resources to collect the data more often than annually.	Timeliness and Quality of Care
			Element 10: Humana should present strong evidence that the process being measured is meaningfully associated with outcomes.	Quality of Care
		Step 6: Review the Data Collection Procedures	Element 1: Humana should Include a systematic method for collecting valid and reliable data that represents the PIP population.	Quality of Care
			Element 4: Humana should clearly identify the data elements to be collected.	Quality of Care
			Element 5: Humana should connect the data collection plan to the data analysis plan to ensure	Quality of Care

Table 3. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
			appropriate data are available.	
			Element 6: Humana should include data collection instruments that allow for consistent and accurate data collection over PIP time periods.	Quality of Care
			Element 11: Humana should include guidelines developed for abstraction staff.	Quality of Care
		Step 7: Review the Data Analysis and Interpretation PIP Results	Element 1: Humana should show data analysis was conducted in accordance with the data analysis plan.	Quality of Care
			Element 5: Humana should identify factors that threaten internal or external validity of findings.	Quality of Care
			Element 7: Humana should present information on factors that could impact comparability or threaten validity of findings in a concise and easily understood manner.	Quality of Care
		Step 8: Assess the Improvement Strategies	Element 1: Humana should present strategies that are evidence-based.	Quality of Care
			Element 2: Humana should relate strategies to barriers identified through data analysis and quality improvement processes.	Quality of Care
			Element 4: Humana should have strategies that are culturally and linguistically appropriate.	Access to Care
			Element 5: Humana should have strategies that are reflective of major confounding factors that could have an obvious impact on PIP outcomes.	Quality of Care
		Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred	Element 1: Humana should have spoken to the planned methodology for future measurements.	Quality of Care

Table 3. PIP Weaknesses (AONs)

PIP	PIP Type	PIP Step	Weaknesses	Domain of Care
HCBS Service Planning	Nonclinical	Step 2: Review the PIP Aim Statement	Element 4: Humana should have one concise aim statement.	Quality of Care
		Step 5: Review the Selected PIP Variables and Performance Measures	Element 3: Humana should have an appropriate performance measure based on the availability of data and resources to collect the data more often than annually.	Timeliness and Quality of Care
			Element 10: Humana should demonstrate strong evidence that their process being measured is meaningfully associated with outcomes.	Quality of Care
		Step 6: Review the Data Collection Procedures	Element 4: Humana should clearly identify the data elements to be collected.	Quality of Care
			Element 6: Humana should include data collection instruments that allow for consistent and accurate data collection over PIP time periods.	Quality of Care
		Step 7: Review the Data Analysis and Interpretation of PIP Results	Element 1: Humana should show data analysis was conducted in accordance with the data analysis plan	Quality of Care
			Element 5: Humana should identify factors that threaten internal or external validity of findings.	Quality of Care
			Element 7: Humana should present information on factors that could impact comparability or threaten validity of findings in a concise and easily understood manner.	Quality of Care
		Step 8: Assess the Improvement Strategies	Element 1: Humana should present strategies that are evidence based.	Quality of Care
			Element 2: Humana should relate strategies to barriers identified through data analysis and quality improvement processes.	Quality of Care
			Element 4: Humana should have strategies that are culturally and linguistically appropriate.	Access to Care

Table 3. PIP Weaknesses (AONs)

PIP	PIP Type	PIP Step	Weaknesses	Domain of Care
			Element 5: Humana should have strategies that are reflective of major confounding factors that could have an obvious impact on PIP outcomes.	Quality of Care
		Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred	Element 1: Humana should have spoken to the measurement methodology they will use for the baseline year.	Quality of Care
UHC				
Improving Care Coordination for Indiana PathWays for Aging HCBS Members	Nonclinical	Step 1: Review the Selected PIP Topic	Element 2: UHC should address whether the PIP topic considered performance on CMS Adult Core Set measures.	Access to Care
		Step 2: Review the PIP Aim Statement	Element 3: UHC should ensure the aim statement clearly specifies the time period as the current PIP cycle.	Timeliness of Care
		Step 6: Review the Data Collection Procedures	Element 1: UHC should ensure the data collection plan clearly describes the systematic method for collecting valid and reliable data that represents the PIP population in further detail.	Quality of Care
			Element 5: UHC should ensure the data collection plan clearly connects to the data analysis plan to ensure appropriate data are available.	Quality 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.	Timeliness and Quality of Care
			Element 9: UHC should ensure the data collection plan describes qualifications of staff responsible for abstracting data (is retrievable).	Quality of Care
			Element 10: UHC should ensure the data collection plan describes the intra- and inter-rater reliability	Quality of Care

Table 3. PIP Weaknesses (AONs)

PIP	PIP Type	PIP Step	Weaknesses	Domain of Care
			processes in place.	
			Element 11: UHC should ensure the data collection plan Includes guidelines developed for abstraction staff.	Quality of Care
		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.	Quality of Care
			Element 5: UHC should ensure the analysis and interpretation identify any factors that threaten the internal or external validity of findings.	Quality of Care
			Element 7: UHC should ensure the analysis and interpretation are presented in a concise and easily understood manner.	Quality of Care
		Step 8: Assess the Improvement Strategies	Element 1: UHC should ensure that improvement strategies are evidence based.	Quality of Care
			Element 2: UHC should ensure the improvement strategies are related to causes/barriers identified through data analysis and quality improvement processes.	Quality of Care
			Element 3: UHC should ensure that improvement strategies are implemented on a rapid-cycle PDSA basis.	Quality of Care
			Element 4: UHC should ensure the improvement strategies are culturally and linguistically appropriate.	Access to Care
			Element 5: UHC should ensure the improvement strategies are reflective of major confounding factors that could have an obvious impact on PIP outcomes.	Quality of Care
			Element 6: UHC should ensure the improvement strategies are successful in terms of improvement with follow-up activities identified.	Quality of Care

Table 3. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
		Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred	Element 1: UHC should acknowledge whether their baseline methodology will remain the same for future remeasurement periods.	Quality of Care
HCBS Service Delivery	Nonclinical	Step 1: Review the Selected PIP Topic	Element 2: UHC should address how/if the PIP topic considered performance on the CMS Adult Core Set measures since it was not specified as not applicable when the PIP topic is selected by OMPP, based on the PIP Summary Form instructions.	Access to Care
		Step 2: Review the PIP Aim Statement	Element 1: UHC should ensure the aim statement clearly specifies the PIP improvement strategy.	Quality of Care
			Element 2: UHC should ensure the aim statement clearly specifies the PIP population.	Quality of Care
			Element 3: UHC should ensure the aim statement clearly specifies the time period for this PIP cycle.	Timeliness of Care
			Element 4: UHC should ensure the PIP aim statement is concise.	Quality of Care
			Element 5: UHC should ensure the PIP aim statement is answerable.	Quality of Care
			Element 6: UHC should ensure the PIP aim statement is measurable.	Quality of Care
		Step 3: Review the Identified PIP Population	Element 1: UHC should ensure the PIP population is clearly defined and consistent throughout the PIP.	Quality of Care
			Element 2: UHC should clearly specify the PIP population as inclusive of the entire population or a representative and generalizable sample.	Quality of Care
			Element 3: UHC should specify if the PIP captures all enrollees to whom the PIP aim statement applies.	Quality of Care

Table 3. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
		Step 5: Review the Selected PIP Variables and Performance Measures	Element 1a: UHC should ensure that the variables are clearly defined and time specific.	Timeliness of Care
			Element 1b: UHC should ensure the variables are available to measure performance and track improvement over time.	Timeliness of Care
			Element 3: UHC should ensure the performance measure is appropriate based on the availability of data and resources to collect the data.	Quality of Care
			Element 4: UHC should cite evidence that the performance measure is based on current clinical knowledge or health services research.	Quality of Care
			Element 5: UHC should ensure the performance measure addresses and tracks performance at a point in time, compare performance measures to benchmarks, and informs the selection and evaluation of quality improvement strategies.	Timeliness and Quality of Care
			Element 6: UHC should address whether the performance measure considered existing measures.	Quality of Care
			Element 7: UHC should ensure the internally developed performance measure addresses all specified requirements.	Quality of Care
			Element 9: UHC should ensure that a strategy for inter-rater reliability is included.	Quality of Care
		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.	Quality of Care
			Element 3: UHC should ensure the data collection plan clearly specifies the data sources.	Quality of Care
			Element 4: UHC should ensure the data collection plan clearly identifies the data elements to be	Quality of Care

Table 3. PIP Weaknesses (AONs)

PIP	PIP Type	PIP Step	Weaknesses	Domain of Care
			collected.	
			Element 5: UHC should ensure the data collection plan clearly connects to the data analysis plan to ensure appropriate data are available.	Quality 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.	Timeliness of Care
			Element 8: UHC should ensure the data collection plan includes an estimated degree of data completeness for administrative data collection.	Quality of Care
			Element 9: UHC should ensure the data collection plan describes qualifications of staff responsible for abstracting data.	Quality of Care
			Element 10: UHC should ensure the data collection plan describes the intra- and inter-rater reliability processes in place.	Quality of Care
			Element 11: UHC should ensure the data collection plan Includes the guidelines that are developed for abstraction staff.	Quality of Care
		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.	Quality of Care
			Element 5: UHC should ensure the analysis and interpretation identify any factors that threaten the internal or external validity of findings.	Quality of Care
			Element 7: UHC should ensure the analysis and interpretation are presented in a concise and easily understood manner.	Quality of Care
		Step 8: Assess the Improvement Strategies	Element 1: UHC should ensure that improvement strategies are evidence based.	Quality of Care

Table 3. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
			Element 2: T UHC should ensure the improvement strategies are related to causes/barriers identified through data analysis and quality improvement processes.	Quality of Care
			Element 3: UHC should ensure that improvement strategies are implemented on a rapid-cycle PDSA basis.	Quality of Care
			Element 4: UHC should ensure the improvement strategies are culturally and linguistically appropriate.	Access to Care
			Element 5: UHC should ensure the improvement strategies are reflective of major confounding factors that could have an obvious impact on PIP outcomes.	Quality of Care
			Element 6: UHC should ensure the improvement strategies are successful in terms of improvement with follow-up activities identified.	Quality of Care
		Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred	Element 1: UHC should address whether the remeasurement methodology is expected to remain the same as the baseline methodology.	Quality of Care
Increasing Member Participation in HCBS Service Planning	Nonclinical	Step 1: Review the Selected PIP Topic	Element 4: UHC should ensure the PIP topic addresses care of special populations or high-priority services.	Quality of Care
		Step 2: Review the PIP Aim Statement	Element 3: UHC should ensure the PIP time period is clearly specified as the current PIP cycle.	Timeliness of Care
			Element 4: UHC should ensure the aim statement is concise.	Quality of Care
			Element 5: UHC should ensure that the aim statement is answerable.	Quality of Care
			Element 6: UHC should ensure the aim statement is	Quality of Care

Table 3. PIP Weaknesses (AONs)

PIP	PIP Type	PIP Step	Weaknesses	Domain of Care
			measurable.	
		Step 3: Review the Identified PIP Population	Element 1: UHC should clearly define the PIP population in terms of the aim statement.	Quality of Care
			Element 2: UHC should clearly indicate if the PIP population included the entire eligible population or a representative and generalizable sample.	Quality of Care
		Step 5: Review the Selected PIP Variables and Performance Measures	Element 1a: UHC should ensure the PIP variables are objective, clearly defined, and time specific.	Timeliness of Care
			Element 1b: UHC should ensure the performance measures are available to measure performance and track improvement over time.	Timeliness of Care
			Element 3: UHC should ensure the performance measures are appropriate based on the availability of data and resources to collect the data.	Quality of Care
			Element 5: UHC should ensure 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.	Timeliness of Care
			Element 6: UHC should address whether the performance measures consider existing measures.	Quality of Care
			Element 8: UHC should address whether the performance measure captures changes in enrollee satisfaction or experience of care.	Quality of Care
		Step 6: Review the Data Collection Procedure	Element 1: UHC should ensure that the data collection plan includes a systematic method for collecting valid and reliable data that represents the PIP population.	Quality of Care
			Element 3: UHC should ensure that the data collection plan clearly specifies the data sources.	Quality of Care
			Element 4: UHC should ensure that the data collection	Quality of Care

Table 3. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
			plan clearly identifies the data elements to be collected.	
			Element 5: UHC should ensure that the data collection plan connects to the data analysis plan to ensure appropriate data are available.	Quality of Care
			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.	Timeliness and Quality of Care
			Element 7: UHC should ensure that the data collection plan specifies well-defined methods to collect meaningful and useful information, if qualitative data collection methods were used.	Quality of Care
			Element 9: UHC should ensure that the data collection plan describes qualifications of staff responsible for abstracting data.	Quality of Care
			Element 10: UHC should ensure that the data collection plan describes the intra- and inter-rater reliability processes in place.	Quality of Care
			Element 11: UHC should ensure the data collection plan includes guidelines developed for abstraction staff.	Quality of Care
		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.	Quality of Care
			Element 5: UHC should ensure the analysis and interpretation identify any factors that threaten the internal or external validity of findings.	Quality of Care
			Element 7: UHC should ensure the analysis and interpretation are presented in a concise and easily understood manner.	Quality of Care

Table 3. PIP Weaknesses (AONs)				
PIP	**PIP Type**	**PIP Step**	**Weaknesses**	**Domain of Care**
		Step 8: Assess the Improvement Strategies	Element 1: UHC should ensure that improvement strategies are evidence based.	Quality of Care
			Element 2: UHC should ensure the improvement strategies are related to causes/barriers identified through data analysis and quality improvement processes.	Quality of Care
			Element 3: UHC should ensure that improvement strategies are implemented on a rapid-cycle PDSA basis.	Quality of Care
			Element 4: The MCE should ensure the improvement strategies are culturally and linguistically appropriate.	Access to Care
			Element 5: UHC should ensure the improvement strategies are reflective of major confounding factors that could have an obvious impact on PIP outcomes.	Quality of Care
			Element 6: UHC should ensure the improvement strategies are successful in terms of improvement with follow-up activities identified.	Quality of Care
		Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred	Element 1: UHC should acknowledge whether their baseline methodology will remain the same for future remeasurement periods.	Quality of Care

Improvements Since the MY 2023 PIP Validation

For PIPs that receive AONs for any element, Qsource provides technical assistance to help the MCEs understand CMS protocol 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 of said corrections; the details of each PIP CAP response and evaluation

will be presented under MCE improvements within the 2026 EQR Technical Report.

As this was the first year for the PathWays program, no applicable comparisons were available for PIPs validated for MY 2024 (July 2024-June 2025).

Conclusions and Recommendations

Anthem

Anthem submitted three PIP topics for MY 2024: a clinical PIP titled *Care Coordination* and two nonclinical PIPs titled *HCBS Service Delivery* and *HCBS Service Planning.* All three PIPs were in their Baseline Measurement Year. The PIPs received scores of 72.22%, 72.97%, and 63.41%, respectively, achieving a Validation 1 Rating of Low Confidence, Low Confidence, and No 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 complete information for most of the study activities; however, a lack of concise aim statement, clear PIP population, improvement strategies, and data resources for performance measures were missing in one or more 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 increase understanding of the protocol requirements.

The Care Coordination PIP topic addresses timeliness and access to care for all members who receive HCBS care; the MCE noted that this topic is the foundation of all care given through the PathWays program. The HCBS Delivery PIP topic addresses access to care delivered to members with a new NFLOC determination, noting that this access to care will allow the member to age in place comfortably. The HCBS Planning PIP topic addresses the quality of care delivered in the previous PIP topic, as it assesses the level of satisfaction members have regarding their HCBS care.

Humana

Humana submitted three PIP topics for MY 2024: a clinical PIP titled *HCBS Service Delivery* and two nonclinical PIPs titled *Care Coordination* and *HCBS Service Planning*. All three PIPs were in their Baseline Measurement Year. The PIPs received scores of 67.57%, 50.00%, and 67.50%, respectively, achieving a Validation 1 Rating of No Confidence for all three PIPs. All three PIPs received a Validation 2 Rating of NA, due to the PIPs being in their Baseline year.

Each of Humana's PIP Summary Forms contained complete information for most of the study activities; however, a lack of concise aim statement, clear PIP population, improvement strategies, data resources, and data analysis plans for performance measures were missing in one or more 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 HCBS Delivery PIP topic addresses access to care by improving the delivery of HCBS through increasing collaboration between providers and members. The HCBS Planning PIP topic addresses the quality of, and access to, care by increasing collaboration between providers and members and providing members with the tools they need to manage their health conditions. The Care Coordination PIP topic addresses timeliness and access to care by focusing on increasing the percentage of members whose LTSS care plans are shared with their PCPs.

UHC

UHC submitted three PIP topics for MY 2024: *Improving Care Coordination for Indiana PathWays for Aging HCBS Members, HCBS Service Delivery,* and *Increasing Member Participation in HCBS Service Planning*. All three PIPs were in their Baseline Measurement Year. The PIPs received scores of 53.85%, 11.90%, and 21.95%, respectively, achieving a Validation 1 Rating of No Confidence for all three PIPs. All three PIPs received a Validation 2 Rating of NA, due to the PIPs being in their Baseline year.

Each of UHC's PIP Summary Forms contained complete information for most of the study activities; however, a lack of clear information regarding PIP populations, performance measures, improvement measures, aim statements, and data collection plan for performance measures were missing in one or more 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 Care Coordination PIP topic addresses timeliness and access to care by focusing on ensuring proper coordination between a member's PMP and the LTSS in their care plan. The HCBS Delivery PIP topic addresses timeliness and access to care by timely service delivery for better health outcomes and increased independence for members. The HCBS Planning PIP topic addresses access to care by promoting the member's role in the care planning process.

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 from July 1, 2024, the start of the PathWays Program, to December 31, 2024, the end of MY 2024. This measurement period was designated as a Readiness Period in which the MCEs were responsible for calculating a baseline for certain measures while others were waived as there was not a full year's worth of data to calculate measures.

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

OMPP identified performance measures to be calculated and reported by the contracted MCEs as required in Activity 1 of the Protocol. 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 noted 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 14 presents the criteria used to determine the MCE's rating.

Table 14. 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 for Validation

Qsource obtained the list of performance measures and technical specifications for the measures from OMPP's *Indiana Health Coverage Programs 2024-2027 Quality Strategy Plan*. The performance measures from this document can be divided into three groups: OMPP-chosen goals, CMS-chosen goals, and CAHPS®-related goals.

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 for Validation

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. In a normal measurement year, each MCE undergoes this audit, and Qsource reviews the submitted HEDIS® Record of Administration, Data Management and Processes (Roadmap) and ISCAT to support findings. Due to the Readiness Period and the start date of PathWays, there was no data to audit; therefore, no HEDIS® performance measures were reported.

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 the 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 MCE has 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 15**.

Table 15. Performance Measures

Measure Name	Domain of Care
Completion of Initial Health Needs Screening (HNS) and Comprehensive Health Assessment Tool (CHAT) within 30 days or 90 Days of MCE Enrollment Based on Care Program	Quality of Care, Timeliness of Care, and Access to Care
Service Coordinators who Have Successfully Completed Person-Centered Planning Competency Training within 90 days of Hire	Timeliness of Care and Quality of Care
Care Management Individualized Care Plan (ICP) Developed and Implemented within 60 Days of MCE Effective Date for Members with Complex Care Management Level of Service or within 90 Days of MCE Effective Date for Members with Care Management Level of Service	Quality of Care, Timeliness of Care, and Access to Care

After validating the Performance Measures through source data, the validation results were extrapolated to the additional performance measures listed in **Table 16**.

Table 46. Additional Performance Measures

Measure Name	Domain of Care
Institution for Mental Disease (IMD) Member Use	Access to Care
Dentists and Oral Surgeons Network Adequacy	Access to Care

CMS Measures

The evaluation timeframe for this year's EQR overlapped with the PathWays program Readiness Period; therefore, the MCEs reporting requirements for measures that did not yet have annual data available were waived by OMPP. Below is the list of CMS-based performance measures that the MCEs will be responsible for reporting in the 2026 EQR.

- Medicaid MLTSS Comprehensive Assessment and Update
- Medicaid MLTSS Comprehensive Care Plan and Update
- Medicaid MLTSS Shared Care Plan with Primary Care Provider
- Medicaid MLTSS Reassessment/Care Plan Update after Inpatient Discharge
- Screening, Risk Assessment, and Plan of Care to Prevent Future Falls
- Medicaid MLTSS Admission to a Facility from the Community
- Medicaid MLTSS Minimizing Facility Length of Stay
- Medicaid MLTSS Successful Transition after Long-Term Facility Stay

CAHPS Measures

Below is the list of performance measures based on the CAHPS survey that the MCEs will be responsible for reporting starting in the 2026 EQR. For the Readiness Period, this performance measure was waived by OMPP.

- Participants who, in the Last 3 Months, Reported that Their Service Plan Included Most or all of the Things that are Important to Them.
- Participants Who Report Knowing Who Their MCE Care Manager Is.

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 performed on the analysts who perform the audits on claims data. Encounter data must then be extracted from the claims data for submission to the state and timeliness tracking.

Enrollment/Eligibility Data System

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

Provider Systems

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

Data Integration, Software Integration, and Measure Development
The organizational infrastructure for housing both HEDIS® and non-HEDIS® measure data must be verified for standard control procedures and completeness of data. All MCEs were required to provide source code and source data (claims data) for the measures chosen by OMPP as the focus for the 2025 PMV. The source code and source data were used to validate the rates the MCEs reported. The primary source verification and measure validation results were extrapolated to all measures.

Table 17 presents the validation findings across all MCEs for the ISCA and the validated performance measures.

Table 5. Data Integration, Data Control, and Performance Measure Documentation

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

Performance Measure Validation Status and Findings Summary

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 18. Table 19, Table 20, and Table 21 include reported rates for each measure by MCE. These rates are listed to the first or second decimal points based on how the data is reported by the MCE.

Table 18. Key Performance Measure Review Results

Measure	Anthem	Humana	UHC
Completion of Initial HNS and CHAT within 30 days or 90 Days of MCE Enrollment based on care program	The MCE demonstrated the Healthy Innovations Platform and detailed performance measure data collection, calculation software, and regulatory reporting program used to validate the source data for this performance measure. The findings associated with this measure included a well-established system used to track the completion of HNS and CHAT completion and the platform Confluence, used for regulatory reporting. The MCE cited programming logic updates currently in effect that improve the accuracy of reporting that were not in place during the EQR's data look back period. EQR recommendations advise the MCE to monitor adherence to OMPP requirements and definitions of member HNS and CHAT completion.	The MCE demonstrated Guiding Care, a care coordination site within the HealthEdge platform, and detailed performance measure data collection, calculation software, and regulatory reporting environment used to validate the source data for this performance measure. The findings associated with this measure included HNS timeliness and accuracy of the performance measure data reported; however, differences of technical specification relative to OMPP requirements for the CHAT were noted.	The MCE demonstrated the Community Care platform and detailed performance measure data collection, calculation software, and regulatory reporting environment used to validate the source data for this performance measure. The findings associated with this measure included a positive reflection of HNS timeliness and performance measure production; however, differences of calculation methodology relative to OMPP requirements for the CHAT were also noted.
Service Coordinators who Have Successfully Completed Person-Centered Planning Competency Training within 90 days of Hire	The MCE demonstrated the human resources platform, Workday, as the repository of staff training and detailed how performance measure data was tracked and utilized for the regulatory reporting of this performance measure. A flat file method was used to validate source data for this performance measure. The findings associated with this measure included limitations to review previously contracted Service Coordinator information and a lack of evidenced standardization for the Service Coordinator role. EQR recommendations advise the MCE to	The MCE demonstrated internal processes used to collect Service Coordinator Competency data for reporting as well as the HealthEdge system used to retrospectively validate the source data. The findings associated with this measure included an overall strength for the MCE in the performance measure data tracking for Person-Centered Planning Training; however, differences between Service Coordination and Care Coordination were noted as	The MCE detailed internal processes of the Service Coordinator Competency performance measure for data collection and reporting used to validate the source data. The findings associated with this measure included initial issues with EQR preparedness; however, an overall strength was noted for the MCE in their Person-Centered Training program, including a well-established program curriculum, training competency completion

Table 18. Key Performance Measure Review Results			
Measure	**Anthem**	**Humana**	**UHC**
	develop and implement a systematic approach to Service Coordinator competency that aligns with OMPP-established definitions.	potential barriers for data accuracy.	certificates, and well-organized service coordinator performance data tracking.
Care Management ICP Developed and Implemented within 60 Days of MCE Effective Date for Members with Complex Care Management Level of Service or within 90 Days of MCE Effective Date for Members with Care Management Level of Service	The MCE demonstrated the Healthy Innovations Platform and detailed performance measure data collection, calculation software, and regulatory reporting program used to validate the source data for this performance measure. The findings associated with this measure included discrepancies between the reported data and that which was found among the raw data files. Widespread challenges, namely the dates that were identified in association with member Care Plan completion and implementation. EQR recommendations advise the MCE to assess regulatory programming to improve the accuracy of data reported for this performance measure.	The MCE demonstrated the HealthEdge platform and detailed performance measure data collection, calculation software, source code, and regulatory reporting program used to validate the source data for this measure. The findings associated with this measure included the inability to produce evidence of care plan completion for members among the randomized sample. Issues with care plan management during the 2024 review period were acknowledged by the MCE with updates in place to mitigate this issue.	The MCE demonstrated the Community Care platform and detailed performance measure data collection, calculation software, source code, and regulatory reporting program used to validate the source data for this performance measure. The findings associated with this measure included discrepancies within the primary source files in comparison to the reported performance measure data and lack of care plan completion for members noted among sample case files.

