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

Due date	Last edited	Edited by	Status
06/29/2023	05/03/2024	Cinthia Gonzales Cruz	Submitted

Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Selected

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Indiana
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Cinthia Gonzales
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	cinthia.gonzalescruz@fssa.in.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Cinthia Gonzales Cruz
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	cinthia.gonzalescruz@fssa.in.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	05/03/2024

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2022
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2022
A6	**Program name** Auto-populated from report dashboard.	Hoosier Healthwise (HHW)

Add plans (A.7)

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

	Indicator	Response
	Plan name	Managed Health Services (MHS) CareSource MDwise Inc Anthem Blue Cross Blue Shield

Add BSS entities (A.8)

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

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

	Indicator	Response
	BSS entity name	Maximus Health Services, Inc

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled.	2,190,884
BI.2	**Statewide Medicaid managed care enrollment** Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or more than one managed care plan.	1,772,237

Topic III. Encounter Data Report

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

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities.	The State and our MCE SIU partners underwent a focused CMS audit on our activities (Summer and early Fall of 2022). We are awaiting draft results from that, but plan on focusing on member eligibility verification based upon feedback we received in our exit interview. Additionally, with the state adopting a new mLTSS model, the LTSS services have started to come under focus.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	7.4 Program Integrity Overpayment Recovery (page 184)
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether	In cases involving wasteful or abusive provider billing or service practices (including overpayments) identified by the OMPP PI Unit, FSSA may recover any identified overpayment directly from the provider or may require

	the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	Contractor to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by the OMPP PI Unit. The OMPP PI Unit may also take disciplinary action against any provider identified by Contractor or the OMPP PI Unit as engaging in inappropriate or abusive billing or service provision practices. If the fraud referral from the MCE generates an action that results in a monetary recovery, the reporting MCE does get a share of the final monetary amount (the contracts does allow for the State and MFCU to retrain the cost of pursuing the final action)
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	The MCEs submit monthly, quarterly, and yearly reports that detail the ongoing activities and status on overpayments. Additionally, members of the PI staff meet with each MCE monthly to discuss ongoing activities.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	The Contractor shall be responsible for verifying member eligibility data and reconciling with capitation payments for each eligible member. The Contractor shall reconcile its eligibility and capitation records monthly. If the Contractor receives either enrollment information or capitation, the Contractor is financially responsible for the member. In accordance with 42 CFR 438.608(c)(3), if the Contractor discovers a discrepancy in eligibility

		or capitation information, the Contractor must notify FSSA and the State fiscal agent within thirty (30) calendar days of discovering the discrepancy and no more than ninety (90) calendar days after FSSA delivers the eligibility records. The Contractor must return any capitation overpayments to FSSA within forty-five (45) calendar days of discovering the discrepancy. If the Contractor receives either enrollment information or capitation for a member, the Contractor is financially responsible for the member. The Contractor must accept enrollment data in electronic format, currently via secure file transfer protocol ("FTP"), as directed by FSSA and as detailed in the Indiana Health Coverage Program Companion Guide – 834 Contractor Benefit Enrollment and Maintenance Transaction ("834 Companion Guide), which shall be updated by FSSA.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state	No

	find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	No
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	The state did not conduct any audits during the contract year, 2022, to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans. The most recent encounter data audit in CY 2020 for the EQR, focused on claims adjudication timeliness as well as encounter timeliness and completeness. (https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/) . The next encounter data audit will be completed CY 2023.

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Indiana has a contract with each MCE: Anthem (PROFESSIONAL SERVICES CONTRACT Contract #69767), MHS (PROFESSIONAL SERVICES CONTRACT Contract #69680), MDwise (#69716), CareSource (#69768))
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2017
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-	Behavioral health Dental Transportation

	service should not be listed here.	
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	In accordance with Federal law (EPSDT), all medically necessary dental services are provided for children under age 21 even if the service is not otherwise covered under Package A (state plan). All medically necessary dental services are provided for children enrolled in Package C even if the service is not otherwise covered under CHIP. For package A members, non-emergency travel is available without prior authorization. For Package C members, Ambulance services for non-emergencies between medical facilities are covered when requested by a participating physician; $10 co-payment applies. Any other non-emergent transportation is not covered. Since all members under 21 receive additional benefits due to EPSDT, there are few differences in dental coverage for HHW members. EPSDT offers coverage for sealants which Package A does not cover and it also allows for more frequent maintenance/cleanings than the state plan.
C1I.5	**Program enrollment** Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	879,366
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	The Public Health Emergency (PHE) for the COVID-19 pandemic continued throughout CY 2022. There were no downgrades to benefits or disenrollment's (unless a member is deceased, voluntarily withdraws, or moves out of state) during this time. Due to this policy, HHW

enrollment has continued to increase every quarter.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Overall data accuracy (as determined through data validation) Other, specify – completeness of claims adjudicated and later submitted as encounters, Contractor must achieve no less than a ninety-seven percent (97%) compliance rate with pre-cycle edits
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract	8.6.3 Encounter Claims Quality, Exhibit 2: Encounter Data Quality Report

	section references, not page numbers.	
C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	6. Encounter Data Quality Report (part of exhibit 2) 7. Non-compliance with Shadow/Encounter Claims Submission Requirements. (part of exhibit 2)
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	Exhibit 2: Non-Financial Incentives
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	Indiana did not identify any barriers during CY2022.

Topic IV. Appeals, State Fair Hearings & Grievances

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

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

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	During CY 2022, the HHW MCEs experienced difficulty meeting the orthodontia standards outlined in their contract. The shortage of orthodontia providers appears to be a statewide issue. MDWISE noted that during their outreach, they received feedback that one reason to not contract with Medicaid was staffing shortages, which limited their bandwidth. The MCEs also experienced difficulty maintaining durable medical equipment, OB/GYN, and home health standards.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	To help the MCEs address gaps in network adequacy, Indiana provides MCE access to the state's IHCP portal. The portal helps the MCE identify IHCP enrolled providers.

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Access measure total count: 30

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

1 / 30

C2.V.2 Measure standard

The contractors shall meet or exceed the following provider-to-member ratio: 1:1,000 for PMPs (includes all physician and advanced practice nurses enrolled as a PMP with the Contractor)

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Member Access to Providers Annual Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

2 / 30

C2.V.2 Measure standard

The contractors shall meet or exceed the following provider-to-member ratio, 1:1,000 for Behavioral Health Providers (excluding physicians, CMHCs, and inpatient)

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Member Access to Providers Annual Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

3 / 30

C2.V.2 Measure standard

The contractors shall meet or exceed the following provider-to-member ratio, 1:2,000 for OB/GYNs

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	STATEWIDE	Adult and pediatric

C2.V.7 Monitoring Methods

Member Access to Providers Annual Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

4 / 30

C2.V.2 Measure standard

The contractors shall meet or exceed the following provider-to-member ratio, 1:2,000 for Pediatricians

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	STATEWIDE	Pediatric

C2.V.7 Monitoring Methods

Member Access to Providers Annual Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

5 / 30

C2.V.2 Measure standard

The contractors shall meet or exceed the following provider-to-member ratio,1:2,000 for Dentists

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
DENTAL	STATEWIDE	Adult and pediatric

C2.V.7 Monitoring Methods

Member Access to Providers Annual Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

6 / 30

C2.V.2 Measure standard

The contractors shall meet or exceed the following provider-to-member ratio, 1:5,000 for Anesthesiology, Cardiology, Endocrinology, Gastroenterology, Nephrology, Ophthalmology, Orthopedic Surgery, General Surgery,Pulmonology, Rheumatology, Psychiatry, Urology, Infectious Disease, Otolaryngology, Oncology, Dermatology, and Physiatry/Rehabilitative

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
SPECIALTY CARE	STATEWIDE	Adult and pediatric

C2.V.7 Monitoring Methods

Member Access to Providers Annual Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

7 / 30

C2.V.2 Measure standard

The transport distance to a hospital from the member's home shall be the usual and customary, not to exceed thirty (30) miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Member Access to Providers Annual Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

8 / 30

C2.V.2 Measure standard

The transport distance to a hospital from the member's home shall be the usual and customary, not to exceed sixty (60) miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Member Access to Providers Annual Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

9 / 30

C2.V.2 Measure standard

The Contractor shall ensure access to PMPs within at least thirty (30) miles of the member's residence.Providers that may serve as PMPs include internal medicine physicians, general practitioners, family medicine physicians, pediatricians, obstetricians, gynecologists, endocrinologists (if primarily engaged in internal medicine), and physician extenders

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	STATEWIDE	Adult and pediatric

C2.V.7 Monitoring Methods

Member Access to Providers Annual Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

10 / 30

C2.V.2 Measure standard

The Contractor shall provide, at a minimum, two providers for each specialty type within sixty (60) miles of the member's residence: Anesthesiologists, Cardiologists, Dentists, Oral Surgeons, Endocrinologists, Gastroenterologists, General surgeons, Hematologists, Nephrologists, Neurologists, OB/GYNs, Occupational therapists, Occupational therapists, Oncologists, Ophthalmologists, Diagnostic testing, Optometrists,