Table 19. 2025 PMV: Completion of Initial Health Needs Screening and Comprehensive Health Assessment Tool						
Month	**# of Members Eligible for Completion of an HNS and CHAT**	**# of Members with HNS Completed within 30 Days**	**Total # of Members with HNS Completed**	**# of Members with CHAT Completed within 30 Days**	**# of Members with CHAT Completed within 90 Days**	**Total # of Members with CHAT Completed**
Anthem						
July	44,108	2,071	2,201	0	0	90
August	44,410	2,057	4,931	0	0	895
September	44,479	2,051	7,567	0	0	1,930

Table 19. 2025 PMV: Completion of Initial Health Needs Screening and Comprehensive Health Assessment Tool						
Month	**# of Members Eligible for Completion of an HNS and CHAT**	**# of Members with HNS Completed within 30 Days**	**Total # of Members with HNS Completed**	**# of Members with CHAT Completed within 30 Days**	**# of Members with CHAT Completed within 90 Days**	**Total # of Members with CHAT Completed**
October	44,660	2,078	10,420	0	0	3,287
November	44,442	2,079	12,144	0	0	4,307
December	44,484	2,100	13,865	0	0	5,518
Humana						
July	35,742	2,019	2,019	9	394	780
August	35,067	519	2,461	0	736	1,547
September	34,960	2,074	6,332	10	2,131	4,552
October	35,046	2,142	9,633	14	2,307	8,015
November	34,947	2,280	11,647	44	2,341	9,850
December	34,895	2,433	13,154	93	2,505	11,449
UHC						
July	36,516	1,466	1,621	0	0	366
August	38,564	216	1,978	0	0	894
September	36,782	261	2,515	0	0	760
October	36,907	329	3,145	0	0	276
November	36,716	192	2,418	0	0	203
December	36,863	3,226	2,501	0	0	205

Table 20. 2025 PMV: Service Coordinators who Successfully Completed Person-Centered Competency Training			
# of Service Coordinators New and Active Since Last Reporting	# of Service Coordinators Active for a Minimum of 60 Days	# of Service Coordinators Who Completed Training Modules	% of Service Coordinators Active at Least 60 Days and Completed Training Modules
Anthem			
174	161	160	99%
Humana			
155	11	152	106%*
UHC			
167	163	163	100%

**This percentage is due to some service coordinators completing the training modules but were active for less than 60 days.*

Table 21. 2025 PMV: ICP Developed and Implemented within 90 Days for Members with Care Management Level of Service				
MCE	Month	# of Members Active in Care Management	# of Members Identified for ICPs	# of ICPs Implemented within Designated Timeline
Anthem	**90 Days for Members with Care Management Level of Service**			
	July	4,175	18,988	0
	August	5,698	19,172	22
	September	9,069	19,222	35
	October	10,208	19,329	41
	November	11,081	19,186	38
	December	12,109	19,155	41
	60 Days for Members with Complex Care Management Level of Service			
	July	8,805	23,544	38
	August	10,629	23,755	312
	September	13,901	23,886	318

Table 21. 2025 PMV: ICP Developed and Implemented within 90 Days for Members with Care Management Level of Service				
MCE	**Month**	**# of Members Active in Care Management**	**# of Members Identified for ICPs**	**# of ICPs Implemented within Designated Timeline**
	October	15,100	24,085	338
	November	16,023	24,164	353
	December	17,191	24,287	379
Humana	**90 Days for Members with Care Management Level of Service**			
	July	558	558	0
	August	950	950	3
	September	1,191	1,191	4
	October	1,349	1,349	9
	November	1,705	1,705	57
	December	1,983	1,983	79
	60 Days for Members with Complex Care Management Level of Service			
	July	2,021	2,021	20
	August	3,643	3,643	57
	September	4,789	4,789	60
	October	6,025	6,025	96
	November	6,885	6,885	141
	December	7,377	7,377	189
UHC	**90 Days for Members with Care Management Level of Service**			
	July	54	56	1
	August	429	7,198	36
	September	776	706	125

Table 21. 2025 PMV: ICP Developed and Implemented within 90 Days for Members with Care Management Level of Service				
MCE	**Month**	**# of Members Active in Care Management**	**# of Members Identified for ICPs**	**# of ICPs Implemented within Designated Timeline**
	October	1,232	1,235	84
	November	1,524	1,526	99
	December	1,822	1,823	79
	60 Days for Members with Complex Care Management Level of Service			
	July	458	458	32
	August	1,623	13,818	452
	September	2,449	2,445	117
	October	3,177	3,178	148
	November	3,846	3,845	106
	December	4,329	4,330	122

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 22 displays the data for member use of IMD.

Table 22. 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	**Quarter 3**				
	Serious Mental Illness (SMI) Impatient	150	10	15	0
	Substance Use Disorder (SUD) Inpatient	39	6.5	6	0

Table 22. 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	564	11	37	0
	Other IMDs	23	7.7	3	0
	Quarter 4				
	SMI Impatient	184	6.8	20	0
	SUD Inpatient	61	5.5	8	0
	SUD Residential	998	16.5	46	0
	Other IMDs	40	10	4	0
Humana	**Quarter 3**				
	No data reported.				
	Quarter 4				
	SMI Impatient	457	9	51	0
	SUD Inpatient	151	7.9	19	0
	SUD Residential	359	5.1	59	0
	Other IMDs	564	8.5	68	0
UHC	**Quarter 3**				
	SMI Impatient	59	7.4	8	0
	SUD Inpatient	23	5.8	4	0
	SUD Residential	198	17	9	0
	Other IMDs	134	9.6	12	0
	Quarter 4				
	SMI Impatient	59	7.4	8	0
	SUD Inpatient	23	5.8	4	0

Table 22. 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	198	17	9	0
	Other IMDs	134	9.6	12	0

Table 23 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 MCE. OMPP's goal for the measure was 2 within 60 miles per county. None of the MCEs met this performance measure. Humana was the most compliant with this requirement out of the three MCEs with 76.09% of counties meeting the standard.

Table 23. 2025 PMV: Dentists and Oral Surgeons Network Adequacy				
MCE	Total # of Counties	# of Counties Meeting Standard	# of Counties Not Meeting Standard	Percentage Met
Anthem	92	2	90	2.17%
Humana	92	70	22	76.09%
UHC	92	13	79	14.13%

CMS Measures

The evaluation timeframe for this year's EQR overlapped with the PathWays program Readiness Period; therefore, the MCEs reporting requirements for measures that did not yet have annual data available were waived by OMPP. Below is the list of CMS-based performance measures that the MCEs will be responsible for reporting in the 2026 EQR.

- MLTSS Comprehensive Assessment and Update
- Medicaid MLTSS Comprehensive Care Plan and Update
- Medicaid MLTSS Shared Care Plan with Primary Care Provider
- Medicaid MLTSS Reassessment/Care Plan Update after Inpatient Discharge
- Screening, Risk Assessment, and Plan of Care to Prevent Future Falls
- Medicaid MLTSS Admission to a Facility from the Community
- Medicaid MLTSS Minimizing Facility Length of Stay
- Medicaid MLTSS Successful Transition after Long-Term Facility Stay

CAHPS® Measures

Below is the list of performance measures based on the CAHPS® survey that the MCEs will be responsible for reporting starting in the 2026 EQR. For the Readiness Period, this performance measure was waived by OMPP.

- Participants Who, in the Last 3 Months, Reported that Their Service Plan Included Most or all of the Things that are Important to Them.
- Participants Who Report Knowing Who Their Care Manager Is.

HEDIS® Measures

HEDIS® measures are 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, followed by an evaluation of the ability to comply with HEDIS® specifications. In a typical measurement year, each MCE undergoes this audit. Due to the Readiness Period, there was no data available to audit; therefore, no HEDIS® performance measure results were included in this report. All applicable performance of these measures in addition to the results of the HEDIS® Audit will be included in the 2026 PMV when this data is available.

Table 24 presents the HEDIS® measures. Please note that all goals in the following tables are listed as TBD and the measures themselves are listed as Not Required (NQ) due to the Readiness Period and lack of data to audit. The MCEs will be responsible for reporting all HEDIS® measures in the 2026 EQR.

Table 24. 2025 PMV: HEDIS® Measures

Measure Names	Goal	Anthem		Humana		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Adults' Access to Preventive/ Ambulatory Health Services	TBD*		NQ†		NQ		NQ
Acute Hospital Utilization	TBD		NQ		NQ		NQ
Blood Pressure Control for Patients with Diabetes	TBD		NQ		NQ		NQ
Controlling High Blood Pressure	TBD		NQ		NQ		NQ
HbA1c Testing	TBD		NQ		NQ		NQ

Table 24. 2025 PMV: HEDIS® Measures

Measure Names	Goal	Anthem		Humana		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Eye Exam for Patients with Diabetes	TBD		NQ		NQ		NQ
Emergency Department Utilization	TBD		NQ		NQ		NQ
Follow-Up After Emergency Department Visit for Substance Use – 7-Day and 30-Day Follow-Up	TBD		NQ		NQ		NQ
Follow-Up After Hospitalization for Mental Illness – 7-Day and 30-Day Follow-Up	TBD		NQ		NQ		NQ
Follow-Up After Emergency Department Visit for Mental Illness – 7-Day and 30-Day Follow-Up	TBD		NQ		NQ		NQ
Glycemic Status Assessment for Patients with Diabetes	TBD		NQ		NQ		NQ
Hemoglobin A1c Control for Patients with Diabetes - Poor HbA1c Control	TBD		NQ		NQ		NQ
Hemoglobin A1c Control for Patients with Diabetes	TBD		NQ		NQ		NQ
Initiation and Engagement of Alcohol and Other Drug	TBD		NQ		NQ		NQ
Kidney Health Evaluation for Patients with Diabetes	TBD		NQ		NQ		NQ

Table 24. 2025 PMV: HEDIS® Measures

Measure Names	Goal	Anthem		Humana		UHC	
		Rate	Measure Designation	Rate	Measure Designation	Rate	Measure Designation
Oral Evaluation, Dental Services	TBD		NQ		NQ		NQ
Plan All-Cause Readmissions	TBD		NQ		NQ		NQ
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	TBD		NQ		NQ		NQ
Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia	TBD		NQ		NQ		NQ
Diabetes Monitoring for Persons with Diabetes and Schizophrenia	TBD		NQ		NQ		NQ
Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications	TBD		NQ		NQ		NQ

**To Be Determined.*
†Not Required.

Improvements from 2024 PMV

As this is the first year the PathWays program has been in operation, there is no data to compare.

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 25 displays the strengths demonstrated in the PMV, and Table 26 displays the weaknesses.

Table 25. PMV Strengths

MCE	Strength
Anthem	None identified.
Humana	Humana displayed strong data tracking capabilities in the Person-Centered Planning performance measure.
UHC	UHC displayed a strong training program, including a well-established curriculum, certificates, and well-organized data tracking, for the Person-Centered Planning performance measure.

Table 26. PMV Weaknesses

MCE	Weakness
Anthem	Anthem did not align with OMPP requirements and definitions in the HNS and CHAT performance measure and the Service Coordinator Competency performance measure.
	Anthem displayed discrepancies between reported data and raw data files in the Care Management performance measure.
	Anthem was not compliant in 90 counties in the Dentists and Oral Surgeons Network Adequacy performance measure.
Humana	Humana did not align with OMPP for technical specifications in the completion of the CHAT for the HNS and CHAT performance measure.
	Humana displayed an inability to produce evidence of care plan completion for members in the randomized sample in the Care Management performance measure.
	Humana was not compliant in 22 counties in the Dentists and Oral Surgeons Network Adequacy performance measure.

Table 26. PMV Weaknesses	
MCE	**Weakness**
UHC	UHC did not align with OMPP's calculation methodology in CHAT completion for the HNS and CHAT performance measure.
	UHC displayed discrepancies between reported data and primary source files in the Care Management performance measure.
	UHC was not compliant in 79 counties in the Dentists and Oral Surgeons Network Adequacy performance measure.

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 14**, all MCEs achieved the Performance Measure Validation status of partially met.

Anthem

Anthem's main difficulties with the PMV specifically surrounded issues involving alignment with OMPP specifications and requirements for performance measure data and the accuracy of the reported data. Qsource made the following recommendations for Anthem:

- Anthem should monitor adherence to OMPP requirements and definitions of member HNS and CHAT completion.
- Anthem should develop and implement a systematic approach to Service Coordinator competency that aligns with OMPP-established definitions.
- Anthem should assess regulatory programming to improve the accuracy of data reported for the performance measures.
- Anthem should work to improve results of the Dentists and Oral Surgeons Network Adequacy performance measure.

Humana

Humana's main difficulties with the PMV specifically surrounded discrepancies between MCE and OMPP technical specifications for validation, barriers to data accuracy, and a lack of evidence for care plan completion. However, a specific strength was also uncovered in the performance measure data tracking for Person-Centered Planning Training.

Qsource made the following recommendations for Humana:

- Humana should monitor adherence to OMPP requirements, technical specifications, and definitions of member HNS and CHAT completion.
- Humana should ensure that distinctions between service coordination and care coordination are clear so that data is recorded accurately.

- Humana should ensure that care plans are developed and implemented in accordance with OMPP requirements and the documentation of such can be produced.
- Humana should work to improve the target data elements associated with the Dentists and Oral Surgeons Network Adequacy performance measure.

UHC

UHC's main difficulties with the PMV specifically surrounded calculation methodology, discrepancies between primary source files and reported performance measure data, and general EQR preparedness. Qsource also uncovered a specific strength for UHC: the MCE had a strong Person-Centered Training program, including a well-established program curriculum, training competency completion certificates, and well-organized service coordinator performance data tracking.

Qsource made the following recommendations for UHC:

- UHC should monitor adherence to OMPP requirements, calculation methodology, and definitions of member HNS and CHAT completion.
- UHC should ensure that there are no discrepancies between the primary source files and the reported performance measure data.
- UHC should work to improve care plan completion for members.
- UHC should work to improve results of 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 27**. The current three-year cycle is 2025–2027. The current measurement year in which Qsource conducted activities for this report was 2025 (MY 2024).

Table 27. Compliance Standards

CFR Citation	MY 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 Services	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
42 CFR § 438.56	Disenrollment Requirements and Limitations	Access to Care
42 CFR § 438.100	Member Rights Requirements	Quality 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 2025 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 in September and October 2025. During the reviews, 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 28 presents the rating criteria used in the CA validation.

Table 28. 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 assessed 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 29 presents overall compliance scores for all standards by MCE evaluated for the 2025 CA (MY 2024).

Table 29. 2025 Compliance Standard Scores

Standards	Anthem		Humana		UHC	
	Score	Compliance Rating	Score	Compliance Rating	Score	Compliance Rating
Availability of Services	96.43%	High	100%	High	96.43%	High
Assurances of Adequate Capacity and Services	100%	High	100%	High	100%	High
Coordination and Continuity of Care	100%	High	100%	High	97.78%	High
Coverage and Authorization of Services	90.70%	High	97.67%	High	100%	High
Emergency and Poststabilization	100%	High	100%	High	100%	High
Confidentiality	100%	High	100%	High	100%	High
Grievance and Appeals System	77.78%	Low	95.24%	High	100%	High
Subcontractual Relationships and Delegation	100%	High	100%	High	100%	High
Practice Guidelines	100%	High	100%	High	100%	High
Health Information Systems	100%	High	100%	High	100%	High
Quality Assessment and Performance Improvement	100%	High	100%	High	100%	High
Disenrollment Requirements and Limitations	100%	High	100%	High	100%	High
Enrollee Rights Requirements	100%	High	100%	High	100%	High
Provider Selection	100%	High	100%	High	100%	High
Overall Compliance Standard Score	**92.69%**	**High**	**98.46%**	**High**	**99.23%**	**High**

Table 30 presents the file review score for each MCE.

Table 30. 2025 File Review Score

File	Anthem		Humana		UHC	
	Score	Compliance Rating	Score	Compliance Rating	Score	Compliance Rating
UM Denials	98.97%	High	91.11%	High	91.11%	High
Grievances	98.57%	High	100%	High	95.71%	High
Appeals	100%	High	95.71%	High	92.86%	High
Credentialing	96.26%	High	100%	High	99.06%	High
Recredentialing	96.63%	High	98.95%	High	100%	High
Overall File Review Score	**97.92%**	**High**	**97.23%**	**High**	**96.31%**	**High**

Strengths and Weaknesses

Table 31 provides strengths by compliance standard or file review for the CA, while the AONs, or weaknesses, are identified in Table 32. 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 31. CA Strengths by Standard

Standard Title	Strength	Domain of Care
Anthem		
None identified.		
Humana		
None identified.		
UHC		
None identified.		

Table 32. CA Weaknesses (AONs) by Standard		
Standard Title	**AON**	**Domain of Care**
Anthem		
Availability of Services #11: Nurse Triage Services	The MCE should have a policy concerning recording nurse line calls.	Access to Care
Coverage and Authorization of Services #6: Medically Necessary Services	The MCE should include each unmet criteria in the policy or develop a policy that addresses these criteria: growth and development, functional capacity, cure, correct, reduce, or ameliorate, and reduce or ameliorate pain or suffering.	Access to Care/Quality of Care/ Timeliness of Care
Grievance and Appeals #3: Deemed Exhaustion	The MCE should have a policy that states if the MCE fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCE's appeals process and may initiate a State fair hearing.	Timeliness of Care
Grievance and Appeals #18: Extension of Timeframes	The MCE should include additional documentation to the grievance and appeal policies that address the member's request for an extension of the timeframe if the MCE shows (to the satisfaction of OMPP, upon its request) that there is a need for additional information and how the delay is in the member's interest.	Timeliness of Care
Grievance and Appeals #19: Extension Requirements	The MCE should include the criteria related to written notification to the member within two (2) calendar days in the policy.	Timeliness of Care
Grievance and Appeals #26: Punitive Action Prohibited	The MCE should include documentation that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal in the policy.	Access to Care/Quality of Care/ Timeliness of Care
Grievance and Appeals #29: Recordkeeping Requirements – Ongoing Monitoring	The MCE should include language related to the record keeping requirements and review of the information as part of ongoing monitoring procedures and updates and revisions to the Quality Strategy in the policy for appeals.	Access to Care/Quality of Care/ Timeliness of Care

Table 32. CA Weaknesses (AONs) by Standard

Standard Title	AON	Domain of Care
Grievance and Appeals #30: Recordkeeping Requirements – Information	The MCE should include the listed record keeping requirements for each grievance and appeal in the policy.	Access to Care/Quality of Care/ Timeliness of Care
Grievance and Appeals #31: Recordkeeping Requirements – Accuracy and Accessibility	The MCE should include the language related to record maintenance in a manner accessible to OMPP and available upon request to CMS in the policy.	Access to Care/Quality of Care/ Timeliness of Care
Grievance and Appeals #34: Effectuation of Reversed Appeal Resolutions – Services not Furnished while Appeal Pending	The MCE should include language that addresses the criteria, no later than 72 hours from the date it receives notice reversing the determination, in the policy.	Timeliness of Care
UM Denials File Review	The MCE should ensure that Notice of Adverse Benefit Decisions (NABD) notifications are sent in a timely manner.	Timeliness of Care
Grievance File Review	The MCE should ensure that all Grievance decisions are made in a timely manner.	Timeliness of Care
Credentialing File Review	The MCE should ensure that all credentialed providers have active Medicaid identification numbers listed.	Quality of Care
Recredentialing File Review	The MCE should ensure that all recredentialed providers have active Medicaid identification numbers listed.	Quality of Care
Humana		
Coverage and Authorization of Services #14: Timing of Notice	The MCE should include the requirement to mail the NABD for denial of payment, at the time of any action affecting the claim in the policy.	Access to Care/Quality of Care/ Timeliness of Care

Table 32. CA Weaknesses (AONs) by Standard

Standard Title	AON	Domain of Care
Grievance and Appeals #3: Deemed Exhaustion	The MCE should include deemed exhaustion criteria in the policy.	Access to Care/Quality of Care/ Timeliness of Care
Grievance and Appeals #9: Reviewer Requirements	The MCE should include language that individuals who make decisions on grievances and appeals are individuals who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination in the policy.	Access to Care/Quality of Care/ Timeliness of Care
Grievance and Appeals #35: Effectuation of Reversed Appeal Resolutions – Services Furnished While Appeal Pending	The MCE should have a policy that states if the appeal reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE pays for those services.	Access to Care/Quality of Care/ Timeliness of Care
UM Denials File Review	The MCE should ensure that NABD notifications are sent out in a timely fashion.	Timeliness of Care
	The MCE should ensure that provider notifications have all applicable information.	Access to Care
Appeals File Review	The MCE should ensure that all appeal acknowledgements are sent to members in a timely fashion.	Timeliness of Care
	The MCE should ensure that appeal resolution notifications contain all applicable information.	Access to Care
Recredentialing File Review	The MCE should ensure that all recredentialing occurs in a timely fashion.	Timeliness of Care
UHC		
Availability of Services #11: Nurse Triage Services	The MCE should include a policy stating all nurse line calls are recorded.	Access to Care

Table 32. CA Weaknesses (AONs) by Standard

Standard Title	AON	Domain of Care
Coordination and Continuity of Care #20: Direct Access to Specialists	The MCE should have a policy for direct access to specialists.	Quality of Care
UM Denials File Reviews	The MCE should ensure member notifications are included as part of all UM Denials.	Access to Care
	The MCE should ensure that provider notifications are included as part of all UM Denials.	Access to Care
Grievance File Reviews	The MCE should ensure that Grievance acknowledgements are sent out in a timely manner.	Timeliness of Care
	The MCE should ensure that Grievance decisions are made in a timely manner.	Timeliness of Care
Appeals File Review	The MCE should ensure that Appeal acknowledgements are sent out in a timely manner and provided verbally as required.	Timeliness of Care
	The MCE should ensure that Appeal decisions are made in a timely manner.	Timeliness of Care
Credentialing File Review	The MCE should ensure that all credentialed providers have active Medicaid identification numbers listed.	Quality of Care

Performance Improvement

As this is the first year the PathWays program has been in operation, there is no data to compare.

Conclusions and Recommendations

Anthem

Anthem achieved 92.69% overall for the 14 compliance standards assessed and 97.92% overall for the file reviews. Anthem was found to be 100% compliant on 11 of the 14 standards, with a score of 96.43% for the Availability of Services standard, 90.70% for the Coverage and Authorization of Services standard, and 77.78% on the Grievance and Appeals standard. Anthem was found to have one AON each for Availability of Services and Coverage and Authorization of Services and eight AONs for Grievance and Appeals. In addition

to these AONs, Anthem received three AONs during file review: one each for UM Denials, Grievances, and Recredentialing.

Additionally, Qsource would like to note that Anthem should ensure that documentation is updated annually and P&Ps should be compared to the OMPP contract to ensure that all requirements are explicitly included in the documentation. Anthem has shown that they are aware of the contract requirements, but the explicit language is not always present, or documentation cannot be proven to be updated on an annual basis. Should Anthem focus on these issues, many of the AONs would be resolved.

Anthem's rating of High Compliance in 13 of the 14 compliance standards and all of the file reviews indicated that the MCE aligned with OMPP's commitment to quality care. Anthem's score of <90.00% for Emergency and Poststabilization and Coverage and Authorization of Services demonstrate a commitment to providing timely care to enrollees. Anthem's score of <90.00% for Availability of Services, Assurances of Adequate Capacity and Services, and Coordination and Continuity of Care demonstrate a commitment to providing access to care for all members.

Humana

Humana achieved 98.46% overall for the 14 compliance standards assessed and 97.23% overall for the file reviews. Humana was found to be 100% compliant on 12 of the 14 standards, with a score of 97.67% for the Coverage and Authorization of Services standard and 95.24% on the Grievance and Appeals standard. Humana was found to have one AON for Coverage and Authorization and three for Grievance and Appeals. In addition to these AONs, Humana received five AONs during file reviews: two each for UM Denials and Appeals, and one for Recredentialing.

Humana's rating of High Compliance in all 14 compliance standards and all file reviews indicated that the MCE aligned with OMPP's commitment to quality care. Humana's score of <90.00% for Emergency and Poststabilization and Coverage and Authorization of Services demonstrate a commitment to providing timely care to enrollees. Humana's score of 100% for Availability of Services, Assurances of Adequate Capacity and Services, and Coordination and Continuity of Care demonstrate a commitment to providing access to care for all members.

UHC

UHC achieved 99.23% overall for the 14 compliance standards assessed and 96.31% overall for the file reviews. UHC was found to be 100% compliant on 12 of the 14 standards, with a score of 96.43% for the Availability of Services standard and 97.78% on the Coordination and Continuity of Services standard. UHC was found to have one AON in each of those standards. In addition to these AONs, UHC received seven AONs during file reviews: two each for UM Denials, Grievances, and Appeals, and one for Credentialing.

UHC's rating of High Compliance in all 14 compliance standards and all file reviews indicated that the MCE aligned with OMPP's commitment to quality care. UHC's score of 100% for Emergency and Poststabilization and Coverage and Authorization of Services demonstrate a commitment to providing timely care to enrollees. UHC's score of 100% for Availability of Services, Assurances of Adequate Capacity and Services, and Coordination and Continuity of Care demonstrate a commitment to providing access to care for all members.

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 report presents the results of the ANA review. It describes the review methodologies, the findings for each task, and 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 July 1 to December 31, 2024, and measured member access to provider service types. OMPP required the following activities be included in Qsource's analysis of network adequacy:

- Evaluation of network adequacy including:
  - Evaluation of the methods and processes used by the MCEs to meet OMPP time and distance standards; and
  - Review and evaluate network contracting and MCE processes for meeting network adequacy standards.
- Validation of access to care and confirmation of an adequate network including:
  - Sample and cold calls of providers listed in MCE networks, using a valid sampling methodology to verify the percentage of providers that have available appointments within the OMPP standard for new patients; and
  - Validation of OMPP measurement processes for network adequacy, when available.

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

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

Geographic Network Adequacy Analysis

Objectives

The MCE's contract with OMPP establishes minimum requirements for access and availability of services and indicates that each MCE must demonstrate that it:

- offers an appropriate range of specialists, dental specialists, acute care, preventative, primary care, specialty services, rehabilitative services, LTSS, and HCBS that is adequate for the anticipated number of enrolled members;
- provides a sufficient number and geographic distribution of acute care hospital facilities to serve the expected enrollment and maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrolled members;
- contracts with at least 90% of all inpatient geriatric psychiatric facilities in Indiana;
- ensures the availability of one dialysis treatment center within sixty miles of the member's residence; and
- meets the standards for each provider type.

The MCEs' contracts include geographical access distance standards and provider-to-member ratio standards for urban and rural 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 July 1, 2025.

Qsource conducted an ISCA as required by Activity 3 during the virtual systems review as part of *Protocol 2: Performance Measure Validation*. ISCATs were reviewed by Qsource for general information, the integrity of all systems capabilities including administrative data (medical claims), enrollment data systems, provider data, data completeness, integration of data for performance measure calculation, and ancillary data and integration processes. The complete findings from the virtual systems review are located in the *2025 Performance Measure Validation Reports*.

Methodology

Qsource reviewed the FSSA Indiana Health Care Plan Provider Enrollment Type and Specialty Matrix. In addition, Qsource subcontracted with Myers and Stauffer to conduct Geomapping to determine if provider networks met quantitative standards, such as distance standards, and to calculate provider-to-member ratios by type of provider and geographic area. Geomapping involved obtaining data as of July 1, 2025.

Data Collection

Qsource Analytics derived the data for quantitative analyses from provider data files as of July 1, 2025, supplied by the MCEs, and enrollment/eligibility files as of July 1, 2025, provided by OMPP.

To be included in the analysis, a member had to have:

- active eligibility and enrollment in the MCE as of July 1, 2025;
- an address within Indiana; and
- a valid address as defined during data standardization.

To be included in the analysis, a provider had to have:

- an active contract with the MCE as of July 1, 2025;
- status as a network provider; and
- a valid address as defined during data standardization.

Data Standardization

Qsource assessed geographical access to primary and specialty care providers by calculating the travel time and distance between MCE members and providers. Myers and Stauffer utilized Environmental Systems Research Institute, Inc. ArcGISTM™ (ESRI ArcGIS) mapping software to assign standardized addresses and geocoding 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.