Orthodontists, Orthopedic surgeons, Otolaryngologist, Physical therapists, Psychiatrists, Pulmonologists, Speech therapists, Urologists

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
specialty care	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Member Access to Providers Annual Report, Count of Enrolled Providers Report, Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

11 / 30

C2.V.2 Measure standard

The Contractor shall provide, at a minimum, one specialty provider within ninety (90) miles of the member's residence: Cardiothoracic surgeons, Dermatologists, Infectious disease specialists, Interventional radiologists, neurosurgeons, non-hospital based anesthesiologist, pathologists, radiation oncologists,rheumatologists

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
specialty care	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review, Member Access to Providers Annual Report, Count of Enrolled Providers Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

12 / 30

C2.V.2 Measure standard

Two (2) durable medical equipment providers shall be available to provide services to the Contractor's members in each county

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
equipment provider	county, regardless of size	Adult and pediatric

C2.V.7 Monitoring Methods

Member Access to Providers Annual Report, Count of Enrolled Providers Report, Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

13 / 30

C2.V.2 Measure standard

two home health providers

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
home health	county, regardless of size	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review, Member Access to Providers Annual Report, Count of Enrolled Providers Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

14 / 30

C2.V.2 Measure standard

The Contractor or its PBM must provide at least two (2) pharmacy providers within thirty (30) miles or thirty (30) minutes from a member's residence

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
pharmacy	county, regardless of size	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review, Member Access to Providers Annual Report, Count of Enrolled Providers Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

15 / 30

C2.V.2 Measure standard

Contract with a minimum of 90% of IHCP enrolled Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) located in the State of Indiana.

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

16 / 30

C2.V.2 Measure standard

the Contractor shall provide at least one (1) behavioral health provider within thirty (30) minutes or thirty (30) miles

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review, Member Access to Providers Annual Report, Count of Enrolled Providers Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

17 / 30

C2.V.2 Measure standard

the Contractor shall provide at least one (1) behavioral health provider within forty-five (45) minutes or forty-five (45) miles from the member's home

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review, Member Access to Providers Annual Report, Count of Enrolled Providers Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

18 / 30

C2.V.2 Measure standard

The transport distance to an inpatient psychiatric facility from the member's home shall be the usual and customary, not to exceed sixty (60) miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review, Member Access to Providers Annual Report, Count of Enrolled Providers Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

19 / 30

C2.V.2 Measure standard

The Contractor shall ensure the availability of a MAT provider within thirty (30) miles of the member's residence.

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

20 / 30

C2.V.2 Measure standard

The Contractor shall ensure the availability of a dentist practicing in general, family, and pediatric dentistry within thirty (30) miles of the member's residence. This can include dental providers who provide service within a federally qualified health center (FQHC).

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
dental	statewide	Pediatric

C2.V.7 Monitoring Methods

Plan provider roster review, Member Access to Providers Annual Report, Count of Enrolled Providers Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

21 / 30

C2.V.2 Measure standard

Specialty dentists such as orthodontists and dental surgeons shall be available within sixty (60) miles of the member's residence

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
dental	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review, Member Access to Providers Annual Report, Count of Enrolled Providers Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

22 / 30

C2.V.2 Measure standard

Permit any American Indian or Alaska Native (AI/AN) enrollee who is eligible to receive services from a participating Indian healthcare provider to choose to receive covered services from Indian healthcare providers in and out-of-network. In the event that timely access to Indian healthcare providers in network cannot be guaranteed due to few or no network participating Indian healthcare providers, the sufficiency standard is satisfied if: AI/AN enrollees, living on or off tribal lands, are permitted by the Contractor, to access out-of-state Indian healthcare providers; or This circumstance is deemed a good cause reason under the managed care plan contract for AI/AN enrollees to disenroll from the managed care program into fee-for-service

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Less than annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

23 / 30

C2.V.2 Measure standard

The Contractor shall ensure the availability of one dialysis treatment center within sixty (60) miles of the member's residence

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
specialty care	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review, Member Access to Providers Annual Report, Count of Enrolled Providers Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

24 / 30

C2.V.2 Measure standard

The Contractor shall ensure the availability of at least two OB/GYNs practicing within sixty (60) miles of the member's residence

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	STATEWIDE	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review, Member Access to Providers Annual Report, Count of Enrolled Providers Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

25 / 30

C2.V.2 Measure standard

The Contractor shall ensure the availability of at least one OB/GYNs practicing within thirty (30) miles of the member's residence

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	STATEWIDE	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review, Member Access to Providers Annual Report, Count of Enrolled Providers Report

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

26 / 30

C2.V.2 Measure standard

Contract with a minimum of 90% of IHCP enrolled acute care hospitals located in the State of Indiana

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	STATEWIDE	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

27 / 30

C2.V.2 Measure standard

The Contractor shall have a mechanism in place to ensure that contracted PMPs provide or arrange for coverage of services twenty-four (24)-hours-a day, seven (7)- days-a-week and that PMPs have a mechanism in place to offer members direct contact with their PMP, or the PMP's qualified clinical staff person, through a toll-free telephone number twenty-four (24)-hours-a-day, seven (7)-days-a-week

C2.V.3 Standard type

Hours of operation

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	STATEWIDE	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review, The MCEs must submit a 24-hour availability audit annually.

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

28 / 30

C2.V.2 Measure standard

the Contractor shall establish a network of behavioral health providers, addressing both mental health and addiction, including the following: Outpatient mental health and addiction clinics, Community mental health centers, Licensed clinical addiction counselors, Licensed psychologists, Health services providers in psychology (HSPPs), Licensed clinical social workers, Licensed independent practice school psychologists, Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center, Licensed marital and family therapists; and, Licensed mental health counselors.

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	STATEWIDE	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

29 / 30

C2.V.2 Measure standard

The Contractor shall establish a network of SUD treatment providers that provide the continuum of the American Society of Addiction Medicine (ASAM) levels of care

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	STATEWIDE	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 30 / 30

C2.V.2 Measure standard

FSSA strongly encourages the Contractor to contract or enter into business agreements with any health departments that are willing to coordinate with the Contractor and are able to meet the Contractor's credentialing and service delivery requirements.

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	ENCOURAGED STATEWIDE	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://www.in.gov/medicaid/partners/medicaid-partners/maximus/
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	Member materials must be written at a fifth grade reading level. Alternative formats must be made available; these formats must consider the requirements of the Americans with Disabilities Act and the special needs of those who, for example, may be visually limited or have limited English proficiency.2. If a member calls with their own TTY services, Maximus will accept those calls and handle those calls as they would any other calls. Also, if a member requests TTY services for hearing impaired members maximus will refer them to TTY services that are offered.
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	N/A
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	Oversight of Maximus is completed by a state official that serves as the contract manager. The contract manager ensures that Maximus is completing all the deliverables outlined in the contract and submits quarterly report on their performance. Additionally, Maximus must submit monthly reports to the state, including a performance standard report. This report

		includes data on helpline performance, staff turnover, and timely reporting.

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	Yes

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	**Managed Health Services (MHS)** 202,885 **CareSource** 86,263 **MDwise Inc** 241,219 **Anthem Blue Cross Blue Shield** 348,999
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Managed Health Services (MHS)** 9.26% **CareSource** 3.94% **MDwise Inc** 11.01% **Anthem Blue Cross Blue Shield** 15.93%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a	**Managed Health Services (MHS)** 11.44% **CareSource**

percentage of total Medicaid enrollment in any type of managed care?

- Numerator: Plan enrollment (D1.I.1)
- Denominator: Statewide Medicaid managed care enrollment (B.I.2)

4.87%

MDwise Inc

13.61%

Anthem Blue Cross Blue Shield

19.69%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	**Managed Health Services (MHS)** 84.9% **CareSource** 78.1% **MDwise Inc** 85.5% **Anthem Blue Cross Blue Shield** 84%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Managed Health Services (MHS)** Program-specific statewide **CareSource** Program-specific statewide **MDwise Inc** Program-specific statewide **Anthem Blue Cross Blue Shield** Program-specific statewide
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific	**Managed Health Services (MHS)** N/A **CareSource**

	populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	N/A **MDwise Inc** N/A **Anthem Blue Cross Blue Shield** N/A
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Managed Health Services (MHS)** Yes **CareSource** Yes **MDwise Inc** Yes **Anthem Blue Cross Blue Shield** Yes
N/A	Enter the start date.	**Managed Health Services (MHS)** 01/01/2019 **CareSource** 01/01/2019 **MDwise Inc** 01/01/2019 **Anthem Blue Cross Blue Shield**

		01/01/2019
N/A	Enter the end date.	**Managed Health Services (MHS)** 12/31/2019 **CareSource** 12/31/2019 **MDwise Inc** 12/31/2019 **Anthem Blue Cross Blue Shield** 12/31/2019

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Managed Health Services (MHS)** The Contractor shall submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week, or other date and time as specified by the State. FSSA will use an overall average of calendar month submissions to assess compliance with this encounter claim submission requirement. **CareSource** The Contractor shall submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week, or other date and time as specified by the State. FSSA will use an overall average of calendar month submissions to assess compliance with this encounter claim submission requirement. **MDwise Inc** The Contractor shall submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week, or other date and time as specified by the State. FSSA will use an overall average of calendar month submissions to assess compliance with this encounter claim submission requirement.