After geocoding, duplicate provider records were eliminated. The provider data used in the analysis reflected the following:

- a single provider with multiple addresses was counted once for each address;
- multiple providers at the same address were counted as distinct providers;
- a single provider with more than one specialty was counted for each specialty; and
- providers whose National Provider Identifiers (NPIs) had been deactivated were excluded from the analyses.

Results were summarized by county and program to identify potential issues. Underserved members were measured by the count of members not having sufficient access within provider service type and county combinations.

Calculations

After the member and provider data were standardized and geocoded, county-level (urban and rural) calculations established the travel time and distance from each member location to each of the provider and facility types. The State defines minimum network access standards, including minimum acceptable distance from member residence to provider for urban and rural counties and provider-to-member ratios by provider type. If the member location had at least one provider/facility location within the established criteria, that member was factored into the percentage-with-access category. If not, the member was without the desired access to care.

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. Figure 2 illustrates Anthem's member population; Figure 9 illustrates Humana's member population; Figure 18 illustrates UHC's member population.

Table 33 provides the accessibility standards and adequacy results for all provider service types as well as links to the figures that illustrate where members do not have sufficient access to providers.

Additionally, the table displays a number of providers that are listed as Not Reported. Qsource found that the majority of these were HCBS and LTSS services. However, Qsource also found that sometimes when a provider type was Not Reported, there was a similar specialty which was reported and met adequacy (e.g., Cardiovascular Surgeon vs. Cardiothoracic Surgeon). There were also instances when a provider type was Not Reported but that there were specific specialties that could be classified in the general provider type but was reported as the specific specialty instead (e.g., Psychiatrist was reported and is a part of the Behavioral Health Provider general provider type). Furthermore, there were several instances where the MCE reported specialties that had similar names to requested specialties, but, due to a different provider type code and provider specialty code, Qsource was unable to verify if those were the same specialty (e.g., Home Health Providers were requested but Home Health Agency with a different provider code and specialty provider code was reported). If the Not Reported provider type had one of these mitigating factors attached to it, this was noted in the table.

Table 33. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		Anthem	Humana	UHC	Anthem	Humana	UHC	Anthem	Humana	UHC
Primary Care										
PMPs-Physicians	1 within 30 miles	Met	Not Met	Met	-	1	-		Figure 10	
Specialty Care										
Anesthesiologists	2 within 60 miles	Met	Met	Met	-	-	-			
Cardiologists	2 within 60 miles	Met	Met	Met	-	-	-			
Cardiothoracic Surgeons	1 within 90 miles	NR*†	Not Met	Not Met		51	79		Figure 11	Figure 19
Cardiovascular Surgeons	1 within 90 miles	Met	Met	Met	-	-	-			
Dentists	1 within 30	Not Met	Not Met	Not Met	1	87	2	Figure 3	Figure 12	Figure 20

Table 33. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		Anthem	Humana	UHC	Anthem	Humana	UHC	Anthem	Humana	UHC
	miles									
Dermatologists	1 within 90 miles	Met	Met	Met	-	-	-			
Diagnostic Testing	2 within 60 miles	Met	Met	Not Met	-	-	72			Figure 21
Endocrinologists	2 within 60 miles	Met	Met	Met	-	-	-			
Gastroenterologists	2 within 60 miles	Met	Met	Met	-	-	-			
General Surgeons	2 within 60 miles	NR‡	Met	Met		-	-			
Geriatrician	1 within 90 miles	Met	Met	Met	-	-	-			
Gynecologists	2 within 60 miles	Not Met	Not Met	Not Met	1	5	5	Figure 4	Figure 13	Figure 22
Infectious Disease Specialists	1 within 90 miles	Met	Met	Met	-	-	-			
Interventional Radiologists	1 within 90 miles	Met	Met	Not Met	-	-	92			Figure 23
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	Met	NR**	9	-		Figure 5		

Table 33. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		Anthem	Humana	UHC	Anthem	Humana	UHC	Anthem	Humana	UHC
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	Met	8	92	-	Figure 6	Figure 14	
Orthodontists	2 within 60 miles	Not Met	Not Met	Not Met	52	92	31	Figure 7	Figure 15	Figure 24
Orthopedic Surgeons	2 within 60 miles	Met	Met	Met	-	-	-			
Otologist/ Laryngologist/ Rhinologist	2 within 60 miles	NR	NR	NR						
Pathologists	1 within 90 miles	NR‡	Met	Met		-	-			
Pharmacy	2 within 30 miles	Met	Not Met	Met	-	67	-		Figure 16	
Physical Therapists	2 within 60 miles	Met	Met	Met	-	-	-			
Prosthetic Suppliers	1 within 90 miles	Met	Met	NR	-	-				
Pulmonologists	2 within 60 miles	Met	Met	Met	-	-	-			

Table 33. Accessibility by Provider Service Type										
Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		Anthem	Humana	UHC	Anthem	Humana	UHC	Anthem	Humana	UHC
Radiation Oncologists	1 within 90 miles	NR§	NR§	NR§						
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	-	-	-			
Facility/Group/Organization										
Acute Care Hospitals	Urban - 1 within 30 miles Rural - 1 within 60 miles	Met	Met	Met	-	-	-			
Dialysis Treatment Center	1 within 60 miles	Met	Met	Met	-	-	-			
Extended Facility (Skilled Nursing Facility)	1 per County	NR¶	Met	NR¶		-				
Inpatient Psychiatric Facilities	1 within 60 miles	Met	Met	Met	-	-	-			
HCBS/LTSS Services										
Attendant Care	1 per county	NR	NR	NR						
Community Transitions	1 per county	NR	NR	NR						
Community Transportation	1 per county	NR	NR	NR						

Table 33. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		Anthem	Humana	UHC	Anthem	Humana	UHC	Anthem	Humana	UHC
Durable Medical Equipment (DME)	2 per county	NR¶	NR	NR						
Home & Community Assistance	1 per county	NR	NR	NR						
Home Delivered Meals	1 per county	NR	NR	NR						
Home Health Providers	1 per county	NR¶	NR¶	NR¶						
Home Modifications	1 per county	NR	NR	NR						
Hospice	2 per county	NR	NR	NR						
Integrated Healthcare Coordination	1 per county	NR	NR	NR						
Nutritional Supplements	1 per county	NR	NR	NR						
Personal Emergency Response	1 per county	NR	NR	NR						
Pest Control	1 per county	NR	NR	NR						
Respite	1 per county	NR	NR	NR						
Service Coordination	1 per county	NR	NR	NR						
Specialized Medical Equipment	1 per county	NR	NR	NR						
Structured Family Care	1 per county	NR	NR	NR						
Vehicle Modification	1 per county	NR	NR	NR						
Behavioral Health										
Behavioral Health Providers	Urban -1 within 30 miles	NR#	NR#	NR#						

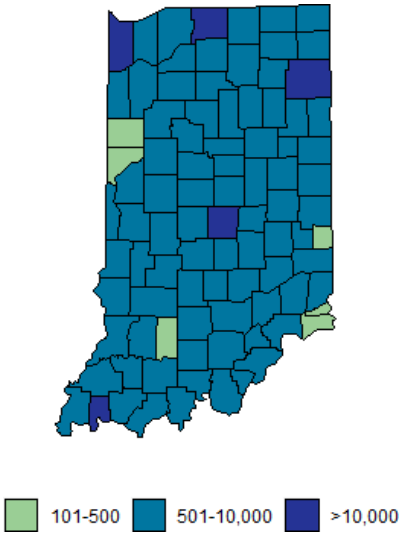
Table 33. Accessibility by Provider Service Type

Provider Service Type	Accessibility Standard	Standard Met/Not Met			Number of Counties Not Met			Map Figure Number		
		Anthem	Humana	UHC	Anthem	Humana	UHC	Anthem	Humana	UHC
	Rural - 1 within 45 miles									
Non-Psychiatrist Non-SUD and Behavioral Health Provider	Urban -1 within 30 miles Rural - 1 within 45 miles	Met	Met	Met	-	-	-			
Psychiatrists	2 within 60 miles	Met	Met	Met	-	-	-			
SUD Providers	1 within 30 miles	Not Met	Not Met	Not Met	44	54	64	Figure 8	Figure 17	Figure 25

**Not Reported.*
†This specialty was not reported; however, Cardiovascular Surgeon and Cardiologist were reported, and both met the access standard.
‡This specialty could not be calculated based on the data provided.
§This specialty does not have a provider or provider specialty code for reporting (see Appendix B); therefore, Radiologist and Oncologist were reported and met the access standard.
¶This specialty was not reported, though a similarly named specialty was reported; however, due to different provider type codes and provider specialty codes, Qsource was unable to verify if the two specialties were the same.
#This specialty type was not reported, but specific specialty provider types that fit into this general provider type were reported with some meeting accessibility standards and others not meeting accessibility standards.
***This specialty was not reported; however, Anesthesiologist was reported and met the access standard.*

Anthem Member Population

Figure 2. Anthem Member Population



Anthem Accessibility by Provider Type

Figure 3. Dentists

Figure 4. Gynecologists

Figure 5. Non-Hospital Based Anesthesiologists

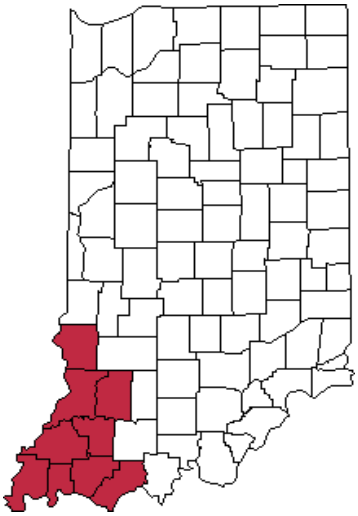


Figure 6. Oral Surgeons

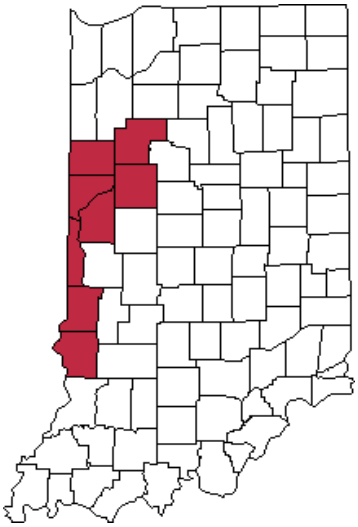


Figure 7. Orthodontists

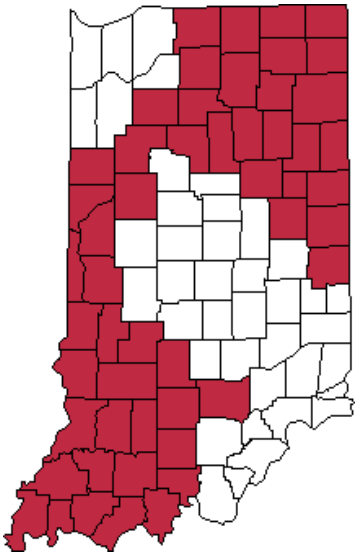
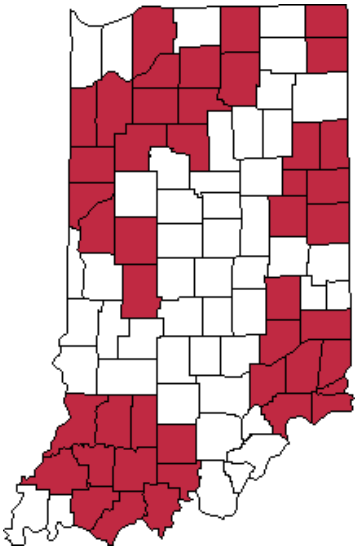
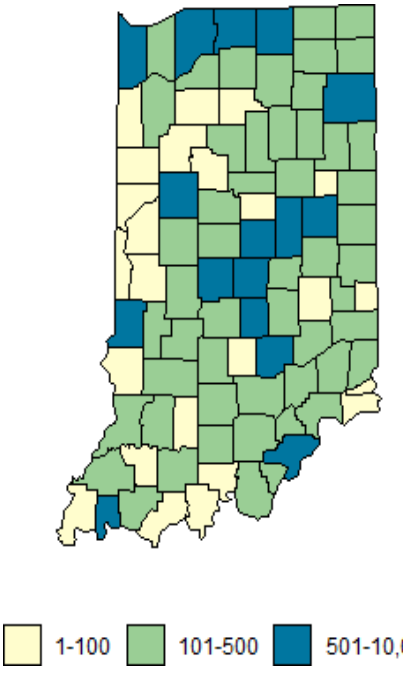


Figure 8. SUD Providers



Humana Member Population

Figure 9. Humana Member Population



Humana Accessibility by Provider Service Type

Figure 10. PMP – Physicians

Figure 11. Cardiothoracic Surgeons

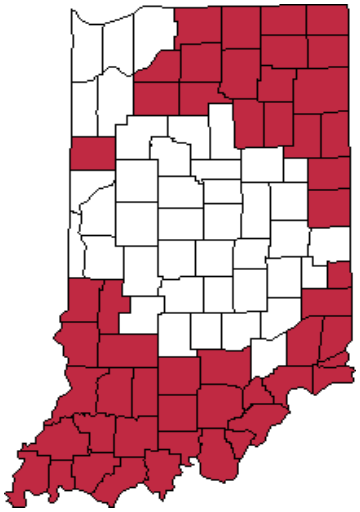


Figure 12. Dentists

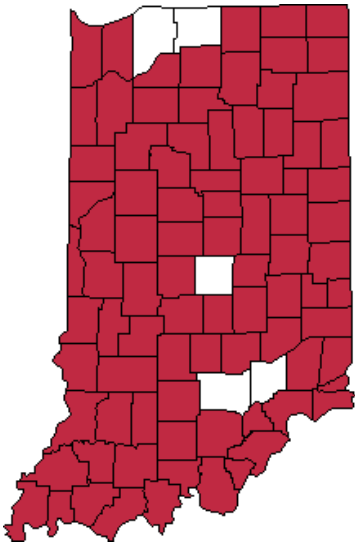


Figure 13. Gynecologists

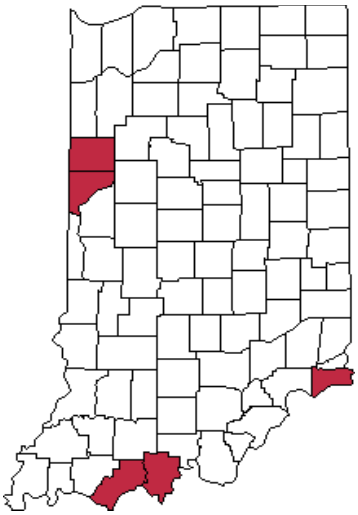


Figure 14. Oral Surgeons

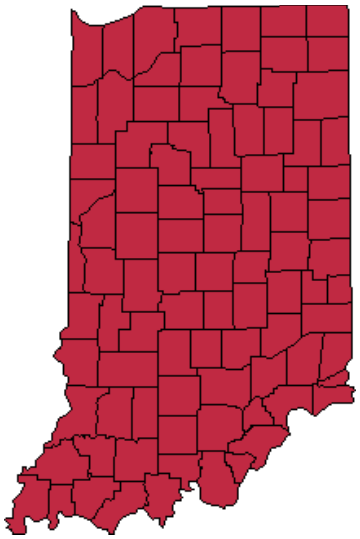


Figure 15. Orthodontists

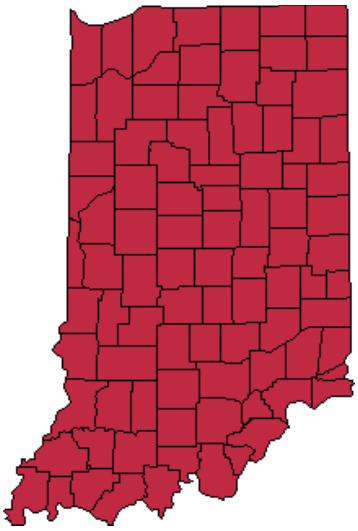


Figure 16. Pharmacy

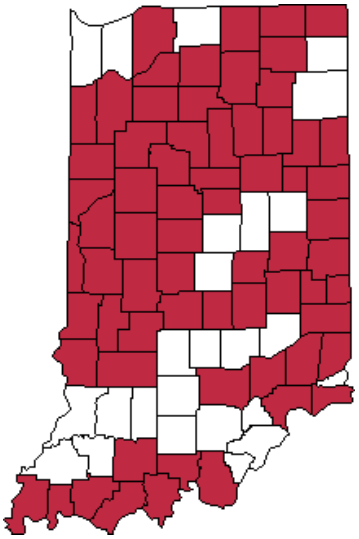
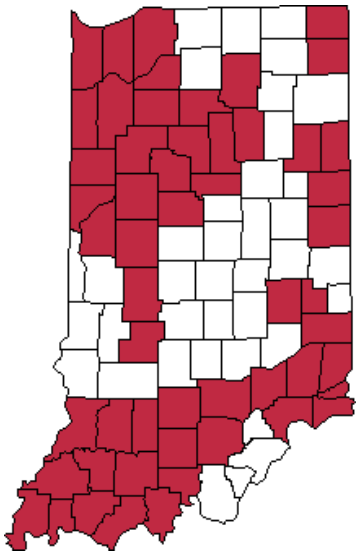
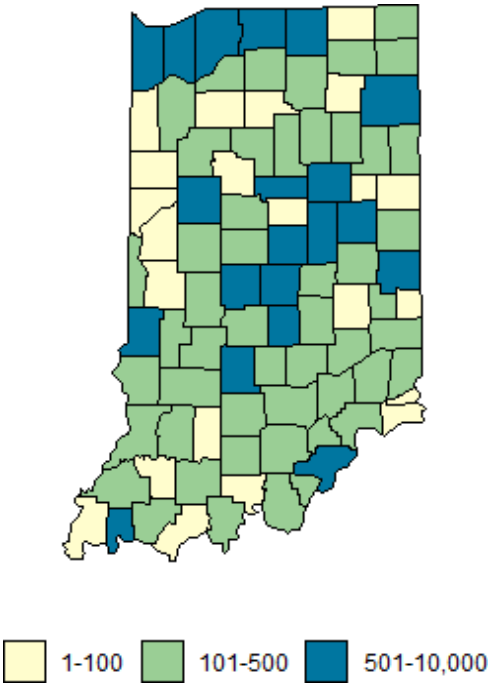


Figure 17. SUD Providers



UHC Member Population

Figure 18. UHC Member Population



UHC Accessibility by Provider Service Type

Figure 19. Cardiothoracic Surgeons

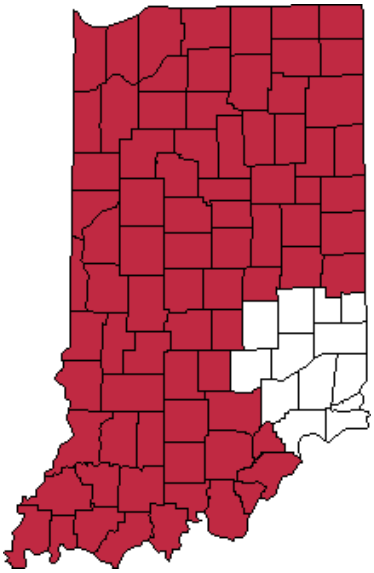


Figure 20. Dentists

Figure 21. Diagnostic Testing

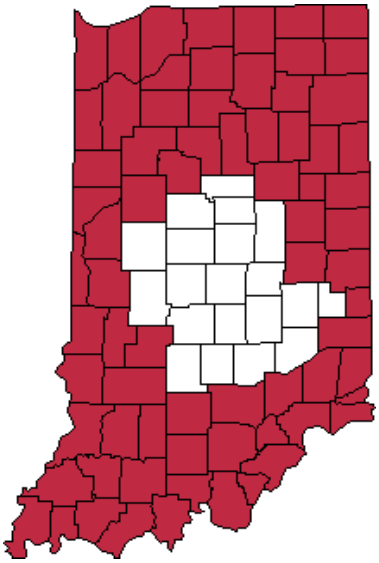


Figure 22. Gynecologists

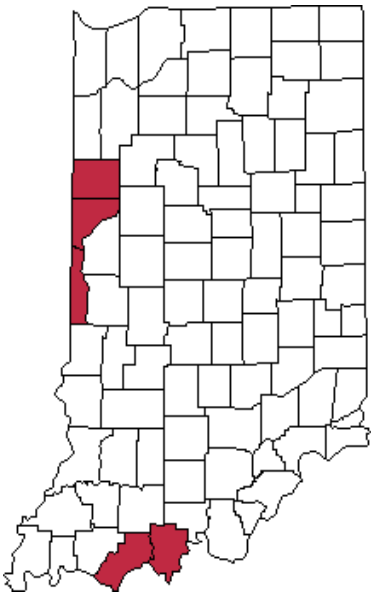


Figure 23. Interventional Radiologists

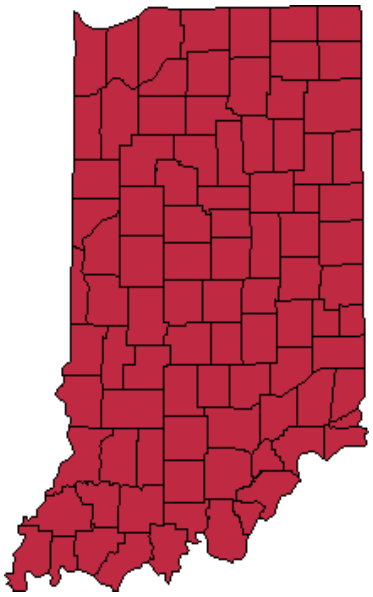


Figure 24. Orthodontists

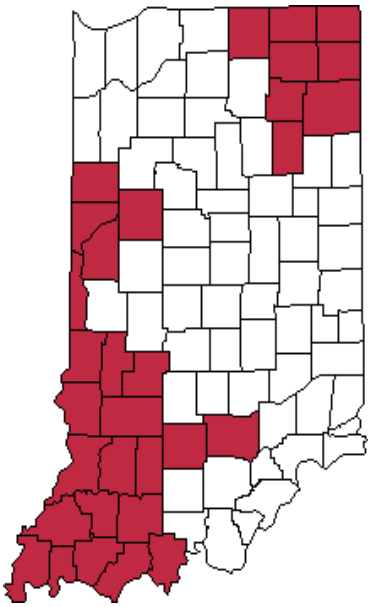
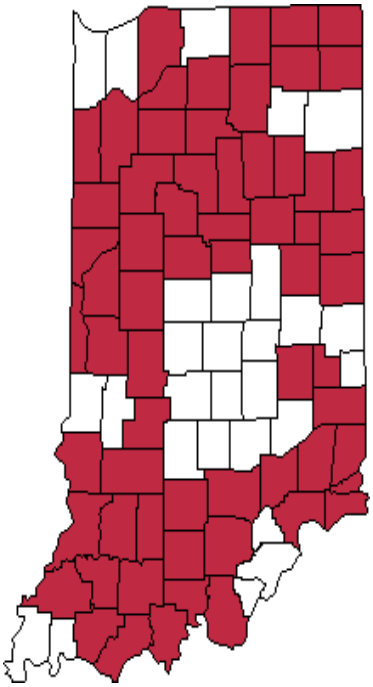


Figure 25. SUD Providers



Secret Shopper Survey

Objectives

MCE agreements with OMPP establish minimum requirements for access and availability of services and indicate that each MCE must demonstrate that it has the capacity to serve the expected enrollment in accordance with standards for access and timeliness of care.

This Secret Shopper study was conducted over a random sample of PMP, Gynecologist (GYN), Behavioral Health (BH) providers, SUD providers, and General Dentists (GD) across the state.

Provider Sampling Methodology

In this survey, Qsource call center staff assumed the role of a member attempting to obtain a new patient appointment for routine, non-urgent, non-emergency care. Qsource obtained a sample from the provider directory using a valid sampling methodology. Only providers listed in the MCE's networks were selected for the sample. A statistically valid sample was selected for each provider type (PMP, GYN, BH, SUD, and GD). The secret shopper activity validated the accuracy of each MCE's provider directory and verified appointment availability. Appointment availability was measured against the OMPP standards requiring MCEs to ensure providers offer new patient appointments within 30 calendar days for routine, non-emergency care visits.

Qsource requested a digital version of each plan's provider directory. Our staff compared provider directory information to provider responses to validate providers' network status, addresses, hours of operation, phone numbers, and accepting new patients as part of the survey. When a provider is included in the Secret Shopper Survey, the surveyor compared the office information from the calls to the information in the MCE provider directory. For example, was the phone number listed in the directory a valid working number or if the directory stated that the provider was accepting new patients, did the provider respond that they were accepting new patients. Qsource conducted the survey by calling provider types that would be able to set up a new patient appointment without needing a referral. The staff attempted the call a maximum of three times during standard operating hours.

Survey Procedure

Qsource call center staff were required to complete a training program specific to the Secret Shopper Survey prior to contacting providers, where staff reviewed the Secret Shopper Survey script used for call completion and data collection. Qsource call center staff attempted the call a maximum of three times at different times of the day during standard operating hours. If three calls proved unsuccessful, the provider was considered non-responsive and recorded as such in the database.

The date range provided at the time of the secret shopper call (the date from the call to the date of the appointment offered) was compared to the time and access requirements set by OMPP.

Survey Results

Table 34 displays the total number of providers sampled, the number of providers that were reached and unable to be reached, the completed and not completed call counts, and the percentage of calls that were completed for each MCE. Humana had the highest rate of call completion at 28.21%.

Table 34. Secret Shopper Totals

MCE	Total Providers	Unable to Reach	Providers Reached	Unable to Complete	Completed Calls	Percent
Anthem	377	235	142	125	17	11.97%
Humana	368	134	234	168	66	28.21%
UHC	370	136	234	185	49	20.94%

Table 35 presents an overall breakdown of the reasons that providers were unable to be reached for each MCE. The most common reason for a provider being listed as "unable to be reached" was due to the secret shopper being told that the provider was not at the location or number any longer. This counted for more than 50.00% of the total "unable to reach" reasons for each MCE.

Table 35. Secret Shopper Unable to Reach Reasons

MCE	Provider Not at This Location/ Number	Voicemail	Invalid Phone Number	No Answer	Closed Permanently/ Number Disconnected	Always Busy	Retired	Fax Number	Total Providers
Anthem	148	31	13	13	13	11	5	1	**235**
Humana	75	27	5	12	7	5	2	1	**134**
UHC	75	41	5	5	4	2	4	0	**136**

Table 36 presents an overall breakdown of the reasons that the providers were unable to complete the survey for each MCE. The most common reason that a secret shopper was unable to secure an appointment was due to being told that the provider does not take appointments.