		Anthem Blue Cross Blue Shield The Contractor shall submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week, or other date and time as specified by the State. FSSA will use an overall average of calendar month submissions to assess compliance with this encounter claim submission requirement.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	**Managed Health Services (MHS)** N/A **CareSource** N/A **MDwise Inc** N/A **Anthem Blue Cross Blue Shield** N/A
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance?	**Managed Health Services (MHS)** N/A **CareSource** N/A

If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	**MDwise Inc** N/A **Anthem Blue Cross Blue Shield** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved as of the first day of the last month of the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Managed Health Services (MHS)** 386 **CareSource** 180 **MDwise Inc** 318 **Anthem Blue Cross Blue Shield** 381
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Managed Health Services (MHS)** 72 **CareSource** 2 **MDwise Inc** 20 **Anthem Blue Cross Blue Shield** 102
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf	**Managed Health Services (MHS)** N/A **CareSource**

	of LTSS users. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	N/A **MDwise Inc** N/A **Anthem Blue Cross Blue Shield** N/A
D1IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”. Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”. The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in	**Managed Health Services (MHS)** N/A **CareSource** N/A **MDwise Inc** N/A **Anthem Blue Cross Blue Shield** N/A

relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.
To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Managed Health Services (MHS)** 406 **CareSource** 170 **MDwise Inc** 345 **Anthem Blue Cross Blue Shield** 405

D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Managed Health Services (MHS)** 9 **CareSource** 8 **MDwise Inc** 6 **Anthem Blue Cross Blue Shield** 33
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Managed Health Services (MHS)** 362 **CareSource** 170 **MDwise Inc** 352 **Anthem Blue Cross Blue Shield** 426
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that	**Managed Health Services (MHS)** 0 **CareSource** 0

were related to the plan's reduction, suspension, or termination of a previously authorized service.

MDwise Inc

0

Anthem Blue Cross Blue Shield

14

D1IV.6c

Resolved appeals related to payment denial

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.

Managed Health Services (MHS)

53

CareSource

70

MDwise Inc

0

Anthem Blue Cross Blue Shield

0

D1IV.6d

Resolved appeals related to service timeliness

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).

Managed Health Services (MHS)

0

CareSource

0

MDwise Inc

0

Anthem Blue Cross Blue Shield

0

D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Managed Health Services (MHS)** 9 **CareSource** 0 **MDwise Inc** 1 **Anthem Blue Cross Blue Shield** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**Managed Health Services (MHS)** 0 **CareSource** 0 **MDwise Inc** 0 **Anthem Blue Cross Blue Shield** 0
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability**	**Managed Health Services (MHS)** 0

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.

CareSource

0

MDwise Inc

0

Anthem Blue Cross Blue Shield

0

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Managed Health Services (MHS)** 26 **CareSource** 15 **MDwise Inc** 3 **Anthem Blue Cross Blue Shield** 5
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Managed Health Services (MHS)** 255 **CareSource** 126 **MDwise Inc** 0 **Anthem Blue Cross Blue Shield** 23
D1IV.7c	**Resolved appeals related to inpatient behavioral health services**	**Managed Health Services (MHS)** 28

	Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**CareSource** 5 **MDwise Inc** 18 **Anthem Blue Cross Blue Shield** 17
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**Managed Health Services (MHS)** 30 **CareSource** 23 **MDwise Inc** 2 **Anthem Blue Cross Blue Shield** 26
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**Managed Health Services (MHS)** 58 **CareSource** 20 **MDwise Inc** 224

		Anthem Blue Cross Blue Shield 147
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Managed Health Services (MHS)** 0 **CareSource** 1 **MDwise Inc** 0 **Anthem Blue Cross Blue Shield** 0
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	**Managed Health Services (MHS)** N/A **CareSource** N/A **MDwise Inc** N/A **Anthem Blue Cross Blue Shield** N/A
D1IV.7h	**Resolved appeals related to dental services**	**Managed Health Services (MHS)** 18

Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".

CareSource

8

MDwise Inc

93

Anthem Blue Cross Blue Shield

97

D1IV.7i

Resolved appeals related to non-emergency medical transportation (NEMT)

Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".

Managed Health Services (MHS)

0

CareSource

0

MDwise Inc

0

Anthem Blue Cross Blue Shield

0

D1IV.7j

Resolved appeals related to other service types

Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".

Managed Health Services (MHS)

0

CareSource

11

MDwise Inc

13

Anthem Blue Cross Blue Shield

125

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	**Managed Health Services (MHS)** 0 **CareSource** 1 **MDwise Inc** 1 **Anthem Blue Cross Blue Shield** 0
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Managed Health Services (MHS)** 0 **CareSource** 0 **MDwise Inc** 0 **Anthem Blue Cross Blue Shield** 0
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered	**Managed Health Services (MHS)** 0 **CareSource**

	during the reporting year that were adverse for the enrollee.	0 **MDwise Inc** 1 **Anthem Blue Cross Blue Shield** 3
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) prior to reaching a decision.	**Managed Health Services (MHS)** 0 **CareSource** N/A **MDwise Inc** 0 **Anthem Blue Cross Blue Shield** N/A
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A".	**Managed Health Services (MHS)** 6 **CareSource** 6 **MDwise Inc** 1 **Anthem Blue Cross Blue Shield**

	External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	16
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Managed Health Services (MHS)** 4 **CareSource** 7 **MDwise Inc** 11 **Anthem Blue Cross Blue Shield** 22

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Managed Health Services (MHS)** 83 **CareSource** 1,812 **MDwise Inc** 313 **Anthem Blue Cross Blue Shield** 705
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Managed Health Services (MHS)** 0 **CareSource** 148 **MDwise Inc** 27 **Anthem Blue Cross Blue Shield** 69
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the	**Managed Health Services (MHS)** N/A **CareSource**

	reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	N/A **MDwise Inc** N/A **Anthem Blue Cross Blue Shield** N/A
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field.	**Managed Health Services (MHS)** N/A **CareSource** N/A **MDwise Inc** N/A **Anthem Blue Cross Blue Shield** N/A

	Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Managed Health Services (MHS)** 83 **CareSource** 1,812 **MDwise Inc** 313 **Anthem Blue Cross Blue Shield**

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Health Services (MHS)** 0 **CareSource** 0 **MDwise Inc** 0 **Anthem Blue Cross Blue Shield** 18
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Health Services (MHS)** 0 **CareSource** 0 **MDwise Inc** 0 **Anthem Blue Cross Blue Shield** 232
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan	**Managed Health Services (MHS)** 1 **CareSource**

during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".

0

MDwise Inc

0

Anthem Blue Cross Blue Shield

2

D1IV.15d

Resolved grievances related to outpatient behavioral health services

Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".

Managed Health Services (MHS)

1

CareSource

0

MDwise Inc

0

Anthem Blue Cross Blue Shield

14

D1IV.15e

Resolved grievances related to coverage of outpatient prescription drugs

Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".

Managed Health Services (MHS)

0

CareSource

6

MDwise Inc

0

Anthem Blue Cross Blue Shield

7

D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Health Services (MHS)** 0 **CareSource** 0 **MDwise Inc** 0 **Anthem Blue Cross Blue Shield** 0
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Health Services (MHS)** N/A **CareSource** N/A **MDwise Inc** N/A **Anthem Blue Cross Blue Shield** N/A
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan	**Managed Health Services (MHS)** 2

	during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**CareSource** 75 **MDwise Inc** 7 **Anthem Blue Cross Blue Shield** 40
D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Health Services (MHS)** 7 **CareSource** 2 **MDwise Inc** 44 **Anthem Blue Cross Blue Shield** 7
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	**Managed Health Services (MHS)** 72 **CareSource** 1,729 **MDwise Inc** 262

Anthem Blue Cross Blue Shield

385

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Managed Health Services (MHS)** 5 **CareSource** 89 **MDwise Inc** 0 **Anthem Blue Cross Blue Shield** 14
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Managed Health Services (MHS)** 8 **CareSource** 0 **MDwise Inc** 0 **Anthem Blue Cross Blue Shield** 20

D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Managed Health Services (MHS)** 1 **CareSource** 75 **MDwise Inc** 180 **Anthem Blue Cross Blue Shield** 97
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Managed Health Services (MHS)** 3 **CareSource** 0 **MDwise Inc** 16 **Anthem Blue Cross Blue Shield** 46
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that	**Managed Health Services (MHS)** 0 **CareSource** 5

	were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**MDwise Inc** 0 **Anthem Blue Cross Blue Shield** 7
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	**Managed Health Services (MHS)** 5 **CareSource** 870 **MDwise Inc** 56 **Anthem Blue Cross Blue Shield** 252
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row	**Managed Health Services (MHS)** 0 **CareSource** 0 **MDwise Inc** 2

	should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Anthem Blue Cross Blue Shield** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Managed Health Services (MHS)** 0 **CareSource** 0 **MDwise Inc** 0 **Anthem Blue Cross Blue Shield** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Managed Health Services (MHS)** 2 **CareSource** 1 **MDwise Inc** 0 **Anthem Blue Cross Blue Shield** 15