Table 36. Secret Shopper Unable to Complete Reasons

MCE	Provider Type Does Not Take Appointments	Required Medicaid ID or Patient Info Before Scheduling	Not Accepting New Patients	Does not Accept Medicaid/ PathWays	Not Contracted with Plan	Total Providers
Anthem	70	25	14	13	3	**125**
Humana	64	43	43	11	7	**168**
UHC	69	65	37	9	5	**185**

For Anthem, the rate of reaching a provider's representative (i.e., completed calls) with the phone number from the online directory averaged 11.97%. The most prevalent reason for not completing the survey call was due to the provider no longer practicing at the location. The most prevalent reason for not obtaining an appointment was due to the provider type not taking appointments.

For Humana, the rate of reaching a provider's representative (i.e., completed calls) with the phone number from the online directory averaged 28.21%. The most prevalent reason for not completing the survey call was due to the provider no longer practicing at the location. The most prevalent reason for not obtaining an appointment was due to the provider type not taking appointments.

For UHC, the rate of reaching a provider's representative (i.e., completed calls) with the phone number from the online directory averaged 20.94%. The most prevalent reason for not completing the survey call was due to the provider no longer practicing at the location. The most prevalent reason for not obtaining an appointment was due to the provider type not taking appointments.

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 37 shows the percentage of appointments offered that met the MCE's standards.

Table 37. Appointment Wait Time Compliance

MCE	Provider Type	Access Standard (in Days)	Average Number of Days	Total Providers	Providers Compliant	Compliance Rate
Anthem	GD	30	29.50	2	1	50.00%
	GYN	30	49.00	3	1	33.33%
	PMP	30	83.60	10	4	40.00%
	SUD	30	10.00	1	1	100%
	Total	**30**	**65.75**	**16**	**7**	**43.75%**
Humana	BH Provider	30	132	1	0	0.00%
	GYN	30	56.30	10	4	40.00%
	PMP	30	37.69	52	32	61.54%
	SUD	30	NR*	0	0	NR
	Total	**30**	**42.14**	**63**	**36**	**57.14%**
UHC	BH Provider	30	11.40	10	8	80.00%
	GD	30	29.82	11	7	63.64%
	GYN	30	60.20	5	2	40.00%
	PMP	30	38.41	22	13	59.09%
	Total	**30**	**33.08**	**48**	**30**	**62.50%**

**Not Reported; the three provider calls in this category did not provide a valid date for appointments and were marked as invalid.*

For all three MCEs, the reported data reflects the status of the individual provider sampled and does not take into account earlier appointments that may have been offered with other providers within the group/practice contacted.

Overall, 43.75% of Anthem's appointments offered were within the MCE's wait time standards. Additionally, the Secret Shopper Methodology included BH providers, only fourteen providers of this type were included in the randomized sample. These provider calls resulted in the inability to complete the Secret

Shopper Survey; therefore, the provider category is not shown within the following data validation tables.

Overall, 57.14% of Humana's appointments offered were within the MCE's wait time standards. Additionally, the Secret Shopper Methodology originally included GD providers; however, only one provider of this type was included in the randomized sample. This provider was unable to be surveyed; therefore, the provider category is not shown within the following data validation tables. Further, as noted in the table, the three SUD providers in the sample did not provide a valid date for appointments and were marked as invalid; thus, this validation is listed as Not Reported.

Overall, 62.50% of UHC's appointments offered were within the MCE's wait time standards. Additionally, while the Secret Shopper Methodology included SUD providers, only one provider of this type was included in the randomized sample. This provider was unable to be reached; therefore, the provider category is not shown within the following data validation tables.

Provider Directory Inaccuracies

Certain online provider directory information for the providers sampled was verified with the provider representatives during the secret shopper survey. **Table 38** 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.

Table 38. Provider Directory Inaccuracies

MCE	Provider Type	Correct	Incorrect	Total Providers Sampled	Compliance Rate
Anthem	**Address**				
	GD	2	0	2	100%
	GYN	1	2	3	33.33%
	PMP	6	5	11	54.55%
	SUD	1	0	1	100%
	Total	**10**	**7**	**17**	**58.82%**
	Telephone Number				
	GD	2	0	2	100%

Table 38. Provider Directory Inaccuracies					
MCE	Provider Type	Correct	Incorrect	Total Providers Sampled	Compliance Rate
	GYN	3	0	3	100%
	PMP	11	0	11	100%
	SUD	1	0	1	100%
	Total	**17**	**0**	**17**	**100%**
	Hours of Operation				
	GD	1	1	2	50.00%
	GYN	0	3	3	0.00%
	PMP	3	8	11	27.27%
	SUD	0	1	1	0.00%
	Total	**4**	**13**	**17**	**23.53%**
	New Patient Availability				
	GD	2	0	2	100%
	GYN	3	0	3	100%
	PMP	10	1	11	90.91%
	SUD	1	0	1	100%
	Total	**16**	**1**	**17**	**94.12%**
	Provider Type				
	GD	2	0	2	100%
	GYN	3	0	3	100%
	PMP	10	1	11	90.91%
	SUD	1	0	1	100%
	Total	**16**	**1**	**17**	**94.12%**

Table 38. Provider Directory Inaccuracies					
MCE	**Provider Type**	**Correct**	**Incorrect**	**Total Providers Sampled**	**Compliance Rate**
Humana	**Address**				
	BH Provider	1	0	1	100%
	GYN	9	2	11	81.82%
	PMP	48	5	53	90.57%
	SUD	0	1	1	0.00%
	Total	**58**	**8**	**66**	**87.88%**
	Telephone Number				
	BH Provider	1	0	1	100%
	GYN	11	0	11	100%
	PMP	51	2	53	96.23%
	SUD	0	1	1	0.00%
	Total	**63**	**3**	**66**	**95.45%**
	Hours of Operation				
	BH Provider	0	1	1	0.00%
	GYN	3	8	11	27.27%
	PMP	16	37	53	30.19%
	SUD	0	1	1	0.00%
	Total	**19**	**47**	**66**	**28.79%**
	New Patient Availability				
	BH Provider	1	0	1	100%
	GYN	11	0	11	100%
	PMP	53	0	53	100%
	SUD	0	1	1	0.00%

Table 38. Provider Directory Inaccuracies					
MCE	**Provider Type**	**Correct**	**Incorrect**	**Total Providers Sampled**	**Compliance Rate**
	Total	**65**	**1**	**66**	**98.48%**
	Provider Type				
	BH Provider	1	0	1	100%
	GYN	11	0	11	100%
	PMP	52	1	53	98.11%
	SUD	0	1	1	0.00%
	Total	**64**	**2**	**66**	**96.97%**
UHC	**Address**				
	BH Provider	8	2	10	80.00%
	GD	8	3	11	72.73%
	GYN	5	0	5	100%
	PMP	20	3	23	86.96%
	Total	**41**	**8**	**49**	**83.67%**
	Telephone Number				
	BH Provider	10	0	10	100%
	GD	11	0	11	100%
	GYN	5	0	5	100%
	PMP	23	0	23	100%
	Total	**49**	**0**	**49**	**100%**
	Hours of Operation				
	BH Provider	1	9	10	10.00%
	GD	1	10	11	9.09%
	GYN	1	4	5	20.00%

Table 38. Provider Directory Inaccuracies					
MCE	Provider Type	Correct	Incorrect	Total Providers Sampled	Compliance Rate
	PMP	4	19	23	17.39%
	Total	**7**	**42**	**49**	**14.29%**
	New Patient Availability				
	BH Provider	10	0	10	100%
	GD	11	0	11	100%
	GYN	5	0	5	100%
	PMP	23	0	23	100%
	Total	**49**	**0**	**49**	**100%**
	Provider Type				
	BH Provider	10	0	10	100%
	GD	11	0	11	100%
	GYN	5	0	5	100%
	PMP	22	1	23	95.65%
	Total	**48**	**1**	**49**	**97.96%**

Anthem

The following observations were noted during the verification process:

- **Provider Address:** GD and SUD providers sampled had 100% accuracy for their address; however, PMPs were accurate only just over half of the time (54.55%) and GYNs were only accurate 33.33% of the time.
- **Telephone Number:** All provider types were 100% accurate for telephone number in the provider directories.
- **Hours of Operation:** GD providers were the most accurate of the provider types sampled at 50.00%. GYN and SUD were accurate 0.00% of the time, and PMPs were accurate only 27.27% of the time.
- **Accepting/Not Accepting New Patients:** Of the providers sampled, GDs, GYNs, and SUD providers were 100% accurate in the provider directories. PMPs were accurate 90.91% of the time.

- **Provider Type/Specialty:** In the provider directory, sampled GDs, GYNs, and SUD providers were accurate 100% of the time. PMPs were accurate 90.91% of the time.

Humana

The following observations were noted during the verification process:

- **Provider Address:** BH providers sampled had 100% accuracy for their address, and GYN and PMPs were accurate most of the time at 81.82% and 90.57%, respectively. However, SUD providers were 0.00% accurate.
- **Telephone Number:** Sampled BH providers and GYNs were accurate 100% of the time with PMPs accurate 96.23% of the time. SUD providers were 0.00% accurate.
- **Hours of Operation:** PMPs were the most accurate of the provider types sampled at 30.19%. BH providers and SUD were accurate 0.00% of the time, and GYNs were accurate only 27.27% of the time.
- **Accepting/Not Accepting New Patients:** Of the providers sampled, BH providers, GYNs, and PMPs were 100% accurate in the provider directories. Conversely, SUD providers were accurate 0.00% of the time.
- **Provider Type/Specialty:** In the provider directory, sampled BH providers and GYNs were accurate 100% of the time. PMPs were accurate 98.11% of the time, while SUD providers were 0.00% accurate.

UHC

The following observations were noted during the verification process:

- **Provider Address:** Sampled GYNs had 100% accuracy for their address. PMPs, BH providers, and GDs were accurate most of the time at 86.96%, 80.00%, and 72.73%, respectively.
- **Telephone Number:** All sampled providers were 100% accurate.
- **Hours of Operation:** GYNs were the most accurate of the provider types sampled at 20.00%. PMPs, BH providers and GDs sampled were 17.39%, 10.00%, and 9.09% accurate, respectively.
- **Accepting/Not Accepting New Patients:** All providers sampled were 100% accurate.
- **Provider Type/Specialty:** Sampled BH providers, GDs, and GYNs were 100% accurate, with sampled PMPs accurate 95.65% of the time.

ANA Validation

The overall purpose of this *Protocol 4: Validation of Network Adequacy Report* is to validate the MCE's provider network adequacy against standards determined by OMPP. To get a comprehensive view of each MCE's network adequacy, Qsource analyzed and mapped geographic network access and conducted surveys targeting providers to determine their appointment access.

Qsource developed the network adequacy rating to present comparative findings from the analysis. **Table 39** presents the network adequacy rating criteria for the MCEs.

Table 39. Network Adequacy Rating Criteria	
Rating	**Criteria**
High Adequacy	Of all standards assessed, 75% to 100% were met
Moderate Adequacy	Of all standards assessed, 50% to <75% were met
Low Adequacy	Of all standards assessed, 25% to <50% were met
No Adequacy	Below 25% of all standards were met

Table 40 presents the network adequacy ratings for the MCEs.

Table 40. Network Adequacy Rating				
Standards	**# Of Standards Met**	**# Of Applicable Standards**	**Rate**	**Network Adequacy Rating**
Anthem				
Distance Standards	32	63	50.79%	Moderate Adequacy
Statewide Provider-to-Member Ratios	20	40	50.00%	Moderate Adequacy
Access to Care Standards Met-Secret Shopper Survey	13	24	54.17%	Moderate Adequacy
Overall Total	**65**	**127**	**51.18%**	**Moderate Adequacy**
Humana				
Distance Standards	34	63	53.97%	Moderate Adequacy
Statewide Provider-to-Member Ratios	21	41	51.22%	Moderate Adequacy
Access to Care Standards Met-Secret Shopper Survey	8	24	33.33%	Low Adequacy
Overall Total	**63**	**128**	**49.22%**	**Low Adequacy**
UHC				
Distance Standards	31	63	49.21%	Low Adequacy

Table 40. Network Adequacy Rating				
Standards	**# Of Standards Met**	**# Of Applicable Standards**	**Rate**	**Network Adequacy Rating**
Statewide Provider-to-Member Ratios	21	41	51.22%	Moderate Adequacy
Access to Care Standards Met-Secret Shopper Survey	12	24	50.00%	Moderate Adequacy
Overall Total	**64**	**128**	**50.00%**	**Moderate Adequacy**

Strengths and Weaknesses

The ANA review assists OMPP, Qsource, and the MCEs 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.

Table 41 displays the strengths from each MCE, and Table 42 displays the weaknesses.

Table 41. ANA Strengths	
MCE	**Strength**
Anthem	None identified
Humana	None identified
UHC	None identified.

Table 42. ANA Weaknesses	
MCE	**Weaknesses**
Anthem	Anthem did not report data on 26 provider types, the majority of which were LTSS and HCBS.
	Anthem did not meet 31 of the 63 applicable distance standards.
	Anthem did not meet 20 of the 40 statewide provider-to-member ratios.
	Anthem's providers only met 43.75% of the appointment wait time standards.

Table 42. ANA Weaknesses	
MCE	**Weaknesses**
	Anthem did not have accurate Provider Directory information for Hours of Operation or Provider Address.
Humana	Humana did not report data on 21 provider types, the majority of which were LTSS and HCBS.
	Humana did not meet 29 of the 63 applicable distance standards.
	Humana did not meet 20 of the 40 statewide provider-to-member ratios.
	Humana providers only met 57.14% of the appointment wait time standards.
	Humana did not have accurate Provider Directory information for Hours of Operation or Provider Address.
UHC	UHC did not report data on 24 provider types, the majority of which were LTSS and HCBS.
	UHC did not meet 32 of the 63 applicable distance standards.
	UHC did not meet 20 of the 40 statewide provider-to-member ratios.
	UHC providers only met 62.50% of the appointment wait time standards.
	UHC did not have accurate Provider Directory information for Hours of Operation.

Performance Improvements

As this is the first year the PathWays program has been in operation, there is no data to compare.

Conclusions and Recommendations

Anthem

Through the validation and calculation review of geographic network access, Qsource found that Anthem's network access was inadequate for the majority of provider types. For the surveys conducted by Qsource, the most common reason for not being able to complete a call was due to the provider not being at the dialed location. This occurred 148 times. However, more concerning, there were 27 times where providers or their appointment schedulers reported that they were not accepting Medicaid or were not accepting new Medicaid patient appointments. When a provider was able to provide appointment information, results indicated that, on average, a new Medicaid patient could get an appointment in 29.50 days for a general dentistry provider, 49.00 days for a GYN, 83.60 days for a PMP, and 10.00 days for a SUD provider. Overall, Anthem's network access for distance and availability of care was inadequate and

issues surrounding the accuracy of Provider Directory information were present.

For these reasons, Qsource offers the following recommendations:

- Anthem should ensure that all data is reported for all provider types, including those within HCBS and LTSS service types.
- Anthem should work to improve its applicable distance standards.
- Anthem should work to improve its provider-to-member ratios.
- Anthem should work to improve its compliance with appointment wait time standards.
- Anthem should work to improve the accuracy of its Provider Directories.

Humana

Through the validation and calculation review of geographic network access, Qsource found that Humana's network access was inadequate for the majority of provider types. For the surveys conducted by Qsource, the most common reason for not being able to complete a call was due to the provider not being at the dialed location. This occurred 75 times. However, more concerning, there were 54 times where providers or their appointment schedulers reported that they were not accepting Medicaid or were not accepting new Medicaid patient appointments. When a provider was able to provide appointment information, results indicated that, on average, a new Medicaid patient could get an appointment in 132 days for a BH provider, 56.30 days for a GYN, and 37.69 days for a PMP. There was no valid data for appointment availability for SUD providers. Overall, Humana's network access for distance and availability of care was inadequate and issues surrounding the accuracy of Provider Directory information were present.

For these reasons, Qsource offers the following recommendations:

- Humana should ensure that all data is reported for all provider types, including those within HCBS and LTSS service types.
- Humana should work to improve its applicable distance standards.
- Humana should work to improve its provider-to-member ratios.
- Humana should work to improve its compliance with appointment wait time standards.
- Humana should work to improve the accuracy of its Provider Directories.

UHC

Through the validation and calculation review of geographic network access, Qsource found that UHC's network access was inadequate for the majority of provider types. For the surveys conducted by Qsource, the most common reason for not being able to complete a call was due to the provider not being at the dialed location. This occurred 75 times. However, more concerning, there were 46 times where providers or their

appointment schedulers reported that they were not accepting Medicaid or were not accepting new Medicaid patient appointments to the secret shoppers. When a provider was able to provide appointment information, results indicated that, on average, a new Medicaid patient could get an appointment in 11.40 days for a BH provider, 29.82 days for a GD, 60.20 days for a GYN, and 38.41 days for a PMP. Overall, UHC's network access for distance and availability of care was inadequate and issues surrounding the accuracy of Provider Directory information were present.

For these reasons, Qsource offers the following recommendations:

- UHC should ensure that all data is reported for all provider types, including those within HCBS and LTSS service types.
- UHC should work to improve its applicable distance standards.
- UHC should work to improve its provider-to-member ratios.
- UHC should work to improve its compliance with appointment wait time standards.
- UHC should work to improve the accuracy of its Provider Directories.

Protocol 5: Encounter Data Validation

Overview

Title 42 of the CFR, part 438, subpart E (42 CFR § 438, subpart E) sets forth the guidelines that must be followed for performing the four required and six optional EQR activities. Qsource conducted one of the five optional EQR-related activities, *Protocol 5: Encounter Data Validation (EDV)* for encounter data files submitted by the MCEs to OMPP for the PathWays program.

CMS EQR Protocol defines encounter data as "the information related to the receipt of any item or service by an enrollee in a managed care plan (MCP). Encounter data reflect that a provider rendered a specific service under a managed care delivery system, regardless of if or how the MCP ultimately reimbursed the provider." Encounter data are typically the detailed service data for providers whose services are covered under a capitation financial arrangement (i.e., per member per month payments) and, therefore, are not billed as individual claims. Validation determines the accuracy and completeness of encounter data to inform policy and operational decision-making, assess quality, monitor program integrity, determine capitation payment rates, conduct risk adjustments, and incorporate alternative payment methods.

EQR Protocol 5 includes five activities:

- Activity 1: Review of State Requirements involved submission of encounter data in standard format through the FSSA Enterprise Data Warehouse (EDW) to house encounters submitted quarterly by MCE.
- Activity 2: Review of MCE's Capacity was completed by review of information provided in the MCE's Information Systems Capabilities Assessment Tool (ISCAT).
- Activity 3: Analyze Electronic Encounter Data including analyses of various aspects, such as volume, consistency, accuracy, and completeness of encounter data.
- Activity 4: Review of Medical Records was completed with a randomized statistically significant sample of statewide encounter data.
- Activity 5: Submit Findings was completed with the submission of the 2025 Encounter Data Validation Reports to the State.

Encounter data were analyzed at the institutional and professional levels. Institutional data included any records submitted by a healthcare institution via a CMS-1450 form (UB-04 [Uniform Bill]), a standard billing claim form for institutional medical claims. Professional data include any records submitted by a provider via a CMS-1500 form (Health Insurance Claim Form), a standard claim form for non-institutional medical

provider claims. This report includes the MCEs' encounter data for service dates from October 1, 2024, through December 31, 2024, and an analysis of the volume, consistency, completeness, and validity of the data of distinct institutional and professional encounters submitted by the MCE to OMPP.

Activity 1: Review of State Requirements

According to OMPP's contract with each MCE, the MCE is required to submit encounter claims to OMPP for every service rendered to a member for which the MCEs either paid or denied reimbursement per 42 CFR 438.604(a)(1), 42 CFR 438.606, and 42 CFR 438.818.(a)(2)-(3). Encounter data provides reports of individual patient encounters with the MCE's health care network. These claims contain fee-for-service (FFS) equivalent details as to procedures, diagnoses, place of service, units of service, billed amounts and rendering providers' identification numbers, and other detailed claims data required for quality improvement monitoring and utilization analysis. The MCEs are required to ensure that submitted encounter claims reflect the final adjudication of payment made from the MCE to the provider.

After the initial payment, if changes in provider payment or third-party contributions change the amount paid by the MCE, it must submit an adjustment to the encounter claim displaying the final payment made to the provider, along with any updated data fields relevant to the final provider payment. This includes payments that were changed based on post-payment audit, even if the provider did not resubmit the claim with the updated data fields. OMPP uses encounter data to make tactical and strategic decisions related to the PathWays program and to the Contract. OMPP defines "paid amount" as the amount paid to the Provider excluding Third Party Liability, Provider withhold and Provider incentives, and Medical Assistance cost-sharing. OMPP defines "allowed amount" as the Provider contracted rate prior to any exclusions or add-ons.

Data Standards

Encounter Submission Requirements

According to the Contract, the MCE is required to submit all encounter claims in an electronic format that adheres to the data specifications in the Companion Guides and any other state or federally mandated electronic claims submission standards. As applicable, all required data fields must be included on all encounter claims, including Resource Utilization Group score for nursing facility claims, Diagnosis Related Group and Severity of Illness for inpatient claims, revenue codes for outpatient claims, procedure codes, diagnosis codes, National Drug Codes (NDCs), units of service, place of service, dates of service, paid dates, billing and rendering provider identifications (IDs), billed, allowed, and paid amounts, patient liability (for nursing home claims), copayments/coinsurance/deductible amounts (for both Medicare and commercial coordination of

benefits), the claim filing indicator code, and all other fields that may be relevant to payment or patient acuity. The MCEs' encounter claims must include the NDCs when an encounter involves products or services with NDCs, including medical and institutional claims where medications with NDCs are included and billed separately. An indication of claim payment status and an identification of claim transaction type (i.e., original, void/cancel or replacement) is also required, in the form designated by FSSA.

If the MCE uses a Subcontractor to administer a benefit, for example a dental administrator or Pharmacy Benefit Manager, the "paid amount" is defined as the amount paid to the Provider excluding Third Party Liability, Provider withhold, Provider incentives, and Medical Assistance cost-sharing by the Subcontractor. The MCE is required to submit Home and Community-Based Services encounter data pursuant to the X12 837P national standard. This includes type of service, units of service, and dates of service, sufficient to provide CMS with the required audit trail. The MCE must submit individual-enrollee specific, claim-level data on all post-payment recoveries for all claims on a quarterly basis, in a format determined by the State. This is in addition to the corrected encounter submitted. The MCE is required to submit via secure file transfer protocol a complete batch of encounter data for all adjudicated claims for paid and denied claims and any claims not previously submitted weekly at a date and time as specified by the State.

State Standards

Timeliness

The MCE must submit 98.00% of adjudicated claims within 21 calendar days of adjudication. The MCE must submit all encounter claims within 15 months of the earliest date of service on the claim. The MCE must submit claim adjustments, both voided and replacement claims, within two years from the date of service.

Compliance with Pre-cycle Edits

The State or its designee assesses each encounter claim for compliance with pre-cycle edits. The MCE must correct and resubmit any encounter claims that do not pass the pre-cycle edits.

Accuracy

The MCE shall demonstrate that it implements policies and procedures to ensure that encounter claims submissions are accurate; that is, that all encounter claims detail being submitted accurately represent the services provided and that the claims are accurately adjudicated according to the MCE's internal standards and all state and federal requirements.

Completeness

The MCE is required to have in place a system for monitoring and reporting the completeness of claims and encounter data received from providers, i.e., for every service provided, providers shall submit a corresponding claim or encounter data with claim detail identical to that required for FFS claims submissions, including NDCs as applicable. The MCE must also have in place a system for verifying and ensuring that providers

are not submitting claims or encounter data for services that were not provided.

Capitated Provider Requirements

Encounter data, including encounter data from any network provider the MCE is compensating on the basis of capitation payments and adjudicated claims and encounter data from any subcontractors, must be processed no later than one business day after receiving the data from providers. The MCE must verify the accuracy and timeliness of data reported by providers, including data from network providers the MCE is compensating on the basis of capitation payments. In addition, FSSA requires the federally qualified health center or rural health clinic and the Contractor to maintain and submit records documenting the number and types of valid encounters provided to members each month. Capitated federally qualified health clinics and rural health clinics shall also submit encounter data (e.g., in the form of shadow claims to the MCE) each month.

Other Relevant Information

In the future, Qsource along with OMPP and the MCE may determine further information is relevant to encounter data validation. No other documentation was utilized in the EDV.

Activity 2: Review of Data Production Capacity

ISCAT Review

Qsource performed a systems review with the MCEs. Prior to the virtual review, the ISCAT was reviewed by Qsource for general information about the MCEs, the MCEs' integrity of all systems capabilities including administrative data (medical claims), enrollment data systems, provider data, data completeness, integration of data for performance measure calculation and ancillary data and integration processes. The MCEs all prepared acceptable ISCATs which facilitated the Virtual Systems Review process. The review of the MCEs' ISCATs, the systems demonstrations, along with interviews with personnel helped Qsource to identify weaknesses in the MCEs' information systems, if any. This step in the Protocol helped determine where and how information systems may be vulnerable to incomplete or inaccurate data capture or processing, integration, storage, or reporting.

Activity 3: Data Analysis

Qsource developed claims data layouts for required submissions. Qsource analyzed file submissions received from OMPP and the MCEs to determine the number of records. Qsource compared the volume of records in the MCE's transaction system to the volume of adjudicated encounter records submitted to OMPP by the MCE to establish a level of overall data completeness. Each MCE provided claims data to Qsource in flat file format for the time period of October 2024 through December 2024.

Qsource developed tools or used established tools meeting EQR protocol requirements for assessing MCE compliance with standards for claim and encounter data submission layouts and formats to determine the degree of volume, consistency, accuracy, and completeness of data. Qsource used SQL to incorporate the files into a usable format and performed an analytic comparison of volume extracted from the MCEs' transaction systems to the encounter data volume provided by OMPP. This process allowed for a comparative analysis between the MCEs' claims and OMPP encounter volumes, for the same time period, to assess data completeness. Data consistency, distribution by type of service, payment time frames, and completeness and validity for critical fields were examined using the adjudicated encounter files provided to Qsource from OMPP.

Activity 3 findings will inform development of long-term monitoring strategies for assessing data quality and identifying problem areas in subsequent reporting years.

Step 1: Data Quality Test Plan

Qsource used SQL software to analyze encounter data and statistically determine frequencies and rates for specific fields or variables created explicitly for data validation. Analyzing MCE-submitted data, Qsource conducted basic integrity checks to determine if the data were present, if the data met expectations, and if they were of sufficient quality to proceed with more complex analyses. The data quality test plan addresses the following elements:

1. The general magnitude of missing encounter data
2. The types of encounters that may be missing information from these providers
3. The overall data quality issues
4. The MCE's data submission issues

Having no data present in one or more of these fields counted as an incomplete record. Within completed fields, Qsource examined data for accuracy as determined by specified accuracy checks described below. Accuracy checks reveal overall data quality.