D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Managed Health Services (MHS)** 0 **CareSource** 0 **MDwise Inc** 0 **Anthem Blue Cross Blue Shield** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	**Managed Health Services (MHS)** 59 **CareSource** 772 **MDwise Inc** 59 **Anthem Blue Cross Blue Shield** 254

Topic VII: Quality & Performance Measures

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

Quality & performance measure total count: 6

Complete

D2.VII.1 Measure Name: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 months to 17 years

1 / 6

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0058

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-USING HEDIS

Measure results

Managed Health Services (MHS)

78%

CareSource

82.23%

MDwise Inc

75.82%

Anthem Blue Cross Blue Shield

77.07%

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care: 1. Timeliness of Prenatal Care 2. Postpartum Care

D2.VII.2 Measure Domain

Maternal and perinatal health

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

1517

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-USING HEDIS

Measure results

Managed Health Services (MHS)

1. Timeliness of Prenatal Care: 83.70% 2. Postpartum Care: 82.00

CareSource

1. Timeliness of Prenatal Care: 84.43% 2. Postpartum Care: 84.67%

MDwise Inc

1. Timeliness of Prenatal Care: 81.71 2. Postpartum Care: 81.40%

Anthem Blue Cross Blue Shield

1. Timeliness of Prenatal Care: 83.21% 2. Postpartum Care: 80.54%

Complete

D2.VII.1 Measure Name: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 months to 17 years

3 / 6

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0058

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-USING HEDIS

Measure results

Managed Health Services (MHS)

78%

CareSource

82.23%

MDwise Inc

75.92%

Anthem Blue Cross Blue Shield

77.07%

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: ages 6-17

4 / 6

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-USING HEDIS

Measure results

Managed Health Services (MHS)

7 Days: 41.34% 30 days: 67.81%

CareSource

7 Days: 50.81% 30 days: 75.95%

MDwise Inc

7 Days: 46.54% 30 days: 70.30%

Anthem Blue Cross Blue Shield

7 Days: 48.92% 30 days: 72.89%

Complete

D2.VII.1 Measure Name: ADV-TOTAL

5 / 6

D2.VII.2 Measure Domain

Dental and oral health services

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

1388

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-USING HEDIS

Measure results

Managed Health Services (MHS)

49.95%

CareSource

45.09%

MDwise Inc

50.09%

Anthem Blue Cross Blue Shield

49.36%

Complete

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

6 / 6

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

NA

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

Program-specific rate

D2.VII.6 Measure Set

CAHPS

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

Yes

D2.VII.8 Measure Description

CAHPS (Child): Rating of child's personal doctor (9+10). Question 21.

Measure results

Managed Health Services (MHS)

76.40%

CareSource

78.00%

MDwise Inc

76.90%

Anthem Blue Cross Blue Shield

79.20%

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

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

Sanction total count: 18

Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 18

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

CareSource

D3.VIII.4 Reason for intervention

3 consecutive quarters of inaccurate and incomplete encounter data submission.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

10/19/2022

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

Yes, remediated 01/06/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

2 / 18

D3.VIII.2 Intervention topic

claims errors

D3.VIII.3 Plan name

CareSource

D3.VIII.4 Reason for intervention

MCE was incorrectly billing and requesting payment for drugs subject to the 340b pricing program rebate.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/06/2022

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

3 / 18

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

CareSource

D3.VIII.4 Reason for intervention

Submission of incorrect and inaccurate quarterly encounter data.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$49,200

D3.VIII.7 Date assessed

10/12/2022

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

Yes, remediated 10/19/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

4 / 18

D3.VIII.2 Intervention topic

credentialing timeliness

D3.VIII.3 Plan name

MDwise Inc

D3.VIII.4 Reason for intervention

MDwise did not meet compliance with the credentialing timeliness standards related to the 14 American Senior Communities facilities submitted on May 17, 2021.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/16/2022

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

Yes, remediated 06/07/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

5 / 18

D3.VIII.2 Intervention topic

Timely access

D3.VIII.3 Plan name

MDwise Inc

D3.VIII.4 Reason for intervention

MDwise was placed on a Corrective Action Plan for failure to meet the contractual requirements for the following contractual provision by not adhering to all NCQA standards and appropriate timeframes.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/26/2022

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

Yes, remediated 08/04/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

6 / 18

D3.VIII.2 Intervention topic

Timely access

D3.VIII.3 Plan name

Anthem Blue Cross Blue Shield

D3.VIII.4 Reason for intervention

failed Member Appeals Timeliness. Issue occurred Q2 & Q4 2022. Awaiting Q1 2023 reporting to determine compliance. Anthem placed themselves on a voluntary CAP in 2022, but they have since closed it.