Step 2: Verification of Data Integrity

In Step 2 of Activity 3, the EQRO was tasked to analyze and interpret data in specified fields as well as check the data for volume and consistency. Qsource applied accuracy checks to encounter data, verifying critical data fields contained all values in the correct format and specificity and within required ranges. The validation techniques employed for analyses addressed the following field-specific questions:

1. **Was there information in the field, and was that information of the type requested?** Qsource checked each data field to determine if the information was the correct type and size in relation to the data dictionary (e.g., Current Procedural Terminology, 4th Edition (CPT-4) procedure codes should have five digits; member IDs should have the correct number of letters and digits). Qsource applied data integrity checks on key institutional and professional claims fields.
2. **Compared to an external standard, were the values in the field valid and in the correct format?** Values in the

diagnosis field, for example, should use current and valid diagnosis codes. Qsource applied data validity checks on key institutional and professional claims fields.

3. **Were the data available?** All required data elements should be reported, and the data should exist for all service types with no gaps.
4. **Did the data meet basic consistency expectations?** Qsource checked for consistency in enrollment and the number of encounters over time.
5. **Were OMPP's Member IDs accurately incorporated into the MCE's information system?** Qsource determined whether there were encounter data for the expected proportion of members compared to utilization norms for similar populations.
6. **Was the information for each critical field within required ranges, and was the volume of data consistent with the MCE's enrollment?** Qsource checked for the ability to analyze data to provide information such as the percentage of members with at least one encounter during the measurement year.

Step 3: Generate and Review Analytic Reports

As part of the reasonability test, each field was evaluated for correct type, correct size, if the field was populated, and the number of valid data points to calculate as a percentage of those with data present to determine completeness. In this stage of analysis, Qsource identified certain fields that had potential data quality issues. To break down this data further, Qsource looked at completeness by the subsets of data including institutional and professional. as well as a particular focus on Nursing Facility encounters as requested by OMPP.

Step 4: Compare Findings to State-Identified Benchmarks

Qsource utilized State-identified benchmarks to evaluate completeness and accuracy including those listed in the MCE contracts and the Quality Strategy Plan.

Validation Results

The first difficulty that Qsource discovered in the MCE-submitted data was found in terms of capitated versus FFS providers. Anthem and UHC both display discrepancies in their explanation of what kind of providers they contract with as compared to OMPP's reporting. Table 43 displays these differences.

Table 43. MCE and OMPP Explanation of MCE's Contracted Capitated Versus FFS Providers

Anthem	Humana	UHC
While Anthem reported in its ISCAT that it had one capitated provider, the submitted claims indicated it had more than one. The field "Capitated Provider" in the data layout provided by Qsource required that when a claim came from a capitated provider with a pre-arranged fixed per-member payment for a	No discrepancies found.	UHC reported on its ISCAT that it had no capitated payment providers and that its claim payments were 100% FFS. Likewise, for the field "Capitated Provider" in the data layout provided by Qsource, UHC left the field blank for all claims data. This Yes/No field is used to indicate whether a claim came from a

Table 43. MCE and OMPP Explanation of MCE's Contracted Capitated Versus FFS Providers		
Anthem	**Humana**	**UHC**
defined set of covered services, and the payment was not based on actual services delivered, the field should be completed with "Y = Yes, the provider is capitated" or "N = No, the provider is NOT capitated." Anthem's claims data submission included 66 providers for which there was at least one claim where this field indicated a capitated payment arrangement.		capitated provider that had a pre-arranged, fixed per-member payment for a defined set of covered services or that of the payment being based on actual services delivered. Therefore, the field should be completed with "Y = Yes, the provider is capitated" or "N = No, the provider is NOT capitated." However, according to OMPP, UHC does have capitated providers. OMPP reported eight providers that it considered to be in a capitated payment arrangement (e.g., Vision and Dental benefit providers). It appears that there may be some confusion between UHC and OMPP as to what constitutes a capitated provider, a vendor, and a third-party subcontractor. Within UHC's ISCAT, it reported receiving no third-party claims or encounter data; rather it lists those benefit providers as separate lines of business. UHC and OMPP should work together to determine how its contracted benefit providers should be classified and reported. Without any claims data designated as capitated, no capitated provider encounters were available, and, therefore, there were no applicable encounters to sample for the Medical Record Review based on the agreed upon activity methodology.

Due to a lack of claim identifiers in plan-submitted encounter files that could be reliably linked to OMPP's encounter data, a one-to-one claim-level match was not possible, and the differences in claim logic will be discussed later in the report. Therefore, the validation relied on a frequency-based comparison of enrollee volumes reported by the plan versus those captured in OMPP's system for the same quarter. **Table 44** displays the enrollee numbers submitted by the MCEs and OMPP by month.

Table 44. Enrollee Volume Comparison Between MCEs and OMPP By Month					
MCE	Date of Service	MCE Enrollee Volume	OMPP Enrollee Volume	Difference	% Difference
Anthem	October 2024	33,255	31,898	-1,357	-4.08%
	November 2024	32,263	30,873	-1,390	-4.31%
	December 2024	32,000	30,551	-1,449	-4.53%
Humana	October 2024	25,866	26,410	-544	-2.06%
	November 2024	24,925	25,527	-602	-2.36%
	December 2024	24,663	25,354	-691	-2.73%
UHC	October 2024	30,080	28,624	-1,456	5.09%
	November 2024	29,404	27,423	-1,981	7.22%
	December 2024	29,274	27,185	-2,089	7.68%

Overall, Anthem's enrollee counts were moderately aligned with OMPP's records. Monthly comparisons showed tight alignment, with differences ranging from -4.08% to -4.53% across the months within the quarter. These results suggest that Anthem's submitted data reasonably reflects the enrollee population captured in OMPP's encounter system.

Humana's enrollee counts were closely aligned with OMPP's records. Monthly comparisons showed differences ranging from -2.06% to -2.73% across the months within the quarter. These results suggest that the plan's submitted data reasonably reflects the enrollee population captured in OMPP's encounter system with some room for improvement in alignment.

Enrollee counts between UHC and OMPP were moderately aligned. On a monthly basis, the plan consistently reported slightly higher enrollee counts than OMPP for each month of the quarter. Differences ranged from 5.09% in October to 7.68% in December. While the plan's monthly volumes were modestly higher across all months, the variances remained within a relatively narrow range, suggesting overall alignment between the two data sources.

Table 45 restricts the enrollee count analysis to those whose place of service corresponds to a skilled nursing facility (SNF) or nursing facility (NF). The enrollee volumes in this place of service show substantial differences between MCE and OMPP reports in two of the three MCEs. This is especially significant, based upon the emphasis that the PathWays program places on these services.

Table 45. Enrollee Volume Comparison Between MCEs and OMPP By Month: SNF/NF					
MCE	Date of Service	MCE Enrollee Volume	OMPP Enrollee Volume	Difference	% Diff
Anthem	October 2024	2,800	5,906	-3,106	-52.59%
	November 2024	2,631	5,875	-3,244	-55.22%
	December 2024	2,765	5,844	-3,079	-52.69%
Humana	October 2024	3,452	3,366	-86	-2.49%
	November 2024	3,155	3,054	-101	-3.20%
	December 2024	3,304	3,195	-109	-3.30%
UHC	October 2024	8,919	3,642	-5,277	-59.17%
	November 2024	8,600	3,603	-4,997	-58.10%
	December 2024	8,628	3,683	-4,945	-57.31%

Across all three months in the quarter, Anthem reported roughly half the number of unique enrollees captured in OMPP's data with a difference of between -3,079 and -3,244 enrollees. The monthly differences ranged from -52.59% to -55.22%, indicating consistent under-representation of enrollees in this setting within the plan's submissions. These results suggest that encounters associated with SNF/NF services may not be fully captured or reported in the plan's data extract; further review of how these service locations are identified and submitted may be warranted.

Humana's reported enrollee volumes were closely aligned with OMPP's data across all three months of the quarter. Differences ranged from -2.49% to -3.30%, with the plan reporting slightly fewer unique enrollees each month. These small and consistent variances indicate that the plan's enrollee representation for SNF/NF services is generally in line with OMPP's records.

The enrollee counts reported by UHC were higher than those captured in OMPP's data. Across all three months, UHC reported approximately 3,603–3,683 enrollees, while OMPP reported 8,600–8,919, resulting in differences ranging from -57.31% to -59.17%. These consistently large gaps indicate that SNF/NF enrollees are significantly underrepresented in the plan's submissions and suggest that encounters in this service setting may not be fully captured or accurately reported.

Volume and Consistency of Encounter Data Submission

As required in Step 2 of Activity 3 of the protocols, Qsource's EDV included an analysis of the volume and consistency of encounter data, as shown in **Table 46**. **Table 47** shows the breakdown of these encounters by month.

Table 46. Total Distinct Encounters by Encounter Type: All Encounters

Anthem	**OMPP (N*=749,501)**	
	Institutional	**Professional**
	199,588 (26.63%)	549,913 (73.37%)
	Anthem (N=780,405)	
	Institutional	**Professional**
	191,826 (24.58%)	588,579 (75.42%)
Humana	**OMPP (N=635,730)**	
	Institutional	**Professional**
	199,514 (31.38%)	436,216 (68.62%)
	Humana (N=708,892)	
	Institutional	**Professional**
	130,670 (18.43%)	578,222 (81.57%)
UHC	**OMPP (N=793,332)**	
	Institutional	**Professional**
	311,411 (39.25%)	481,921 (60.75%)
	UHC (N=800,201)	
	Institutional	**Professional**
	166,192 (20.77%)	634,009 (79.23%)

**N=Number of encounters.*

Table 47. Total Encounters By Month					
MCE	Date of Service	MCE Claim Count	OMPP Claim Count	Difference	% Difference
Anthem	October 2024	277,102	286,848	9,746	3.52%
	November 2024	249,031	241,211	-7,820	-3.14%
	December 2024	256,055	227,807	-28,248	-11.03%
Humana	October 2024	254,638	227,441	-27,197	-10.68%
	November 2024	229,054	200,582	-28,472	-12.43%
	December 2024	225,221	207,707	-17,514	-7.78%
UHC	October 2024	280,327	298,526	18,199	6.49%
	November 2024	256,587	248,700	-7,887	-3.07%
	December 2024	266,418	250,349	-16,069	-6.03%

Anthem reported a total of 780,405 distinct encounters, with 24.58% classified as Institutional and 75.42% as Professional. In comparison, OMPP's system captured 749,501 distinct encounters for the same period, with 26.63% Institutional and 73.37% Professional. While the total encounter volumes differed slightly between the two sources, the proportional distribution across encounter types was generally consistent. Anthem's Institutional encounters were 2.05 percentage points lower than OMPP's, while Professional encounters were 2.05 percentage points higher. These results indicate that Anthem's encounter submissions closely mirror the encounter-type profile reflected in OMPP's data with no substantial shifts in the underlying distribution.

The monthly comparison of encounter volumes shows that Anthem's data remained relatively close to OMPP's counts in the first two months of the quarter, with differences of 3.52% in October and -3.14% in November. The largest variation occurred in December, where Anthem reported -11.03% more encounters than OMPP. Although some fluctuation is expected, the December difference is noticeably larger than the prior months and may reflect timing or submission-related delays in the plan's encounter processing.

Conversely, Humana's distribution of distinct encounters by encounter type shows notable differences when compared to OMPP's data. The plan reported 708,892 total encounters, with 18.43% classified as institutional and 81.57% as professional. In contrast, OMPP identified 635,730 encounters for the same

period, with a significantly higher share of institutional encounters (31.38%) and a lower share of professional encounters (68.62%). This indicates that institutional encounters are underrepresented in the plan's submission relative to OMPP's data, while professional encounters are proportionally higher. The shift of approximately 13 percentage points suggests potential differences in encounter classification, mapping, or completeness of institutional encounter reporting for Humana.

Across all three months of the quarter, Humana consistently reported higher encounter volumes than OMPP. Differences ranged from -7.78% to -12.43%, with the largest gap occurring in November 2024 where the plan exceeded OMPP's count by 28,472 encounters. Although month-to-month variation is expected, the plan's encounter counts remained 7–12% higher than OMPP's throughout the quarter, indicating a persistent overrepresentation in the submitted data relative to OMPP's records.

UHC's distribution of distinct encounters by encounter type shows notable differences when compared to OMPP's data. UHC reported 800,201 distinct encounters, with 20.77% classified as institutional and 79.23% as professional. In contrast, OMPP's data for the same period showed 793,332 encounters, with a substantially higher proportion of institutional encounters (39.25%) and a lower proportion of professional encounters (60.75%).

The significant difference in the institutional category represents a significant difference of nearly 18.48 percentage points in the institutional category, indicating that institutional encounters are underreported or misclassified in the plan's submission relative to OMPP's records. While total encounter counts are similar overall, the distribution by encounter type is not aligned.

Across all three months of the quarter, UHC's volumes showed mixed alignment in comparison with OMPP's data across the quarter. In October 2024, the plan reported 6.49% fewer encounters than OMPP, reflecting a difference of 18,199 encounters. In the following two months, the plan's volumes exceeded OMPP's counts by 3.07% in November and 6.03% in December, with differences of 7,887 and 16,069 encounters, respectively. Overall, monthly variances ranged from approximately -6% to +6%, indicating moderate fluctuation but no consistent over- or under-representation across the quarter.

At OMPP's request and due to the PathWay's focus, Qsource also performed an analysis of the volume and consistency of encounter data for SNF/NF service types, as shown in **Table 48**. **Table 49** shows the breakdown of these encounters by month.

Table 48. Total Distinct Encounters by Encounter Type: SNF/NF		
Anthem	**OMPP (N*=66,672)**	
	Institutional	**Professional**
	49,766 (74.64%)	16,906 (25.36%)
	Anthem (N=24,042)	
	Institutional	**Professional**
	0 (0.00%)	24,042 (100%)
Humana	**OMPP (N=26,439)**	
	Institutional	**Professional**
	9,666 (36.56%)	16,773 (63.44%)
	Humana (N=27,328)	
	Institutional	**Professional**
	5 (0.02%)	27,323 (99.98%)
UHC	**OMPP (N=145,419)**	
	Institutional	**Professional**
	125,418 (86.25%)	20,001 (13.75%)
	UHC (N=31,526)	
	Institutional	**Professional**
	4 (0.01%)	31,522 (99.99%)

**N=Number of encounters.*

Table 49. Total Encounters By Month: SNF/NF					
MCE	**Date of Service**	**MCE Claim Count**	**OMPP Claim Count**	**Difference**	**% Difference**
Anthem	October 2024	8,576	22,865	14,289	166.62%
	November 2024	7,563	21,881	14,318	189.32%
	December 2024	7,888	21,926	14,038	177.97%

Table 49. Total Encounters By Month: SNF/NF

MCE	Date of Service	MCE Claim Count	OMPP Claim Count	Difference	% Difference
Humana	October 2024	10,197	10,067	-130	-1.27%
	November 2024	8,516	7,994	-522	-6.13%
	December 2024	8,610	8,378	-232	-2.69%
UHC	October 2024	10,824	53,857	43,033	397.57%
	November 2024	10,238	46,634	36,396	355.50%
	December 2024	10,438	44,928	34,490	330.43%

For encounters associated with SNF/NF services, Anthem reported 24,042 total encounters, all of which were classified as professional. No institutional encounters were reported in the plan's data. In contrast, OMPP identified 66,672 encounters for the same population, with 74.64% classified as institutional and 25.36% as professional. This indicates a substantial discrepancy in encounter type classification. The absence of institutional encounters in the plan's submission suggests that encounters expected to fall under the institutional category may not be captured, mapped, or submitted correctly for this service setting.

Anthem's monthly SNF/NF encounter volumes were substantially lower than OMPP's counts. Across all three months, Anthem submitted 7,563 to 8,576 encounters, compared to 21,881 to 22,865 in OMPP's data. Monthly differences ranged from 166.62% to 189.32%, indicating that OMPP consistently reported more than double the volume captured in the plan's submission. These results show a persistent and significant underrepresentation of encounters for this service setting within the plan's data extract.

Humana reported 27,323 distinct encounters regarding SNF/NF service locations, almost all of which were classified as professional (99.98%). Only five encounters (0.02%) were submitted as institutional. In contrast, OMPP's 26,439 reported encounters showed that 36.56% of encounters for this setting were institutional, with the remaining 63.44% classified as professional. This substantial discrepancy indicates that institutional nursing facility encounters are not being captured or classified correctly in the plan's submission, resulting in an encounter-type distribution that is not aligned with OMPP's records.

Humana's monthly SNF/NF encounter volumes were moderately aligned with OMPP's data across the quarter. Differences ranged from -1.27% to -6.13%, with the plan reporting slightly higher counts in each month. These small

variances indicate that the plan's encounter volume for this service setting is generally consistent with OMPP's records. This comparison also continues the trend of SNF/NF encounter volumes being more closely aligned between Humana's data and OMPP's records than that of the overall encounter data.

UHC's reporting of SNF/NF encounters displayed 31,526 total distinct encounters, with nearly all 31,522 (99.99%) encounters classified as professional and only 4 (0.01%) encounters reported as institutional. In contrast, OMPP's data showed 145,419 encounters for the same population, with 125,418 (86.25%) classified as institutional and only 20,001 (13.75%) as professional. This stark discrepancy indicates that institutional nursing facility encounters are almost entirely missing or misclassified in UHC's submission. The data suggests systemic issues in how the plan identifies, extracts, or categorizes institutional services for this setting.

UHC's reported encounter volumes by month were dramatically lower than those in OMPP's data. Across all three months, the plan submitted approximately 10,238–10,824 encounters per month, while OMPP reported 44,928–53,857 encounters for the same period. As a result, OMPP's monthly totals were approximately 330% to 398% higher than the plan's submissions. These consistently large discrepancies indicate that a substantial portion of SNF/NF encounters are not being captured or reported in the plan's data extract, aligning with earlier findings showing severe underreporting of institutional services for this setting.

Timeliness

To determine timeliness, Qsource utilized OMPP data to compare the date of adjudication by the MCE to the date "paid" by OMPP (accepted by the Medicaid Management Information System [MMIS]). The timeliness standards set by OMPP are as follows:

1. The MCE must submit 98.00% of adjudicated claims within 21 calendar days of adjudication.
2. The MCE must submit all encounter claims within 15 months of the earliest date of service on the claim.
3. The MCE must submit claim adjustments, both void and replacement claims, within two years from the date of service.

For this report, Qsource was only able to determine the first timeliness standard. This is due to the fact that the PathWays program began on July 1, 2024, and there was only six months of total data for this Protocol. Standards two and three may be included in the following year's analysis, based on guidance from OMPP. **Table 50** presents the timeliness of the MCEs' submission of adjudicated claims to OMPP, or the first timeliness standard. All three MCEs surpassed the timeliness standard.

Table 50. Timeliness of Adjudicated Claim Submissions				
MCE	Claims submitted within 21 Calendar Days	Total Claims Adjudicated	Rate	Target
Anthem	675,746	675,746	100%	98.00%
Humana	343,954	343,954	100%	98.00%
UHC	566,433	566,458	99.995%	98.00%

Table 51 displays the analysis of the number of days between the billed date and paid date as reported by the MCEs and OMPP. Table 52 displays the analysis of the number of days between service date and paid date as reported by the MCEs and OMPP.

Table 51. Average Number of Days and Range from Billed Date to Paid Date			
MCE	Encounter Type	MCE-Reported Data	OMPP-Reported Data
		Avg. Days from Billed Date to Paid Date	Avg. Days from Billed Date to Paid Date
Anthem	Professional	-7.42	10.00
	Institutional	-7.44	80.89
Humana	Professional	No Date Billed	13.41
	Institutional	No Date Billed	91.21
UHC	Professional	No Date Billed	7.43
	Institutional	No Date Billed	71.67

Table 52. Average Number of Days from Service Date to Paid Date			
MCE	Encounter Type	MCE-Reported Data	OMPP-Reported Data
		Avg. Days from Service Date to Paid Date	Avg. Days from Service Date to Paid Date
Anthem	Professional	38.89	51.57
	Institutional	47.03	120.24
Humana	Professional	28.36	79.61

Table 52. Average Number of Days from Service Date to Paid Date			
MCE	Encounter Type	MCE-Reported Data	OMPP-Reported Data
		Avg. Days from Service Date to Paid Date	Avg. Days from Service Date to Paid Date
UHC	Institutional	26.68	148.84
	Professional	42.77	65.98
	Institutional	49.11	144.73

The analysis of the number of days between the billed date and paid date showed that Anthem reported negative averages for both professional (-7.42 days) and institutional (-7.44 days) encounters, indicating that many encounters had a paid date occurring before the billed date. This pattern was confirmed during follow-up review and appears to result from how the plan populates or extracts these fields. In contrast, OMPP's data showed positive average timeframes of 10.00 days for professional encounters and 80.89 days for institutional encounter. The negative values in the plan's data suggest a date sequencing or mapping issue that warrants correction in future submissions.

In the analysis of the number of days between service date and paid date showed that, for professional encounters, Anthem reported an average of 38.89 days from billed date to paid date, which is less than OMPP's statewide average of 51.57 days. This suggests Anthem processes professional payments more quickly than what is reflected in OMPP's data. For institutional encounters, the difference is much more pronounced. Anthem's average of 47.03 days is significantly lower than OMPP's 120.24 days, indicating either considerably faster payment cycles or a potential gap in how institutional billing dates are captured or reported by the plan.

Humana, in the analysis of the number of days between the billed date and paid date, did not populate the billed date field for any encounter, resulting in no calculable average days from billed date to paid date for either professional or institutional services. In contrast, OMPP's data showed an average of 13.41 days for professional encounters and 91.21 days for institutional encounters. The absence of billed dates in the plan's submission indicates a systemic data extraction or mapping issue that prevents assessment of payment timeliness.

In its analysis of the number of days between service date and paid date, Humana showed averages were 28.36 days for professional encounters and 26.68 days for institutional encounters. These timelines are notably shorter than those observed in OMPP's data, which averaged 79.61 days for professional and 148.84 days for institutional encounters. The

substantially shorter payment windows in the plan's submission may reflect differences in how payment dates are captured or submitted, or this could indicate incomplete or truncated payment information relative to OMPP's records.

UHC's analysis of the number of days between the billed date and paid date displayed a lack of billed dates for either professional or institutional encounters, resulting in no measurable timeframe between the billed date and paid date. In contrast, OMPP's data showed average billed-to-paid intervals of 7.43 days for professional encounters and 71.67 days for institutional encounters. The absence of billed dates in the plan's submission indicates a data extract or mapping issue that prevents evaluation of payment timeliness.

The analysis of the number of days between service date and paid date showed that UHC's averages were 42.77 days for professional encounters and 49.11 days for institutional encounters. In comparison, OMPP reported longer timelines of 65.98 days for professional and 144.73 days for institutional encounters. These shorter intervals in the plan's data may reflect differences in how payment dates are captured, or submitted, or may indicate incomplete payment information relative to OMPP's records.

Table 53 and Table 54 display the same analysis as the previous two tables, the analysis of the number of days between the billed date and paid date as reported by the MCEs and OMPP and the analysis of the number of days between service date and paid date as reported by the MCEs and OMPP, but filtered for encounters in the SNF/NF service area.

Table 53. Average Number of Days and Range from Billed Date to Paid Date: SNF/NF

MCE	Encounter Type	MCE-Reported Data	OMPP-Reported Data
		Avg. Days from Billed Date to Paid Date	Avg. Days from Billed Date to Paid Date
Anthem	Professional	55.33	10.00
	Institutional	No Reported Institutional Encounters	80.89
Humana	Professional	No Bill Dates	8.26
	Institutional	No Bill Dates	53.89
UHC	Professional	No Bill Dates	6.96
	Institutional	No Bill Dates	76.37

Table 54. Average Number of Days from Service Date to Paid Date: SNF/NF			
MCE	Encounter Type	MCE-Reported Data	OMPP-Reported Data
		Avg. Days from Service Date to Paid Date	Avg. Days from Service Date to Paid Date
Anthem	Professional	55.33	65.22
	Institutional	No Reported Institutional Encounters	84.04
Humana	Professional	35.19	96.45
	Institutional	54.20	145.35
UHC	Professional	52.76	58.91
	Institutional	No Paid Dates	118.44

In the analysis of the number of days between the billed date and paid date, Anthem reported an average of 55.33 days between the billed and paid dates for professional encounters. No institutional encounters were submitted by the plan for this setting. In comparison, OMPP's data showed an average of 10.00 days for professional encounters and 80.89 days for institutional encounters. The large difference in professional payment timelines suggests variations in billing or payment processing when compared to OMPP's records.

In the analysis of the number of days between service date and paid date, Anthem's professional SNF/NF encounters show an average of 55.33 days from service date to paid date for professional claims, while OMPP shows a slightly longer timeline of 65.22 days. For institutional encounters, OMPP reports a substantially longer payment window than that of professional encounters (84.04 days), whereas Anthem did not submit any institutional encounters with valid payment information for comparison.

As with the general analysis of the number of days between the billed date and paid date, Humana did not populate billed dates for either professional or institutional services in SNF/NF encounters, resulting in no measurable timeframe from billed date to paid date. In contrast, OMPP's data showed an average of 8.26 days for professional encounters and 53.89 days for institutional encounters. The absence of billed dates in the plan's submission indicates a data extraction or mapping issue that prevents assessment of payment timeliness for this service setting.

Humana's SNF/NF encounters, in the analysis of the number of days between service date and paid date, averaged 35.19 days for professional services and 54.20 days for institutional services. These timeframes are considerably shorter than those

observed in OMPP's data, which averaged 96.45 days for professional encounters and 145.35 days for institutional encounters. The substantially shorter intervals in the plan's data may reflect differences in how payment dates are captured or submitted, or this may indicate incomplete payment information relative to OMPP's records.

Just as seen with Humana's SNF/NF encounters, UHC did not populate billed dates for either professional or institutional services in SNF/NF encounters in the analysis of the number of days between the billed date and paid date. This resulted in no measurable timeframe from billed date to paid date. In contrast, OMPP's data showed an average of 6.96 days for professional encounters and 76.37 days for institutional encounters. The absence of billed dates in the plan's file indicates a systemic reporting gap, as billed dates are a standard component of encounter submission and are necessary for evaluating timeliness and payment workflows.

In the analysis of the number of days between service date and paid date analysis, UHC's SNF/NF encounters averaged 52.76 days for professional services. No institutional paid timeframe could be calculated because institutional paid dates were not populated for the plan. OMPP's data showed longer intervals at 58.91 days for professional and 118.44 days for institutional encounters. This suggests that UHC's payment timing information is incomplete or not fully aligned with OMPP's records.

Distribution of Encounters

As has been the trend throughout this EDV, the distribution of general encounters by medical service type between the MCEs and OMPP were generally comparable. It must be noted that encounters listed as Other include any claim that does not fit into the other listed categories and, more importantly, it includes any encounter that is uncoded. As not all institutional claims require a procedure code, the Other claim type is elevated. However, when filtering the encounters based specifically in SNF/NF facilities, the differences in distribution of the encounters between the MCEs and OMPP widens. **Table 55** displays the distribution of general encounters by medical type and **Table 56** display the distribution of SNF/NF encounters.

Table 55. Distribution by Medical Service Type —All Encounters

Source	Total	Anesthesia	Evaluation and Management	Medicine	Pathology and Laboratory	Radiology	Surgery	Other
Anthem								
MCE	939,274	3,594 (0.38%)	218,287 (23.24%)	127,827 (13.61%)	70,345 (7.49%)	61,106 (6.51%)	80,763 (8.60%)	377,352 (40.17%)
OMPP	938,103	3,062 (0.33%)	178,131 (18.99%)	140,500 (14.98%)	59,733 (6.37%)	58,745 (6.26%)	73,434 (7.83%)	424,498 (45.25%)

Table 55. Distribution by Medical Service Type —All Encounters								
Source	**Total**	**Anesthesia**	**Evaluation and Management**	**Medicine**	**Pathology and Laboratory**	**Radiology**	**Surgery**	**Other**
Humana								
MCE	727,679	2,748 (0.38%)	179,199 (24.63%)	93,786 (12.89%)	40,550 (5.57%)	48,637 (6.68%)	53,952 (7.41%)	308,807 (42.44%)
OMPP	803,385	1,857 (0.23%)	150,816 (18.77%)	107,950 (13.44%)	40,527 (5.04%)	44,519 (5.54%)	67,645 (8.42%)	390,071 (48.55%)
UHC								
MCE	974,773	4,044 (0.41%)	225,532 (23.14%)	114,080 (11.70%)	61,740 (6.33%)	60,673 (6.22%)	78,004 (8.00%)	430,700 (44.18%)
OMPP	969,427	2,641 (0.27%)	159,534 (16.46%)	132,374 (13.65%)	43,756 (4.51%)	48,008 (4.95%)	71,016 (7.33%)	512,098 (52.82%)

Table 56. Distribution by Medical Service Type—SNF/NF Encounters								
Source	**Total**	**Anesthesia**	**Evaluation and Management**	**Medicine**	**Pathology and Laboratory**	**Radiology**	**Surgery**	**Other**
Anthem								
MCE	19,899	9 (0.05%)	812 (4.08%)	4,002 (20.11%)	2,595 (13.04%)	1,380 (6.94%)	1,432 (7.20%)	9,669 (48.59%)
OMPP	68,574	0 (0.00%)	15,377 (22.42%)	6,697 (9.77%)	382 (0.56%)	116 (0.17%)	836 (1.22%)	45,166 (65.86%)
Humana								
MCE	0	0 (0.00%)	10,445 (83.36%)	717 (5.72%)	0 (0.00%)	84 (0.67%)	535 (4.27%)	749 (5.98%)
OMPP	27,980	0 (0.00%)	15,276 (54.60%)	1,517 (5.42%)	86 (0.31%)	108 (0.39%)	801 (2.86%)	10,192 (36.43%)
UHC								
MCE	100,877	0 (0.00%)	68,061 (67.47%)	3,973 (3.94%)	3 (0.00%)	4,306 (4.27%)	8,067 (8.00%)	16,467 (16.32%)
OMPP	148,565	0 (0.00%)	18,328 (12.34%)	11,398 (7.67%)	115,744 (77.91%)	1,627 (1.10%)	23 (0.02%)	1,445 (0.97%)

Table 56. Distribution by Medical Service Type—SNF/NF Encounters

Source	Total	Anesthesia	Evaluation and Management	Medicine	Pathology and Laboratory	Radiology	Surgery	Other
OMPP	148,565	0 (0.00%)	18,328 (12.34%)	11,398 (7.67%)	115,744 (77.91%)	1,627 (1.10%)	23 (0.02%)	1,445 (0.97%)

In the general distribution table, most service categories showed similar proportions between Anthem and OMPP, including Anesthesia, Radiology, and Surgery. However, several categories displayed notable differences. The plan reported a higher share of Evaluation and Management encounters (23.24% versus 18.99%) and Pathology and Laboratory services (7.49% versus 6.37%). OMPP, in contrast, showed higher proportions in the Other service category (45.25% vs. 40.17%) and Medicine (14.98% versus 13.61%). In contrast, in the SNF/NF encounters, the distribution of medical service types differed notably between Anthem and OMPP. The plan reported a higher proportion of Medicine (20.11%), Pathology and Laboratory (13.04%), and Radiology (6.94%) services compared to OMPP's reported Medicine (9.77%), Pathology and Laboratory (0.56%), and Radiology (0.17%) services. In contrast, OMPP's data showed a substantially higher share of Evaluation and Management encounters (22.42% versus. 4.08%) and a much larger proportion in the Other category (65.86% versus 48.59%).

In the general distribution table, the distribution of encounters by medical service type showed overall similarity between Humana and OMPP, with both sources reporting the majority of encounters in the Other category. Humana reported a slightly lower share of "Other" services (42.44%) compared to OMPP (48.55%). However, notable differences were observed in some categories. Humana reported a higher proportion of Evaluation and Management encounters (24.63% versus 18.77%) and slightly higher percentages in Radiology and Pathology/ Laboratory. In contrast, OMPP showed higher proportions of Medicine and Surgery encounters. While overall patterns align, these shifts suggest some variation in how service types are coded or classified between the plan's submission and OMPP's data. In contrast, in the SNF/NF encounters, the distribution of medical service types differed notably between Humana and OMPP. The plan reported a high concentration of Evaluation and Management services, which accounted for 83.36% of all encounters, compared to 54.60% in OMPP's records. Most other categories made up a small proportion of the plan's volume, with Medicine, Radiology, and Surgery each representing less than 6%, and Pathology/Lab showing no reported encounters. OMPP's data showed a more varied distribution, with a substantial portion of encounters falling into the Other category (36.43%), which was much lower in Humana's data (5.98%). Humana also reported fewer encounters across Medicine, Surgery, and Pathology/Lab compared to OMPP. These

differences indicate potential inconsistencies in how service types are captured or classified in the plan's nursing facility encounter submissions.

In the general distribution table, UHC reported a higher proportion of Evaluation and Management (23.14%), Pathology/Laboratory (6.33%), and Radiology (6.22%) encounters compared to OMPP. The plan also showed slightly higher proportions for Anesthesia and Surgery. In contrast, OMPP reported a much larger share of encounters in the Other category (52.82%) compared to the plan (44.18%) and showed higher proportions in Medicine services. These shifts suggest potential differences in coding practices or service-type classification between the plan's submission and OMPP's encounter data. In contrast, in the SNF/NF encounters, the distribution of medical service types differed notably between UHC and OMPP. UHC reported a heavy concentration of Evaluation and Management services (67.47% of all encounters), with smaller proportions in Surgery (8.00%), Radiology (4.27%), and Medicine (3.94%). Pathology/ Laboratory services were almost entirely absent from the plan's data. In contrast, OMPP's data showed an overwhelmingly large share of Pathology/Laboratory encounters (77.91%), while Evaluation and Management services accounted for only 12.34%. Categories such as Medicine, Radiology, and Surgery represented less than 9.00% combined. These stark differences indicate that the plan is not capturing or classifying SNF/NF services in a manner consistent with OMPP, with notable underreporting in Pathology/Lab services and overconcentration in Evaluation and Management encounters.

Overall, the service-type patterns between the MCEs and OMPP show significant shifts, suggesting differences in coding practices or in how encounters are categorized, especially for the SNF/NF care setting. In an effort to fully understand the differences in the claims lines, Qsource performed an additional analysis on the claims logic. This analysis, as shown in **Table 57**, uncovered vital differences in the methods of classification of claims.

Table 57. Claim Coding Logic

MCE	Claim Type	Claim Codes
Anthem	**MCE**	
	Professional	Claim = P
	Institutional	Claim = I
	OMPP	
	Professional	Claim_Type IN ("B", "M")

Table 57. Claim Coding Logic		
MCE	**Claim Type**	**Claim Codes**
	Institutional	Claim_Type IN (“A”, “I”, “L”, “C”, “O”, “H”)
Humana	**MCE**	
	Professional	Claim = P
	Institutional	Claim = I
	OMPP	
	Professional	Claim_Type IN (“B”, “M”)
	Institutional	Claim_Type IN (“A”, “I”, “L”, “C”, “O”, “H”)
UHC	**MCE**	
	Professional	Claim_form Medical Inst.
	Institutional	Claim_form Medical Prof.
	OMPP	
	Professional	Claim_Type IN (“B”, “M”)
	Institutional	Claim_Type IN (“A”, “I”, “L”, “C”, “O”, “H”)

As is standard practice in claims coding, OMPP uses “B” and “M” to denote professional codes, and six different letters for different types of institutional codes. Anthem uses only “P” for Professional and “I” for Institutional, which removes some of the additional information that can be gathered from the standard coding logic, such as type of professional or institutional claim. This lack of further information could account for the variance in distribution of medical service type.

Likewise, Humana uses only “P” for Professional and “I” for Institutional, which removes some of the additional information that can be gathered from the standard coding logic, such as type of professional or institutional claim. This lack of further information could account for the variance in distribution of medical service type.

To continue this variance, UHC used numerical claim codes and did not supply a key for deciphering those codes. Instead, Qsource analysts turned to the claim_form column in the

encounter files which listed "Medical Inst." and "Medical Prof." which coincided with professional and institutional encounters. These differences in coding could account for the variance in distribution of medical service type.

After uncovering these differences in coding logic, Qsource performed a deeper analysis on the SNF/NF encounters in an effort to uncover the root of the differences in reported encounters between the MCEs and OMPP. Table 58 displays the distribution of the most used procedure codes for both the MCEs and OMPP.

Table 58. Top 10 Nursing Facility Procedure Codes

MCE	MCE			OMPP		
	Procedure Code	Claim Count	% Claim Count	Procedure Code	Claim Count	% Claim Count
Anthem	*	5,145	24.72%	*	7,235	21.75%
	G0471	1,297	6.23%	99309	6,930	20.84%
	93005	1,218	5.85%	99308	5,955	17.91%
	36415	1,135	5.45%	99307	664	2.00%
	97535	944	4.53%	90832	642	1.93%
	71045	518	2.49%	80053	564	1.70%
	J1644	405	1.95%	99310	552	1.66%
	99285	398	1.91%	99305	514	1.55%
	P9604	388	1.86%	36415	491	1.48%
	G0463	296	1.42%	G8427	478	1.44%
Humana	99309	4,752	29.04%	*	64,178	72.23%
	99308	4,154	18.65%	99309	7,040	7.92%
	90832	427	3.21%	99308	5,941	6.69%
	99307	401	2.79%	36415	690	0.78%
	99310	318	2.31%	99307	615	0.69%

Table 58. Top 10 Nursing Facility Procedure Codes						
MCE	MCE			OMPP		
	Procedure Code	Claim Count	% Claim Count	Procedure Code	Claim Count	% Claim Count
	99305	221	2.29%	99310	569	0.64%
	G8427	220	2.24%	90832	557	0.63%
	99306	195	2.23%	G8427	477	0.54%
	11042	187	1.89%	80053	393	0.44%
	99490	185	1.84%	85025	371	0.42%
UHC	99309	32,975	36.05%	*	49,546	66.91%
	99308	21,180	31.52%	99309	8,450	11.41%
	99490	3,649	3.24%	99308	7,110	9.60%
	99307	3,172	3.04%	99307	955	1.29%
	11720	2,623	2.41%	90832	765	1.03%
	Q0092	2,596	1.68%	99310	657	0.89%
	99310	2,544	1.67%	G8427	633	0.85%
	G0127	2,537	1.48%	99305	410	0.55%
	G0471	2,149	1.42%	99306	390	0.53%
	P9603	2,086	1.40%	T1015	361	0.49%

**The cell is left blank purposely, as the most commonly used procedure code was uncoded.*

Anthem

The distribution of top procedure codes differed substantially between Anthem's submissions and OMPP's data; however, in both cases, the procedure code was left unfilled. This would suggest that the code is institutional in nature, but it could also be an amalgamation of uncoded claim types. This lack of clarity should be noted.

In Anthem's data, the highest-volume procedure category accounted for 24.72% of nursing facility encounters, with the remaining top codes distributed more evenly across laboratory tests, ancillary services, and a small number of evaluation and management codes. No single code dominated the plan's volume. In contrast, OMPP's data showed a much more concentrated pattern, with the top three procedure codes,

including the uncoded category and two evaluation and management categories, representing 60.50% of all SNF/NF encounters.

Overall, Anthem's code distribution appears more diversely distributed in comparison to OMPP's data, suggesting potential differences in coding practices, encounter classification, or completeness of reported procedure codes for this service setting. These differences should be addressed by OMPP and the MCEs to ensure that all information is captured accurately and efficiently by all parties.

Humana

Humana's top nursing facility procedure codes are dominated by Evaluation and Management services, with 99309 (29.04%) and 99308 (18.65%) making up nearly half of all reported encounters. The remaining top codes are distributed across lower-volume Evaluation and Management services and common ancillary procedures, with each representing between 1.84% and 3.21% of total encounters.

In contrast, OMPP's data show a markedly different pattern. The highest-volume line, which appears as an unspecified grouped procedure, accounts for 72.23% of all nursing facility encounters, followed by 99309 (7.92%) and 99308 (6.69%). The remaining top codes each represent less than 1% of total encounters. This indicates that OMPP's records reflect a highly concentrated procedure distribution, whereas the plan's data show a more dispersed pattern with heavier emphasis on Evaluation and Management services.

Overall, the two datasets differ substantially in how procedure codes are distributed, suggesting differences in coding practices, grouping logic, or how procedure information is captured and submitted for SNF/NF encounters. These differences should be addressed by OMPP and the MCEs to ensure that all information is captured accurately and efficiently by all parties.

UHC

UHC's top nursing facility procedure codes are heavily concentrated in Evaluation and Management services, with 99309 (36.05%) and 99308 (31.52%) making up the majority of all encounters. The remaining top procedures are low in volume and primarily include ancillary or supportive services such as 99490, 99307, 11720, Q0092, and G0127, each representing less than 4% of all plan encounters.

OMPP's distribution, however, has a blank procedure code for the majority of encounters (49,546 encounters; 66.91%), followed by a more balanced but significantly lower share of Evaluation and Management services: 99309 (11.41%) and 99308 (9.60%). The remaining codes appear at very small percentages, indicating that OMPP reflects a broader mix of SNF/NF procedures, whereas UHC's data is disproportionately concentrated in two Evaluation and Management codes.

Overall, the two datasets differ substantially in how procedure codes are distributed, suggesting differences in coding practices, grouping logic, or how procedure information is captured and submitted for SNF/NF encounters. These differences should be addressed by OMPP and the MCEs to ensure that all information is captured accurately and efficiently by all parties.

Completeness and Validity of Encounters

Qsource analyzed the completeness and validity of critical encounter data fields. Completeness rates were calculated as the number of data fields with data present, and validity rates were calculated as the number of valid data points as a percentage of those with data present (completeness). As this analysis verifies whether or not all necessary information exists within the claim, Qsource did not perform a separate analysis on claims relating to SNF/NF encounters. Table 59 displays the completeness and validity rates for professional encounters, and Table 60 displays the completeness and validity rates for institutional encounters. Please note that all percentages have been rounded.

Table 59. Completeness and Validity Rates — Professional Encounters

Field	Present	Completeness Rate	Accurate	Validity Rate
Anthem Distinct Encounter Lines (N*=588,579)				
Member ID	588,579	100%	588,579	100%
Claim Number	588,579	100%	588,579	100%
Billing Provider ID	167,770	29.00%	167,770	100%
Rendering Provider ID	0	0.00%	0	0.00%
Diagnosis Code	588,579	100%	588,579	100%
Procedure Code	587,307	100%	587,307	100%
First Date of Service	588,579	100%	587,251	100%
Last Date of Service	588,579	100%	588,579	100%
Date Billed	588,579	100%	588,579	100%
Date Paid	588,579	100%	588,579	100%
Date of Admission	359,325	61.00%	359,323	100%
Date of Discharge	20,170	3.00%	20,170	100%

Table 59. Completeness and Validity Rates — Professional Encounters				
Field	**Present**	**Completeness Rate**	**Accurate**	**Validity Rate**
Capitated Provider	588,579	100%	588,579	100%
Place of Service Code	588,579	100%	588,579	100%
Humana Distinct Encounter Lines (N=578,222)				
Member ID	578,222	100%	578,221	100%
Claim Number	578,222	100%	578,222	100%
Billing Provider ID	409,594	71.00%	409,594	100%
Rendering Provider ID	317,391	55.00%	317,391	100%
Diagnosis Code	578,222	100%	578,222	100%
Procedure Code	578,222	100%	578,222	100%
First Date of Service	578,222	100%	578,222	100%
Last Date of Service	578,222	100%	578,220	100%
Date Billed	0	0.00%	0	0.00%
Date Paid	578,220	100%	578,185	100%
Date of Admission	77,914	13.00%	77,910	100%
Date of Discharge	18,820	3.00%	18,817	100%
Capitated Provider	578,222	100%	578,222	100%
Place of Service Code	578,222	100%	578,215	100%
UHC Distinct Encounter Lines (N=634,010)				
Member ID	634,010	100%	634,010	100%
Claim Number	634,010	100%	634,010	100%
Billing Provider ID	634,010	100%	634,010	100%
Rendering Provider ID	464,614	73.28%	464,614	100%
Diagnosis Code	634,010	100%	634,010	100%

Table 59. Completeness and Validity Rates — Professional Encounters				
Field	**Present**	**Completeness Rate**	**Accurate**	**Validity Rate**
Procedure Code	634,010	100%	634,007	100%
First Date of Service	634,010	100%	632,754	100%
Last Date of Service	634,010	100%	634,010	100%
Date Billed	0	0.00%	0	0.00%
Date Paid	634,010	100%	632,753	100%
Date of Admission	634,010	100%	634,007	100%
Date of Discharge	634,010	100%	634,010	100%
Capitated Provider	0	0.00%	0	0.00%
Place of Service Code	634,010	100%	634,009	100%

**N=Number of encounters.*

Table 60. Completeness and Validity Rates — Institutional Encounters				
Field	**Present**	**Completeness Rate**	**Accurate**	**Validity Rate**
Anthem Distinct Encounter Lines (N*=154,584)				
Member ID	154,584	100%	154,584	100%
Claim Number	154,584	100%	154,584	100%
Billing Provider ID	0	0.00%	0	0.00%
Rendering Provider ID	0	0.00%	0	0.00%
Diagnosis Code	154,584	100%	154,584	100%
Procedure Code	98,719	64.00%	98,719	100%
First Date of Service	154,584	100%	153,469	99.00%
Last Date of Service	154,584	100%	154,577	100%
Date Billed	154,584	100%	154,584	100%

Table 60. Completeness and Validity Rates — Institutional Encounters				
Field	**Present**	**Completeness Rate**	**Accurate**	**Validity Rate**
Date Paid	154,584	100%	154,584	100%
Date of Admission	78,303	51.00%	78,281	100%
Date of Discharge	0	0.00%	0	0.00%
Capitated Provider	154,584	100%	154,584	100%
Place of Service Code	154,584	100%	154,584	100%
Humana Distinct Encounter Lines (N=130,670)				
Member ID	130,670	100%	130,670	100%
Claim Number	130,670	100%	130,670	100%
Billing Provider ID	130,347	100%	130,347	100%
Rendering Provider ID	1,028	1.00%	1,028	100%
Diagnosis Code	130,670	100%	130,668	100%
Procedure Code	79,718	61.00%	79,659	100%
First Date of Service	130,670	100%	130,670	100%
Last Date of Service	130,670	100%	130,667	100%
Date Billed	0	0.00%	0	0.00%
Date Paid	130,670	100%	130,669	100%
Date of Admission	73,297	56.00%	73,191	100%
Date of Discharge	0	0.00%	0	0.00%
Capitated Provider	130,670	100%	130,670	100%
Place of Service Code	130,670	100%	130,665	100%
UHC Distinct Encounter Lines (N=166,192)				
Member ID	166,192	100%	166,192	100%
Claim Number	166,192	100%	166,192	100%

Table 60. Completeness and Validity Rates — Institutional Encounters				
Field	**Present**	**Completeness Rate**	**Accurate**	**Validity Rate**
Billing Provider ID	166,192	100%	166,192	100%
Rendering Provider ID	159,946	96.24%	159,946	100%
Diagnosis Code	166,192	100%	166,192	100%
Procedure Code	96,443	58.03%	70,240	73.83%
First Date of Service	166,192	100%	166,192	100%
Last Date of Service	166,192	100%	166,192	100%
Date Billed	0	0.00%	0	0.00%
Date Paid	166,192	100%	165,896	100%
Date of Admission	166,192	100%	165,992	100%
Date of Discharge	166,192	100%	166,192	100%
Capitated Provider	0	0.00%	0	0.00%
Place of Service Code	166,192	100%	298	0.00%

**N=Number of encounters.*

Anthem

Within the professional encounters, several fields indicate potential data quality issues. Billing Provider ID was present on only 29.00% of encounters, and Rendering Provider ID was not populated at all. These fields are essential for identifying the provider delivering or billing for the service, and their absence limits the ability to conduct provider-level attribution and performance analysis. Additionally, admission and discharge dates were populated on 61.00% and 3.00% of encounters, respectively. These fields are generally expected only for institutional services and do not typically appear on professional encounters. Their presence suggests possible mapping or data export issues.

As within the professional encounters, the institutional encounters indicate that several key fields have potential data quality issues. Both Billing Provider ID and Rendering Provider ID were entirely unpopulated, despite being essential for identifying the billing and servicing providers on institutional claims. Additionally, Date of Admission was present on only 51.00% of encounters, and Date of Discharge was not populated at all. These fields are required components of institutional encounters, and their absence suggests possible extract or

mapping errors. However, it should also be noted that the 64.00% completeness rate for procedure codes is not a concern and is, to an extent, expected for institutional encounters, as not all institutional lines require a procedure code.

Humana

Within the professional encounters, several important elements showed notable gaps. Billing Provider ID was present on only 71.00% of encounters and Rendering Provider ID on 55.00%, limiting the ability to attribute services to specific providers. Date Billed was not populated at all, and Date of Admission (13.00%) and Date of Discharge (3.00%) were present at minimal levels. While admission-related fields are not typically expected for professional claims, the absence of billed dates and the incomplete provider identifiers suggest potential extract or mapping issues that warrant further review.

The institutional encounters also indicated that several key fields have potential data quality issues. While Procedure Codes were only present on 61.00% of encounters, this is expected and still compliant for Institutional encounters as not all institutional lines require a procedure code. However, Rendering Provider ID was present on only 1.00% of encounters, limiting attribution of services. Date Billed and Date of Discharge were not populated at all, and Date of Admission was present for just 56.00% of encounters. Admission and discharge dates are required elements for institutional claims, and the absence or partial population of these fields indicates potential extract or mapping issues in the institutional data submitted by the plan.

UHC

Within the professional encounters, several important elements showed notable gaps. Date Billed and Capitated Provider were not populated at all, limiting the ability to assess billing timeliness and determine whether the encounters were associated with capitated arrangements. Additionally, admission and discharge dates, although complete, are not typically required for professional encounters and may reflect mapping or extract inconsistencies. Overall, while most fields demonstrate strong completeness, the missing billed date and capitated provider fields represent key areas for improvement.

As within the professional encounters, the institutional encounters indicated that several key fields have potential data quality issues. Date Billed and Capitated Provider were not populated for any encounters, preventing assessment of billed-to-paid timeliness and capitated arrangements. Additionally, Place of Service Code, while reported as 100% present, showed 0.00% validity, indicating that the values submitted did not meet expected formatting or code standards. These gaps suggest extract or mapping errors that will require follow-up with the plan to ensure accurate institutional encounter reporting. It should be noted that, while Procedure Codes were populated on only 58.03% of encounter lines, this is generally expected and compliant for institutional claims since not all institutional records require procedure coding.

Activity 4: Review of Medical Records

Qsource used the results from Activity 3 (Analyze Electronic Encounter Data) to guide this activity. Qsource and OMPP determined what the focus of the review would be, and Qsource drew a sample of records for validation to confirm the findings from Activity 3.

Activity 4 of the CMS EDV protocol—medical record review (MRR) of selected encounter records to confirm EDV findings—was conducted for encounters with dates of service between October 1, 2024, and December 31, 2024. However, due to the nature of the PathWays program and its emphasis upon home- and community-based services (HCBS) to aid its members to age in place, not all of the reviewed records are medical in nature. For this reason, these records will be referred to either as "records" or "encounter records" to encompass both medical and non-medical records.

Methodology

In this year's EDV report, Qsource determined that MRR would encompass the MCEs' whole encounter record to develop a baseline understanding of the MCEs' operations; OMPP approved this focus. Qsource selected a statistically valid stratified random sample for service dates from October 1, 2024, through December 31, 2024. Qsource also requested the MCE's secure medical records associated with these encounters from participating providers. The records were reviewed to confirm that key electronic encounter data were supported by the appropriate medical record. Qsource first identified if the appropriate record was available, then validated the following data in each record as compared to the electronic encounter data:

1. MRR Present – Is there a record present with a matching Claim # and Member information?
2. Rendering Provider – When applicable, using National Provider Identifier (NPI) Lookup, confirm accuracy of the name/NPI included in the reviewer worksheet & MCE Record reviewed.
3. Billing Provider Validation – When applicable, using NPI Lookup, confirm accuracy of the name/NPI included in the reviewer worksheet & MCE Record reviewed.
4. Date of Service Validation – Confirm the Date of Service accuracy in the reviewer worksheet and MCE Record reviewed.
5. Procedure Code 1 Validation – Validate the presence and accuracy of primary procedure code.
6. Procedure Code 2, 3 Validation – If applicable, validate the presence and accuracy of procedure codes 2 & 3.
7. Diagnosis Code 1 Validation – Validate the presence and accuracy of primary diagnosis code.
8. Diagnosis Code 2, 3 Validation – If applicable, validate the presence and accuracy of diagnosis codes 2 & 3.

UHC claimed that they had no capitated providers; however, according to OMPP, UHC has eight providers that are considered to be in a capitated payment arrangement with the MCE (e.g., Vision and Dental benefit providers). It appears that there may be some confusion between UHC and OMPP as to what constitutes a capitated provider, a vendor, and a third-party

subcontractor. Without any claims data designated as capitated, no capitated provider encounters were available; therefore, there were no applicable encounters to sample for the Medical Record Review based on the agreed upon activity methodology. Only Anthem and Humana will be discussed in the rest of the MRR section.

Results

Completeness

Based on the encounter data received from the MCEs, Qsource established a sample size for the MRR. In **Table 61** the requested number of files for the sample, the number of files received, the number of files that were deemed to be complete and valid through the medical record check, and the validity rate of those files are shown for Anthem and Humana. Anthem's files were received as distinct medical records in PDF format, and all were found to be complete and accurate. From Humana, Qsource received a total of 171 secure files. These 171 documents contained 101 individual member encounters, primarily DME and HCBS encounters, and one flat file that encompassed over 400 transportation-based service trips within a single log. Humana submitted an additional 69 PDF files that contained provider record requests from Humana to various vendors yet did not include an actual encounter. To validate Humana's encounters for the MRR, Qsource utilized the 101 distinct encounter files in combination with the (1) single transportation log which accounted for 312 total encounters that were validated as having a record present by matching all documented member information to corresponding electronic encounter data. The complete encounters from each MCE are used for the rest of the MRR.

Table 61. Requested Encounters – Completeness

MCE	# of Encounters Requested	# of Documents Received	Complete Encounters	Validity Rate
Anthem	254	254	254	100%
Humana	375	171	312	83.20%

Accuracy

Based on the encounter records received from the MCE, each record was validated for the Billing Provider or Rendering Provider. While Billing Provider codes are included for all encounters, regardless of type, the Billing Provider is not always the same as the Rendering Provider if the service being billed for is from a vendor (i.e., if the transportation vendor is the Billing Provider instead of the specific driver). For this reason, some encounter records are validated for Billing Provider, typically if it is a non-medical, service-based encounter, while other encounter records are validated for Rendering Provider.

Table 62 summarizes the results of the Rendering Provider data field. Table 63 displays the results of the Billing Provider data field.

Table 62. MRR Results – Rendering Provider Validation

MCE	Present and Accurate	Total Records Validated	Validation Rate
Anthem	169	169	100%
Humana	0	0	Not Applicable

Table 63. MRR Results – Billing Provider Validation

MCE	Present and Accurate	Total Records Validated	Validation Rate
Anthem	85	85	100%
Humana	102	312	32.69%

Table 64 displays the validation for the Date of Service data field.

Table 64. MRR Results – Date of Service Validation

MCE	Present and Accurate	Total Records Validated	Validation Rate
Anthem	254	254	100%
Humana	220	312	70.51%

Table 65 displays the validation of the Procedure Code data fields. In each record, the MCE can include up to three Procedure Codes, although only one is necessary. This is due to the fact that each encounter can encompass multiple services in a capitated service arrangement.

Table 65. MRR Results – Procedure Code Validation

Procedure Code Line	MCE	Present and Accurate	Total Records Validated	Validation Rate
Procedure Code 1	Anthem	248	254	97.64%
	Humana	300	312	96.15%
Procedure Code 2	Anthem	139	140	99.29%

Table 65. MRR Results – Procedure Code Validation				
Procedure Code Line	**MCE**	**Present and Accurate**	**Total Records Validated**	**Validation Rate**
	Humana	96	190	50.53%
Procedure Code 3	Anthem	91	92	98.91%
	Humana	1	2	50.00%

Table 66 displays the validation of the Diagnosis Code data fields. The records sampled from the MCE include medical and non-medical records, such as records for transportation, HCBS, and DME providers. These records that include non-medical services do not include diagnosis codes, as there is no physician associated with the encounter. For this reason, not all of the reviewed records have diagnosis codes. Of the 254 records from Anthem, 251 had Diagnosis Codes; out of the 312 records from Humana, 0 had Diagnosis Codes.

Table 66. MRR Results – Diagnosis Code Validation				
Procedure Code Line	**MCE**	**Present and Accurate**	**Total Records Validated**	**Validation Rate**
Diagnosis Code 1	Anthem	249	251	99.20%
	Humana	0	0	NA*
Diagnosis Code 2	Anthem	103	103	100%
	Humana	0	0	NA
Diagnosis Code 3	Anthem	23	23	100%
	Humana	0	0	NA

**Not Applicable*

Activity 5: Submission of EQRO Findings

The submission of the individual *2025 Encounter Data Validation* reports served as a submission of EQRO findings for the EDV activities as defined by CMS Protocol.

Strengths and Weaknesses

The EDV review assists OMPP, Qsource, and the MCEs 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.

Table 67 displays the strengths from each MCE, and Table 68 displays the weaknesses.

Table 67. EDV Strengths

MCE	Strength
Anthem	Anthem scored above 95.00% in every validation category of the MRR.
Humana	None identified
UHC	None identified.

Table 68. EDV Weaknesses

MCE	Weaknesses
Anthem	Anthem underrepresented encounters in the SNF/NF service type within its data extract.
	Anthem's lack of institutional encounters suggests that encounters are not captured, mapped, or submitted correctly.
	Anthem had negative values within its billing cycle data, displaying a date sequencing or mapping issue.
	Anthem displays significant coding practice deviations from that of OMPP.
Humana	Humana's data indicated that institutional encounters are underrepresented, relative to OMPP's data, by 13 percentage points.
	Humana's encounter counts consistently remained 7–12% higher than OMPP's in month-to-month analysis, indicating a persistent overrepresentation in the submitted data.
	Humana had a marked absence of paid dates in their encounters, indicating a systemic data extraction or mapping issue.
	Humana lacked admission and discharge date fields in their institutional encounters, indicating extract or mapping issues.
	Humana displayed significant coding practice deviations from that of OMPP.
	Humana scored 32.69% in the Billing Provider validation of the MRR.

Table 68. EDV Weaknesses	
MCE	**Weaknesses**
	Humana scored 50.23% and 50.00% in Procedure Code 2 and Procedure Code 3 validation, respectively, for the MRR.
UHC	UHC stated that their payments were purely FFS; however, it was found that they had several capitated providers.
	UHC displayed significant underrepresentation of SNF/NF claims in its monthly encounter logs.
	UHC indicated, throughout their data, that there were missing or misclassified institutional SNF/NF encounters.
	UHC lacked billed dates in its encounter files.
	UHC displayed significant coding practice deviations from that of OMPP.
	UHC lacked Date Billed and Capitated Provider information in professional encounters.

Performance Improvements

As this is the first year the PathWays program has been in operation, there is no data to compare.

Conclusions and Recommendations

Overall, the systems review performed for each MCE revealed no issues or weaknesses. All three MCEs prepared acceptable ISCATs. The issues found throughout the EDV, for all three MCEs, were found in Activity 3, the analysis of data volume, consistency, completeness, and validity of encounter data, and in Activity 4, the medical record review.

Anthem

Activity 3 involved analysis of data volume, consistency, completeness, and validity. For this report, Qsource reviewed the volume and consistency, the timeliness, the distribution, and the completeness and validity of the encounter data. In performing these analyses, Qsource uncovered the following findings:

- Anthem stated that they only had one capitated provider; however, it was found that there were more than one.
- Anthem's overall encounter submissions closely mirror the encounter-type profile reflected in OMPP's data with no substantial shifts in the underlying distribution. However, when it comes to encounters specific to SNF/NF services, the encounters may not be fully captured or reported in the plan's data extract; further review of how these service locations are identified and submitted may be warranted. In fact, there is a persistent and significant underrepresentation

of encounters for this service setting within the plan's data extract.

- When examining the total encounters by month, the difference between OMPP's data and Anthem's data for the month of December is noticeably higher than the prior months. This difference may reflect timing or submission-related delays in the plan's encounter processing.
- The absence of institutional encounters in Anthem's submission suggests that encounters expected to fall under the institutional category may not be captured, mapped, or submitted correctly for this service setting.
- There is a vital difference in definition of "paid" between MCE encounters and OMPP encounters. OMPP's definition of "paid" refers to the payment of the MCE. The MCEs' definition of "paid" refers to the payment of the provider. This difference in definition should be addressed by OMPP and the MCE. Additionally, when looking at the billing cycles within the encounters, Anthem had negative values within their data; this suggests a date sequencing or mapping issue that warrants correction in future submissions.
- There are significant differences in coding practices or in how encounters are categorized for this specific care setting. As is standard practice in claims coding, OMPP uses "B" and "M" to denote professional codes, and six different letters for different types of institutional codes. Anthem uses only "P" for Professional and "I" for Institutional which removes some of the additional information that can be gathered from the standard coding logic, such as type of professional or institutional claim. This lack of further information could account for the variance in distribution of medical service type.
- When examining the distribution of encounters, the distribution of top procedure codes differed substantially between Anthem's submissions and OMPP's data; however, in both cases, the procedure code was left unfilled. This would suggest that the code is institutional in nature, but it could also be an amalgamation of uncoded claim types. This lack of clarity should be noted. Overall, Anthem's code distribution appears more diversely distributed in comparison to OMPP's data, suggesting potential differences in coding practices, encounter classification, or completeness of reported procedure codes for this service setting. These differences should be addressed by OMPP and the MCEs to ensure that all information is captured accurately and efficiently by all parties.

Qsource made the following recommendations to improve quality, timeliness, and access to care based on the findings from the EDV:

- Anthem should ensure that encounters expected to fall under the institutional category are captured, mapped, or submitted correctly for the institutional service setting.
- Anthem should ensure that encounters specific to SNF/NF services are fully captured or reported in the plan's data extract, as there is a persistent and significant underrepresentation of encounters for this service setting within the plan's data extract.
- Anthem should ensure that there are no timing or submission-related delays in their encounter processing.

- Anthem should ensure that they are using standardized coding logic in the classification of their claims and encounters.

Humana

Activity 3 involved analysis of data volume, consistency, completeness, and validity. For this report, Qsource reviewed the volume and consistency, the timeliness, the distribution, and the completeness and validity of the encounter data. In performing these analyses, Qsource uncovered the following findings:

- Humana's overall encounter submissions more closely mirror the encounter-type profile reflected in OMPP's data when examining the encounters associated with SNF/NF services. When the encounters of the general member population are analyzed, there is a wider variance.
- The variance between institutional and professional encounters indicates that institutional encounters are underrepresented in Humana's submissions relative to OMPP's data. The shift of approximately 13 percentage points suggests potential differences in encounter classification, mapping, or completeness of institutional encounter reporting for Humana.
- In examining the month-to-month encounter data, Humana's encounter counts remained 7–12% higher than OMPP's throughout the quarter, indicating a persistent overrepresentation in the submitted data relative to OMPP's records.
- There was an absence of billed dates in Humana's encounters which could indicate a systemic data extraction or mapping issue that prevents assessment of payment timeliness. This could play a part in explaining the substantially shorter payment windows in Humana's submissions; the differences may reflect discrepancies in how payment dates are captured or submitted, or this could indicate incomplete or truncated payment information relative to OMPP's records.
- There are vital differences in coding practices or in how encounters are categorized for specific care settings. As is standard practice in claims coding, OMPP uses "B" and "M" to denote professional codes, and six different letters for different types of institutional codes. Humana uses only "P" for Professional and "I" for Institutional which removes some of the additional information that can be gathered from the standard coding logic, such as type of professional or institutional claim. This lack of further information could account for the differences in how procedure codes are distributed, which suggests differences in coding practices, grouping logic, or how procedure information is captured and submitted.
- The absence of billed dates and incomplete provider identifiers in Humana's professional encounters suggest potential extract or mapping issues that warrant further review. Additionally, in institutional encounters, the absence or partial population of these admission and discharge date fields indicate potential extract or mapping issues in the institutional data submitted by the plan.

In Activity 4, the Medical Record Review, Qsource created a randomized sample of 375 encounters for validation. Within that MRR, Humana scored above 95.00% in one field, Procedure Code 1, while displaying room for improvement in the following fields:

- Records Present;
- Billing Provider;
- Date of Service;
- Procedure Code 2; and
- Procedure Code 3.

Qsource made the following recommendations to improve quality, timeliness and access to care based on the findings from the EDV:

- Humana should ensure that encounters expected to fall under the institutional category are captured, mapped, or submitted correctly.
- Humana should ensure that encounters expected to fall under the professional category are mapped or extracted correctly.
- Humana should ensure that all encounters are submitted to OMPP properly, as there appears to be an overrepresentation of encounters from Humana's data.
- Humana should ensure that encounters have all necessary billing and payment information and ensure that there are no systemic data extraction or mapping issues that prevent assessment of payment timeliness.
- Humana should ensure that they are using standardized coding logic in the classification of their claims and encounters.
- Humana should improve data timeliness and completeness by enhancing current processes to retrieve provider service encounters.
- Humana should improve data accuracy by ensuring that data elements used for claim and encounter identification are documented in a consistent format to that which is approved by the state and requested for the EQR.
- Humana should improve data accuracy by ensuring that Billing Provider electronic encounter data are accurately depicted across regulatory reporting and the encounter service record.

UHC

Activity 3 involved analysis of data volume, consistency, completeness, and validity. For this report, Qsource reviewed the volume and consistency, the timeliness, the distribution, and the completeness and validity of the encounter data. In performing these analyses, Qsource uncovered the following findings:

- UHC stated that their payments were purely FFS; however, it was found that they had several capitated providers.
- When examining the monthly encounter logs, there are consistently large gaps between OMPP and UHC data that indicate SNF/NF enrollees are significantly underrepresented in the plan's submissions and suggest that encounters in this service setting may not be fully captured or accurately

reported. Throughout the rest of the analyses, there are stark discrepancies that indicate that institutional nursing facility encounters are almost entirely missing or misclassified in UHC's submission. The data suggests systemic issues in how the plan identifies, extracts, or categorizes institutional services for this setting.

- The distribution of encounters between professional and institutional settings found a discrepancy in the way institutional encounters are represented. While total encounter numbers are similar in volume, the distribution indicates that institutional encounters are underreported or misclassified in the plan's submission relative to OMPP's records.
- The absence of billed dates in the plan's file indicates a systemic reporting gap, as billed dates are a standard component of encounter submission and are necessary for evaluating timeliness and payment workflows.
- The distribution of encounters across procedure codes between OMPP and UHC datasets differ substantially in how procedure codes are distributed, suggesting differences in coding practices, grouping logic, or how procedure information is captured and submitted for all encounters, but especially those in the SNF/NF settings. These differences should be addressed by OMPP and the MCEs to ensure that all information is captured accurately and efficiently by all parties.
- There are vital differences in coding practices or in how encounters are categorized for specific care settings. As is standard practice in claims coding, OMPP uses "B" and "M" to denote professional codes, and six different letters for different types of institutional codes. UHC used numerical claim codes and did not supply a key for deciphering those codes. Instead, Qsource analysts turned to the claim_form column in the encounter files which listed "Medical Inst." and "Medical Prof." which coincided with professional and institutional encounters.
- In validating the completeness of professional encounters, Date Billed and Capitated Provider were not populated in any record, limiting the ability to assess billing timeliness and determine whether the encounters were associated with capitated arrangements. Additionally, admission and discharge dates, although complete, are not typically required for professional encounters and may reflect mapping or extract inconsistencies. Overall, while most fields demonstrate strong completeness, the missing billed date and capitated provider fields represent key areas for improvement.
- Similarly, in validating the completeness of professional encounters, Date Billed and Capitated Provider were not populated for any encounters, preventing assessment of billed-to-paid timelines and capitated arrangements. Additionally, Place of Service Code, while reported as 100% present, showed 0.00% validity, indicating that the values submitted did not meet expected formatting or code standards. These gaps suggest extract or mapping errors that will require follow-up with the plan to ensure accurate institutional encounter reporting. It should be noted that, while Procedure Codes were populated on only 58.03% of encounter lines, this is generally expected and compliant for

institutional claims since not all institutional records require procedure coding.

Due to the differences in data between OMPP and UHC regarding capitated providers, Activity 4, the MRR, could not be completed.

Qsource made the following recommendations to improve quality, timeliness and access to care based on the findings from the EDV:

- UHC should ensure that they are aligned with OMPP on what constitutes a capitated provider.
- UHC should ensure that they are properly identifying, extracting, or categorizing institutional services for the SNF/NF setting.
- UHC should ensure that they are using standardized coding logic in the classification of their claims and encounters.
- UHC should ensure that they understand and classify capitated providers and payment arrangements properly.
- UHC should ensure that they are capturing all applicable information in their encounter records.

2025 EQR Conclusions

Qsource conducted mandatory EQR activities for the OMPP program for the 2025 EQR. 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 any 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 members. OMPP contractually requires the MCEs to complete PIPs annually. Validation of each PIP revealed that the MCEs demonstrated an understanding of the process; however, weaknesses were noted in all 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 quarterly and annually, respectively, and how the information was assessed. Qsource views the results as a learning opportunity for the MCEs and will assist in education in the next remeasurement year. OMPP should continue to monitor the MCEs' PIPs as part of its Quality Strategy to ensure quality, timeliness, and access to care for its enrollees.

PMV

PMV is designed to assess the accuracy of reported quality and performance measures and determine the extent to which the reported rates follow the measure specifications and reporting requirements. Qsource validated processes and systems to determine the MCEs' ability to produce accurate, complete, and timely performance measure reporting. As part of this activity, Qsource evaluated three validated performance measures, "Completion of HNS and CHAT Within 30 Days or 90 Days of MCE Enrollment Based on Care Program," "Service Coordinators who Have Successfully Completed Person-Centered Training Within 90 Days of Hire," and "Care Management ICP Developed and Implemented within 90 Days of MCE Effective Date for Members with Complex Care Management Level of Service or within 60 Days of MCE Effective Date for Members with Care Management Level of Service." Additionally, Qsource evaluated two other performance measures: "IMD Member Use" and "Dentists and Oral Surgeons Network Adequacy." Qsource defined the scope

of the validation to include the OMPP required metrics, with the understanding that these metrics would be expanded in the following measurement year, once the MCEs have had more time to measure the program's outcomes. These validations included data source, reporting frequency, and format of those measures. In addition to document review, Qsource's audit included a request to review each MCE's ISCA, to ensure that each MCE maintained a health information system that can accurately and completely collect, analyze, integrate, and report data on member and provider characteristics, and on services furnished to members.

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

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

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 2025 EQR to evaluate Indiana MCE adherence to compliance standards in accordance with CMS protocol and OMPP guidance performed every three years. This activity evaluated 14 standards and 5 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.

All MCEs achieved a High Confidence rating for overall Compliance Standards and File Review scores in the 2025 EQR indicating an average of 90.00% or greater number of elements were met. It was noted that 10 of the 14 Standards evaluated for 2025 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, Availability of Services, Coordination and Continuity of Care, and Coverage and Authorization of Services. Additionally, the UM Denials file review category is the only file review category to score less than 95.00% compliance among the MCEs for the 2025 CA. The MCEs included

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

ANA

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

Based on the analyses of the MCEs' geographical network adequacy, Qsource concluded there to be a moderate degree of confidence in the provider-to-member ratio and a moderate to low confidence in the geographic access to providers for all three MCEs. This leaves room for improvement.

Likewise, throughout the Secret Shopper Survey, Qsource concluded that there is low to moderate confidence in the access to care standards evaluated across the three MCEs. The wait time standards were met in a range of 43.75% to 62.50%. The most common reason for the surveyors to not receive an appointment was due to the provider not taking appointments, though there was also a small group of providers who claimed to not accept Medicaid/PathWays or was not contracted with the MCE.

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 members and ensure provider lists in member materials are correct.

EDV

This Protocol was chosen by OMPP for MY 2024 as one of the optional protocols recommended by CMS for further analysis of data volume, consistency, completeness, and validity. All aspects of this Protocol's analysis bolster the Quality Strategy Plan's emphasis on access to care, quality of care, and timeliness of care throughout the PathWays program.

Overall, the systems review performed for each MCE revealed no issues or weaknesses. All three MCEs prepared acceptable ISCATs, displaying that their data systems were capable of producing the data necessary for the analyses.

Based on the analysis, however, Qsource uncovered a lack of alignment amongst the three MCEs and between the MCEs and

OMPP in the way that data is classified, mapped, and extracted. Additionally, the coding logic used by the MCEs differs significantly from the standardized coding logic utilized by OMPP. These differences created a deep mismatch in data types and encounter numbers. Qsource recommends that the MCEs and OMPP ensure that they are aligned on claims coding, what constitutes a capitated provider, and what constitutes a professional versus an institutional encounter.

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 Care Coordination for Indiana PathWays for Aging HCBS Member* (Clinical)	
Study Population	The PIP population included all members who were eligible for HCBS services.
Study Variables and Performance Measures	**Performance Measure 1:** Shared Care Plan (SCP) with Primary Care Practitioner – Members who had an LTSS care plan (Service Plan) with nine core elements documented and whose service plan was transmitted to their PCP or to another documented medical care practitioner identified by the member within 30 days of the date when the member agreed to the care plan (31 days total).
Improvement Strategies	None listed.
Measurement Results	**Performance Measure 1:** SCP with Primary Care Practitioner Goal: Not Applicable; Benchmark: To Be Determined MY 2024 Rate: Not Applicable
Anthem: *Home- and Community-Based Services (HCBS) Delivery* (Nonclinical)	
Study Population	The PIP population includes all HCBS members with new Nursing Facility Level of Care (NFLOC) determination as indicated from State 834 enrollment files and all HCBS Providers under provider type 05 (Home Health) and 32 (Waiver).
Study Variables and Performance Measures	**Performance Measure 1:** EVV Compliance – Claims processed during each quarter of the 12-month calendar year remeasurement year.
	Performance Measure 2: Service Delivery Timeliness – Report the total Pathways members enrolled with the MCE as of the end of the reporting month that meet NFLOC that live outside of a nursing facility whose first HCBS service claim activity date is within 20 days of 834 enrollment file date of NFLOC determination. Claim codes and eligible services are outlined in the 1203, and 0703 regulatory reports from the PathWays MCE Reporting Manual.
Improvement Strategies	None listed.
Measurement Results	**Performance Measure 1**: EVV Compliance Goal: 90.00%; Benchmark: To Be Determined MY 2024 Rate: Not Applicable

Table A-1. 2025 PIP Details for MCEs	
	Performance Measure 2: Service Delivery Timeliness Goal: To Be Determined; Benchmark: To Be Determined MY 2024 Rate: Not Applicable
Anthem: *Home- and Community-Based Service (HCBS) Planning* (Nonclinical)	
Study Population	The PIP population included all Anthem, Medicaid-only, PathWays members who are eligible for HCBS services and follow the AHRQ CAHPS® and NCQA HEDIS® sampling methodology.
Study Variables and Performance Measures	**Performance Measure 1:** HCBS CAHPS® – "Important To" Question – Percent of Members Reporting their Service Plan includes most or all of what is important to them, measured annually by the HCBS CAHPS Health Plan Survey 1.0, or in the first two years of the PathWays program, by the state-produced quarterly member experience surveys based on a subset of the HCBS CAHPS survey tool questions. The performance measure is specific to survey question number 56.
	Performance Measure 2: Comprehensive Care Plan and Update – The percentage of long-term services and supports (LTSS) organization members 18 years of age and older who have documentation of a comprehensive LTSS care plan (Service plan) in a specified time frame that includes core elements: Members who had a comprehensive LTSS care plan (service plan) with 9 core elements documented within 120 days of enrollment (for new members).
	Performance Measure 3: Comprehensive Assessment and Update – The percentage of long-term services and supports (LTSS) organization members 18 years of age and older who have documentation of a comprehensive LTSS assessment in a specified time frame that includes documentation of core elements. The following rates are reported: 1. Assessment of Core Elements. Members who had a comprehensive LTSS assessment with 9 core elements documented within 90 days of enrollment (for new members) or during the measurement year (for established members). 2. Assessment of Supplemental Elements. Members who had a comprehensive LTSS assessment with 9 core elements and at least 12 supplemental elements documented within 90 days of enrollment (for new members) or during the measurement year (for established members).
Improvement Strategies	None listed.
Measurement Results	**Performance Measure 1:** HCBS CAHPS® – "Important To" Question Goal: To Be Determined; Benchmark: To Be Determined MY 2024 Rate: To Be Determined
	Performance Measure 2: Comprehensive Care Plan and Update Goal: To Be Determined; Benchmark: To Be Determined

Table A-1. 2025 PIP Details for MCEs	
	MY 2024 Rate: To Be Determined
	Performance Measure 3: Comprehensive Assessment and Update Goal: To Be Determined; Benchmark: To Be Determined MY 2024 Rate: To Be Determined
Humana: *HCBS Delivery* (Clinical)	
Study Population	The PIP population is all members who were newly waivered into HCBS after joining the MCE under the PathWays waiver.
Study Variables and Performance Measures	**Performance Measure 1:** Timely Service Delivery – The percentage of newly waivered HCBS members who received their first HCBS service within 20 business days of notification of newly waivered status from the state.
	Performance Measure 2: Electronic Visit Verification – The percentage of HCBS providers with established information system capacity to meet EVV reporting specifications who exceed 90% reporting levels.
Improvement Strategies	None listed.
Measurement Results	**Performance Measure 1:** Timely Service Delivery Goal To Be Determined; Benchmark: To Be Determined MY 2024 Rate: To Be Determined
	Performance Measure 2: Electronic Visit Verification Goal: To Be Determined; Benchmark: To Be Determined MY 2024 Rate: To Be Determined
Humana: *Improving Care Coordination for Indiana PathWays for Aging HCBS Members* (Nonclinical)	
Study Population	The PIP population is defined as members eligible for a HCBS waiver and within the population for the HEDIS® LTSS measure LTSS-Special Population Units (SPU).
Study Variables and Performance Measures	**Performance Measure 1:** Sharing Care Plan with PCP (LTSS-SCP) – Measures the percentage of members who had a LTSS care plan with nine (9) core elements documented and whose care plan was transmitted to their PCP or to another documented medical care practitioner identified by the member within 30 days of the date when the member agreed to the care plan (31 days total). Documentation must show transmission at least once between August 1 of the year prior to the measurement year and December 31 of the measurement year.
Improvement Strategies	None listed.
Measurement Results	**Performance Measure 1:** Sharing Care Plan with PCP (LTSS-SCP) Goal: To Be Determined; Benchmark: To Be Determined MY 2024 Rate: To Be Determined

Table A-1. 2025 PIP Details for MCEs	
Humana: *Increasing Member Participation in HCBS Service Planning* (Nonclinical)	
Study Population	The PIP population is defined as all members eligible for a HCBS waiver and within the population for the HEDIS® LTSS measures LTSS-Comprehensive Assessment and Update (CAU) and LTSS-Comprehensive Care Plan Update (CPU).
Study Variables and Performance Measures	**Performance Measure 1:** HCBS CAHPS® Question #56 – Percentage of members who reported that their service plan included most or all of the things that are important to them.
	Performance Measure 2: Service Plan Timeliness (LTSS-CPU) – Measures the percent of members included who had a comprehensive LTSS care plan with 9 core elements documented within 120 days of enrollment (for new members) or during the measurement year (for established members).
	Performance Measure 3: Comprehensive Assessment and Update (LTSS-CAU) – Measures the percentage of members who have documentation of a comprehensive LTSS assessment with nine (9) core elements documented within 90 days of enrollment (for new members) or during the measurement year (for established members).
Improvement Strategies	None listed.
Measurement Results	**Performance Measure 1:** HCBS CAHPS® Question #56 Goal: To Be Determined; Benchmark: To Be Determined MY 2024 Rate: To Be Determined
	Performance Measure 2: Service Plan Timeliness (LTSS-CPU) Goal: To Be Determined; Benchmark: To Be Determined MY 2024 Rate: To Be Determined
	Performance Measure 3: Comprehensive Assessment and Update (LTSS-CAU) Goal: To Be Determined; Benchmark: To Be Determined MY 2024 Rate: To Be Determined
UHC: *Improving Care Coordination for Indiana PathWays for Aging HCBS Members* (Nonclinical)	
Study Population	The PIP population is defined as MLTSS participants, aged 18 and older, with a person-centered care plan submitted to their PMP or other medical care provider within 30 days of its development.
Study Variables and Performance Measures	**Performance Measure 1:** Care Plan Coordination – Increase the percentage of care plans shared primary PMPs and other documented medical care practitioners identified in the member's care plan within 30 days of the care plan development: HEDIS® SCP.
Improvement Strategies	None listed.

Table A-1. 2025 PIP Details for MCEs	
Measurement Results	**Performance Measure 1:** Care Plan Coordination Goal: To Be Determined; Benchmark: To Be Determined MY 2024 Rate: To Be Determined
UHC: *HCBS Service Delivery* (Nonclinical)	
Study Population	The PIP population was defined as all members in the PathWays HCBS program.
Study Variables and Performance Measures	**Performance Measure 1:** Timeliness of Service Delivery – The percentage of new HCBS members whose first HCBS service is delivered within 20 days of Service Plan completion.
	Performance Measure 2: Improve the State's Capacity to Collect Service Delivery Data – Increase the number of HCBS providers who have established information system capacity to enable them to meet the state's EVV reporting specifications as well as the percentage of providers who exceed 90% reporting levels.
Improvement Strategies	None listed.
Measurement Results	**Performance Measure 1:** Timeliness of Service Delivery Goal: To Be Determined; Benchmark: To Be Determined MY 2024 Rate: To Be Determined
	Performance Measure 2: Improve the State's Capacity to Collect Service Delivery Data Goal: To Be Determined; Benchmark: To Be Determined MY 2024 Rate: To Be Determined
UHC: *Increasing Member Participation in HCBS Service Planning* (Nonclinical)	
Study Population	The PIP population is defined as all MLTSS participants who have documentation of a comprehensive assessment and fit the description of the LTSS-Comprehensive Assessment and Update (CAU) and LTSS-Comprehensive Care Plan and Update (CPU) HEDIS® measures.
Study Variables and Performance Measures	**Performance Measure 1:** Comprehensive Assessment and Update – HEDIS® LTSS-CAU – The percentage of Medicaid MLTSS participants, aged 18 years and older, who have documentation of a comprehensive assessment, completed in a specified timeframe, which includes documentation of core and supplemental elements.
	Performance Measure 2: LTSS Comprehensive Care Plan and Update – HEDIS® LTSS-CPU – The percentage of Medicaid MLTSS participants, aged 18 years and older, who have documentation of an LTSS comprehensive person-centered plan, completed in a specified timeframe, which includes documentation of core and supplemental elements.
	Performance Measure 3: Increase Member Participation in HCBS Service Planning – HCBS CAHPS® Version 1.0 Question 56; interim state produced survey results based on HCBS CAHPS® subset survey. Improve member involvement in HCBS service planning. The PIP aims to increase the percentage of members reporting that their

Table A-1. 2025 PIP Details for MCEs	
	service plan included most or all of the things that are important to them.
Improvement Strategies	None listed.
Measurement Results	**Performance Measure 1:** Comprehensive Assessment and Update – HEDIS® LTSS-CAU Goal: To Be Determined; Benchmark: To Be Determined MY 2024 Rate: To Be Determined
	Performance Measure 2: LTSS Comprehensive Care Plan and Update – HEDIS® LTSS-CPU Goal: To Be Determined; Benchmark: To Be Determined MY 2024 Rate: To Be Determined
	Performance Measure 3: Increase Member Participation in HCBS Service Planning Goal: To Be Determined; Benchmark: To Be Determined MY 2024 Rate: To Be Determined

Appendix B | Detailed Analysis of Provider Network Access

FSSA Indiana Health Care Plan Provider Enrollment Type and Specialty Matrix

Table B-1 presents the FSSA Enrollment Type and Specialty Matrix used in the analysis of the Provider Accessibility Standard and the Provider-to-Member ratios.

Table B-1. FSSA Indiana Health Care Plan Provider Enrollment Type and Specialty Matrix

Provider Type Code and Description	Provider Specialty Code and Description	Provider Secondary Specialty
01 – Hospital	010 – Acute Care	Not Applicable
01 – Hospital	011 – Psychiatric	Not Applicable
01 – Hospital	012 – Rehabilitation	Not Applicable
01 – Hospital	013 – Long Term Acute Care	Not Applicable
02 – Ambulatory Surgical Center	020 – Ambulatory Surgical Center	Not Applicable
03 – Extended Care Facility	030 – Nursing Facility 031 – Intermediate Care Facility for Individuals with Intellectual Disabilities 032 – Pediatric Nursing Facility 033 – Residential Care Facility	Not Applicable
03 – Extended Care Facility	034 – Psychiatric Residential Treatment Facility	Not Applicable
04 – Rehabilitation Facility	034 – Psychiatric Residential Treatment Facility	Not Applicable
04 – Rehabilitation Facility	040 – Rehabilitation Facility	Not Applicable
04 – Rehabilitation Facility	041 – Comprehensive Outpatient Rehabilitation Facility	Not Applicable
05 – Home Health Agency	050 – Home Health Agency	Not Applicable
06 – Hospice	060 – Hospice	Not Applicable
08 – Clinic	080 – Federally Qualified Health Center	Not Applicable
08 – Clinic	081 – Rural Health Clinic	Not Applicable

Table B-1. FSSA Indiana Health Care Plan Provider Enrollment Type and Specialty Matrix		
Provider Type Code and Description	**Provider Specialty Code and Description**	**Provider Secondary Specialty**
08 – Clinic	082 – Medical Clinic	Not Applicable
08 – Clinic	083 – Family Planning Clinic	Not Applicable
08 – Clinic	084 – Nurse Practitioner Clinic	Not Applicable
08 – Clinic	086 – Dental Clinic	Not Applicable
08 – Clinic	087 – Therapy Clinic	Not Applicable
08 – Clinic	088 – Birthing Center	Not Applicable
09 – Advanced Practice Registered Nurse	090 – Pediatric Nurse Practitioner 091 – Obstetric Nurse Practitioner 092 – Family Nurse Practitioner 093 – Clinical Nurse Specialist 094 – Certified Registered Nurse Anesthetist 095 – Certified Nurse Midwife	Not Applicable
10 – Physician Assistant	100 – Physician Assistant	Not Applicable
11 – Behavioral Health Provider	110 – Outpatient Mental Health Clinic	Not Applicable
11 – Behavioral Health Provider	111 – Community Mental Health Center	Not Applicable
11 – Behavioral Health Provider	114 – Health Service Provider in Psychology	Not Applicable
11 – Behavioral Health Provider	115 – Adult Mental Health and Habilitation Service Provider	Not Applicable
11 – Behavioral Health Provider	611 – Child Mental Health Wraparound Service Provider	Not Applicable
11 – Behavioral Health Provider	612 – Behavioral and Primary Healthcare Coordination	Not Applicable
11 – Behavioral Health Provider	613 – MRO Clubhouse	Not Applicable
11 – Behavioral Health Provider	615 – Applied Behavior Analysis Therapist	Not Applicable
11 – Behavioral Health Provider	616 – Licensed Psychologist	Not Applicable

Table B-1. FSSA Indiana Health Care Plan Provider Enrollment Type and Specialty Matrix

Provider Type Code and Description	Provider Specialty Code and Description	Provider Secondary Specialty
11 – Behavioral Health Provider	617 – Licensed Independent Practice School Psychologist	Not Applicable
11 – Behavioral Health Provider	618 – Licensed Clinical Social Worker	Not Applicable
11 – Behavioral Health Provider	619 – Licensed Marriage and Family Therapist	Not Applicable
11 – Behavioral Health Provider	620 – Licensed Mental Health Counselor	Not Applicable
11 – Behavioral Health Provider	621 – Licensed Clinical Addiction Counselor	Not Applicable
11 – Behavioral Health Provider	622 – Mobile Crisis Unit	Not Applicable
11 – Behavioral Health Provider	623 – Certified Community Behavioral Health Clinic	Not Applicable
11 – Behavioral Health Provider	624 – Applied Behavior Analysis Therapist (Bachelors)	Not Applicable
11 – Behavioral Health Provider	625 – Applied Behavior Analysis Therapist	Not Applicable
11 – Behavioral Health Provider	835 – Opioid Treatment Program	Not Applicable
11 – Behavioral Health Provider	636 – Substance Use Disorder Residential Addiction Treatment Facility	Not Applicable
12 – School Corporation	120 – School Corporation	Not Applicable
13 – Public Health Agency	130 – County Health Department	Not Applicable
14 – Podiatrist	140 – Podiatrist	Not Applicable
15 – Chiropractor	150 – Chiropractor	Not Applicable
17 – Therapist	170 – Physical Therapist 171 – Occupational Therapist 173 – Speech/Hearing Therapist	Not Applicable
18 – Optometrist	180 – Optometrist	Not Applicable
19 – Optician	190 – Optician	Not Applicable
20 – Audiologist	200 – Audiologist	Not Applicable

Table B-1. FSSA Indiana Health Care Plan Provider Enrollment Type and Specialty Matrix		
Provider Type Code and Description	**Provider Specialty Code and Description**	**Provider Secondary Specialty**
22 – Hearing Aid Dealer	220 – Hearing Aid Dealer	Not Applicable
24 – Pharmacy	240 – Pharmacy 250 – Durable Medical Equipment (DME)/Medical Supply Dealer 251 – Home Medical Equipment	Not Applicable
24 – Pharmacy	241 – Pharmacist	Not Applicable
25 – DME/Medical Supply Dealer	250 – DME/Medical Supply Dealer	Not Applicable
25 – DME/Medical Supply Dealer	251 – Home Medical Equipment	Not Applicable
25 – DME/Medical Supply Dealer	252 – Donor Milk Bank	Not Applicable
26 – Transportation Provider	260 – Ambulance	Not Applicable
26 – Transportation Provider	261 – Air Ambulance	Not Applicable
26 – Transportation Provider	262 – Bus	Not Applicable
26 – Transportation Provider	236 – Taxi	Not Applicable
26 – Transportation Provider	264 – Common Carrier (Ambulatory) 265 – Common Carrier (Non-Ambulatory)	Not Applicable
26 – Transportation Provider	266 – Family Member	Not Applicable
26 – Transportation Provider	267 – Transportation Network Company	Not Applicable
26 – Transportation Provider	269 – Broker Fleet	Not Applicable
27 – Dentist	270 – Endodontist 271 – General Dentistry Practitioner 272 – Oral Surgeon 273 – Orthodontist 274 – Pediatric Dentist 275 – Periodontist 277 – Prosthesis	Not Applicable

Table B-1. FSSA Indiana Health Care Plan Provider Enrollment Type and Specialty Matrix		
Provider Type Code and Description	**Provider Specialty Code and Description**	**Provider Secondary Specialty**
27 – Dentist	276 – Mobile Dental Van	Not Applicable
28 – Laboratory	280 – Independent Lab	Not Applicable
28 – Laboratory	281 – Mobile Lab	Not Applicable
28 – Laboratory	282 – Independent Diagnostic Testing Facility	Not Applicable
28 – Laboratory	283 – Mobile Independent Diagnostic Testing Facility	Not Applicable
29 – Radiology	290 – Freestanding X-Ray Clinic 291 – Mobile X-Ray Clinic	Not Applicable
30 – End-Stage Renal Disease Clinic	300 – Freestanding Renal Dialysis Clinic	Not Applicable
31 – Physician	310 – Allergist 311 – Anesthesiologist 312 – Cardiologist 313 – Cardiovascular Surgeon 314 – Dermatologist 315 – Emergency Medicine Practitioner 316 – Family Practitioner 317 – Gastroenterologist 318 – General Practitioner 319 – General Surgeon 320 – Geriatric Practitioner 321 – Hand Surgeon 323 – Neonatologist 324 – Nephrologist 325 – Neurological Surgeon 326 – Neurologist 327 – Nuclear Medicine Practitioner 328 – Obstetrician/Gynecologist 329 – Oncologist 330 – Ophthalmologist 331 – Orthopedic Surgeon 332 – Otologist, Laryngologist, Rhinologist 333 – Pathologist 334 – Pediatric Surgeon	Not Applicable

Table B-1. FSSA Indiana Health Care Plan Provider Enrollment Type and Specialty Matrix

Provider Type Code and Description	Provider Specialty Code and Description	Provider Secondary Specialty
	336 – Physical Medicine and Rehabilitation Practitioner 337 – Plastic Surgeon 338 – Proctologist 339 – Psychiatrist 340 – Pulmonary Disease Specialist 341 – Radiologist 342 – Thoracic Surgeon 343 – Urologist 344 – General Internist 345 – General Pediatrician 346 – Dispensing Physician	
34 – MRT Copy Center	366 – MRT Copy Center	Not Applicable
36 – Genetic Counselor	800 – Genetic Counselor	Not Applicable
37 – Medicare-Only Provider	370 – Medicare-Only Provider	Not Applicable
32 – Waiver Provider	350 – PathWays / Health & Wellness Waiver	A00 – Adult Day Services A01 – Adult Day Services A03 – Adult Family Care 1 A04 – Assisted Living 3 A05 – Attendant Care 2, 3 A06 – Care Management A07 – Community Transition Services A08 – Home Modifications A09 – Integrated Healthcare Coordination A10 – Home Delivered Meals A11 – Home and Community Assistance 3 A12 – Nutritional Supplements A13 – Pest Control A14 – Respite 3 A15 – Participant Directed Attendant Care A16 – Specialized Medical Equipment & Supplies 1, 2 A17 – Transportation 1 A18 – Vehicle Modifications

Table B-1. FSSA Indiana Health Care Plan Provider Enrollment Type and Specialty Matrix		
Provider Type Code and Description	**Provider Specialty Code and Description**	**Provider Secondary Specialty**
		A19 – Personal Emergency Response Systems A20 – Home Modification Assessment A21 – Structured Family Caregiving A22 – Caregiver Coaching and Behavior Management
32 – Waiver Provider	356 – Traumatic Brain Injury Waiver	B00 – Adult Day Services B01 – Adult Day Services B03 – Adult Family Care 1 B04 – Attendant Care 2, 3 B05 – Behavior Management/ Behavior Program & Counseling B06 – Care Management B07 – Community Transition B08 – Home Modifications B09 – Integrated Healthcare Coordination B10 – Home Delivered Meals B11 – Home and Community Assistance 3 B12 – Nutritional Supplements B14 – Personal Emergency Response System B15 – Pest Control B17 – Residential Habilitation and Support B18 – Respite 3 B19 – Specialized Medical Equipment & Supplies1, 2 B21 – Structured Day Program B22 – Supported Employment B23 – Transportation 1 B24 – Vehicle Modifications B25 – Assisted Living 3 B26 – Structured Family Caregiving B27 – Home Modification Assessment
32 – Waiver Provider	359 – Community Integration and Habilitation Waiver	C00 – Adult Day Services (Level 1, 2, 3) C01 – Structured Family Caregiver 1

Table B-1. FSSA Indiana Health Care Plan Provider Enrollment Type and Specialty Matrix		
Provider Type Code and Description	**Provider Specialty Code and Description**	**Provider Secondary Specialty**
		C02 – Behavior Management /Behavior Program & Counseling C03 – Day Habilitation (Group) C04 – Day Habilitation (Individual) C05 – Community Transition Services C06 – Remote Supports 1 Participant C07 – Home Modifications C10 – Facility-Based Support Services C11 – Family and Caregiver Training C12 – Intensive Behavioral Intervention C13 – Music Therapy 1 C14 – Occupational Therapy C15 – Personal Emergency Response Systems C16 – Physical Therapy 1 C17 – Prevocational Services C18 – Psychological Therapy C19 – Recreational Therapy 1 C20 – Rent/Food for Unrelated Live-In Caregiver C21 – Residential Habilitation and Support C22 – Respite 3 C23 – Specialized Medical Equipment & Supplies 1, 2 C24 – Speech/Language Therapy 1 C25 – Extended Services C26 – Transportation Level 1 C27 – Workplace Assistance C28 – Case Management C29 – Transportation Level 2 C30 – Transportation Level 3 C31 – Wellness Coordination C33 – Remote Supports, 2 Participants C34 – Remote Supports, 3 Participants C35 – Remote Supports, 4 Participants C36 – Career Exploration and Planning C37 – Home Modification Assessment

Table B-1. FSSA Indiana Health Care Plan Provider Enrollment Type and Specialty Matrix

Provider Type Code and Description	Provider Specialty Code and Description	Provider Secondary Specialty
32 – Waiver Provider	360 – Family Supports Waiver	D00 – Adult Day Services (Level 1, 2, 3) D01 – Behavior Management /Behavior Program & Counseling D02 – Day Habilitation (Group) D03 – Day Habilitation (Individual) D06 – Facility Based Support Services D07 – Family and Caregiver Training D08 – Intensive Behavioral Intervention D09 – Music Therapy 1 D10 – Occupational Therapy 1 D11 – Personal Emergency Response Systems D12 – Speech/Language Therapy 1 D13 – Physical Therapy 1 D14 – Prevocational Services D15 – Psychological Therapy D16 – Recreational Therapy 1 D17 – Respite 3 D18 – Specialized Medical Equipment & Supplies 1, 2 D19 – Extended Services D20 – Transportation 1 D21 – Workplace Assistance D22 – Case Management D23 – Participant Assistance and Care D24 – Environmental Modification, Install D25 – Environmental Modifications, Maintain D26 – Equipment – Assess/ Inspect/Train D27 – Remote Supports, Equipment D28 – Remote Support, 1 Participant D29 – Remote Support, 2 Participants D30 – Remote Support, 3 Participants D31 – Remote Support, 4 Participants D32 – Transportation, Level 2 D33 – Transportation, Level 3 D34 – Career Exploration and Planning D35 – Home Modification Assessment

Table B-1. FSSA Indiana Health Care Plan Provider Enrollment Type and Specialty Matrix

Provider Type Code and Description	Provider Specialty Code and Description	Provider Secondary Specialty
32 – Waiver Provider	363 – Money Follows the Person	F00 – Adult Day Services (Category 1) F01 – Adult Day Services (Category 2) F02 – Adult Day Services (Category 3) F03 – Adult Family Care F04 – Assisted Living F05 – Attendant Care F06 – Behavior Management/ Behavior Program & Counseling F07 – Case Management F08 – Day Habilitation (Individual) F09 – Day Habilitation (Group) F10 – Community Transition Services F11 – Remote Supports F12 – Home Modifications F15 – Facility Based Support Services F16 – Family and Caregiver Training F17 – Integrated Healthcare Coordination F18 – Home Delivered Meals F19 – Home and Community Assistance F20 – Intensive Behavioral intervention F21 – Music Therapy F22 – Nutritional Supplements F23 – Occupational Therapy F24 – Personal Emergency Response Systems F25 – Pest Control F26 – Physical Therapy F27 – Prevocational Services F28 – Psychological Therapy F29 – Recreational Therapy F30 – Rent/Food for Unrelated Live-In Caregiver F31 – Residential Habilitation and Support F32 – Respite F33 – Participant Directed Home Care F34 – Specialized Medical Equipment & Supplies

Table B-1. FSSA Indiana Health Care Plan Provider Enrollment Type and Specialty Matrix		
Provider Type Code and Description	**Provider Specialty Code and Description**	**Provider Secondary Specialty**
		F35 – Speech/Language Therapy F36 – Structured Day Program F37 – Supported Employment F38 – Transportation F39 – Vehicle Modifications F40 – Workplace Assistance F41 – Home Modification Assessment F42 – Structured Family Caregiving F43 – Wellness Coordination F44 – Extended Services F47 – Career Exploration and Planning

Provider-to-Member Ratios by MCE

Tables B-2 through Table B-4 present the detailed report of provider-to-member ratios for all provider service types having ratio requirements.

Table B-2. Anthem – Provider to Member Ratios			
Service Type	**Actual Ratio**	**Provider Network Standard**	**Percent that Met Target**
Anesthesiologists	1:24	1:5,000	100%
Attendant Care	NR*	1:400	
Behavioral Health Providers	1:54	1:1,000	100%
Cardiologists	1:46	1:5,000	100%
Community Transitions	NR	1:300	
Community Transportation	NR	1:200	
Dentists	1:43	1:2,000	100%

Table B-2. Anthem – Provider to Member Ratios

Service Type	Actual Ratio	Provider Network Standard	Percent that Met Target
Dermatologists	1:214	1:5,000	100%
Endocrinologists	1:293	1:5,000	100%
Gastroenterologists	1:80	1:5,000	100%
General Surgeons	NR	1:5,000	
Geriatrician	1:280	1:5,000	100%
Gynecologists	1:32	1:2,000	100%
Home & Community Assistance	NR	1:400	
Home Delivered Meals	NR	1:200	
Home Health Providers	NR	1:150	
Home Modifications	NR	1:400	
Hospice	NR	1:400	
Infectious Disease Specialists	1:235	1:5,000	100%
Integrated Healthcare Coordination	NR	1:300	
Nephrologists	1:120	1:5,000	100%
Nutritional Supplements	NR	1:400	
Occupational Therapists	NR	1:5,000	
Oncologists	1:71	1:5,000	100%
Ophthalmologists	1:126	1:5,000	100%
Orthopedic Surgeons	1:50	1:5,000	100%

Table B-2. Anthem – Provider to Member Ratios			
Service Type	**Actual Ratio**	**Provider Network Standard**	**Percent that Met Target**
Otolaryngologists	1:131	1:5,000	100%
Personal Emergency Response	NR	1:400	
Pest Control	NR	1:400	
Physical Therapists	NR	1:5,000	
PMPs-Physicians	1:6	1:1,000	100%
Psychiatrists	1:56	1:5,000	100%
Pulmonologists	1:81	1:5,000	100%
Respite	NR	1:150	
Rheumatologists	1:486	1:5,000	100%
Service Coordination	NR	1:300	
Specialized Medical Equipment	NR	1:200	
Structured Family Care	NR	1:400	
Urologists	1:113	1:5,000	100%
Vehicle Modification	NR	1:200	

**Not Reported. Categories were listed in the data standards, but data was not available.*

Table B-3. Humana – Provider to Member Ratios			
Service Type	**Actual Ratio**	**Provider Network Standard**	**Percent that Met Target**
Attendant Care	NR*	1:400	

Table B-3. Humana – Provider to Member Ratios

Service Type	Actual Ratio	Provider Network Standard	Percent that Met Target
Anesthesiologists	1:47	1:5,000	100%
Behavioral Health Providers	1:80	1:1,000	100%
Cardiologists	1:42	1:5,000	100%
Community Transitions	NR	1:300	
Community Transportation	NR	1:200	
Dentists	1:2674	1:2,000	0.00%
Dermatologists	1:197	1:5,000	100%
Endocrinologists	1:200	1:5,000	100%
Extended Facility (Skilled Nursing Facility)	NR	1:400	
Gastroenterologists	1:81	1:5,000	100%
General Surgeons	1:44	1:5,000	100%
Geriatrician	1:429	1:5,000	100%
Gynecologists	1:34	1:2,000	100%
Home & Community Assistance	NR	1:400	
Home Delivered Meals	NR	1:200	
Home Health Providers	NR	1:150	
Home Modifications	NR	1:400	
Hospice	NR	1:400	

Table B-3. Humana – Provider to Member Ratios

Service Type	Actual Ratio	Provider Network Standard	Percent that Met Target
Infectious Disease Specialists	1:212	1:5,000	100%
Integrated Healthcare Coordination	NR	1:300	
Nephrologists	1:112	1:5,000	100%
Nutritional Supplements	NR	1:400	
Occupational Therapists	NR	1:5,000	
Oncologists	1:92	1:5,000	100%
Ophthalmologists	1:102	1:5,000	100%
Orthopedic Surgeons	1:41	1:5,000	100%
Otolaryngologists	1:134	1:5,000	100%
Personal Emergency Response	NR	1:400	
Pest Control	NR	1:400	
Physical Therapists	1:143	1:5,000	100%
PMPs-Physicians	1:12	1:1,000	100%
Psychiatrists	1:48	1:5,000	100%
Pulmonologists	1:94	1:5,000	100%
Respite	NR	1:150	
Rheumatologists	1:318	1:5,000	100%
Service Coordination	NR	1:300	

Table B-3. Humana – Provider to Member Ratios

Service Type	Actual Ratio	Provider Network Standard	Percent that Met Target
Specialized Medical Equipment	NR	1:200	
Structured Family Care	NR	1:400	
Urologists	1:122	1:5,000	100%
Vehicle Modification	NR	1:200	

**Not Reported. Categories were listed in the data standards, but data was not available.*

Table B-4. UHC – Provider to Member Ratios

Service Type	Actual Ratio	Provider Network Standard	Percent that Met Target
Attendant Care	NR*	1:400	
Anesthesiologists	1:42	1:5,000	100%
Behavioral Health Providers	1:11	1:1,000	100%
Cardiologists	1:59	1:5,000	100%
Community Transitions	NR	1:300	
Community Transportation	NR	1:200	
Dentists	NR	1:2,000	
Dermatologists	1:271	1:5,000	100%
Endocrinologists	1:267	1:5,000	100%
Extended Facility (Skilled Nursing Facility)	NR	1:400	

Table B-4. UHC – Provider to Member Ratios

Service Type	Actual Ratio	Provider Network Standard	Percent that Met Target
Gastroenterologists	1:136	1:5,000	100%
General Surgeons	1:61	1:5,000	100%
Geriatrician	1:530	1:5,000	100%
Gynecologists	1:47	1:2,000	100%
Home & Community Assistance	NR	1:400	
Home Delivered Meals	NR	1:200	
Home Health Providers	NR	1:150	
Home Modifications	NR	1:400	
Hospice	NR	1:400	
Infectious Disease Specialists	1:259	1:5,000	100%
Integrated Healthcare Coordination	NR	1:300	
Nephrologists	1:181	1:5,000	100%
Nutritional Supplements	NR	1:400	
Occupational Therapists	NR	1:5,000	
Oncologists	1:109	1:5,000	100%
Ophthalmologists	1:173	1:5,000	100%
Orthopedic Surgeons	1:115	1:5,000	100%
Otolaryngologists	1:205	1:5,000	100%

Table B-4. UHC – Provider to Member Ratios

Service Type	Actual Ratio	Provider Network Standard	Percent that Met Target
Personal Emergency Response	NR	1:400	
Pest Control	NR	1:400	
Physical Therapists	1:283	1:5,000	100%
PMPs-Physicians	1:9	1:1,000	100%
Psychiatrists	1:61	1:5,000	100%
Pulmonologists	1:112	1:5,000	100%
Respite	NR	1:150	
Rheumatologists	1:402	1:5,000	100%
Service Coordination	NR	1:300	
Specialized Medical Equipment	NR	1:200	
Structured Family Care	NR	1:400	
Urologists	1:141	1:5,000	100%
Vehicle Modification	NR	1:200	

**Not Reported. Categories were listed in the data standards, but data was not available.*