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$4,400

D3.VIII.7 Date assessed

09/07/2022

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

7 / 18

D3.VIII.2 Intervention topic

CLAIMS ERRORS

D3.VIII.3 Plan name

Anthem Blue Cross Blue Shield

D3.VIII.4 Reason for intervention

All MCEs were incorrectly billing and requesting payment for drugs subject to the 340b pricing program rebate.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/06/2022

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

8 / 18

D3.VIII.2 Intervention topic

MEMBER/PROVIDER MATERIAL

D3.VIII.3 Plan name

Anthem Blue Cross Blue Shield

D3.VIII.4 Reason for intervention

Anthem is not doing due diligence and ensuring documents are accurate and formatted correctly before submission to the state for approval

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/15/2022

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

9 / 18

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Anthem Blue Cross Blue Shield

D3.VIII.4 Reason for intervention

Anthem failed Member Grievance Timeliness during Q1 2022

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$3,000

D3.VIII.7 Date assessed

05/23/2022

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

Yes, remediated 05/23/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Suspension of new enrollment

10 / 18

D3.VIII.2 Intervention topic

Inappropriate utilization of IRO

D3.VIII.3 Plan name

MDwise Inc

D3.VIII.4 Reason for intervention

Per our contracts, MCEs must rotate which IRO is used when an independent external review is requested. MDwise came out of compliance with this requirement in Oct. 2020. At that time, they were placed on corrective action, but never implemented the plan. MDwise reported that they had come back into compliance, it was later discovered that this was not the case.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/16/2022

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

Yes, remediated 08/05/2022

D3.VIII.9 Corrective action plan

Yes

D3.VIII.1 Intervention type: Corrective action plan

11 / 18

Complete

D3.VIII.2 Intervention topic
CLAIM ERRORS

D3.VIII.3 Plan name
MDwise Inc

D3.VIII.4 Reason for intervention

All MCEs were incorrectly billing and requesting payment for drugs subject to the 340b pricing program rebate.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
12/06/2022

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 04/19/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

12 / 18

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
MDwise Inc

D3.VIII.4 Reason for intervention

Consecutive quarters of inaccurate or incorrect encounter data submissions.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed

12/01/2022

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

13 / 18

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

MDwise Inc

D3.VIII.4 Reason for intervention

Incorrect or inaccurate encounter data submitted for Q2 & Q3 2023

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/01/2022

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

14 / 18

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
MDwise Inc

D3.VIII.4 Reason for intervention

Incorrect or inaccurate encounter data submitted for Q2 & Q3 2022

Sanction details

D3.VIII.5 Instances of non-compliance
2

D3.VIII.6 Sanction amount
$98,400

D3.VIII.7 Date assessed
02/02/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 04/18/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

15 / 18

D3.VIII.2 Intervention topic
Timely access

D3.VIII.3 Plan name
Managed Health Services (MHS)

D3.VIII.4 Reason for intervention

MHS was late when responding to one IQ for the month of March.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$300

D3.VIII.7 Date assessed

04/05/2022

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

Yes, remediated 04/12/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

16 / 18

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Managed Health Services (MHS)

D3.VIII.4 Reason for intervention

Contractor did not meet quality metrics for member appeals outlined in contract during Q1 reporting.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$2,200

D3.VIII.7 Date assessed

06/02/2022

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

Yes, remediated 06/22/2022

D3.VIII.9 Corrective action plan

Yes

D3.VIII.1 Intervention type: Corrective action plan

17 / 18

Complete

D3.VIII.2 Intervention topic
noncompliance

D3.VIII.3 Plan name
Managed Health Services (MHS)

D3.VIII.4 Reason for intervention

During the MHS July Readiness Review Onsite, it was identified that MHS was noncompliant with the IRO timeline expectations.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
08/04/2022

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 11/18/2022

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

18 / 18

D3.VIII.2 Intervention topic
NONCOMPLIANCE

D3.VIII.3 Plan name
Managed Health Services (MHS)

D3.VIII.4 Reason for intervention

All MCEs were incorrectly billing and requesting payment for drugs subject to the 340b pricing program rebate.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed

12/28/2022

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Managed Health Services (MHS)** 5 **CareSource** 3 **MDwise Inc** 5 **Anthem Blue Cross Blue Shield** 8
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**Managed Health Services (MHS)** 92 **CareSource** 38 **MDwise Inc** 23 **Anthem Blue Cross Blue Shield** 110
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened	**Managed Health Services (MHS)** 0.45:1,000 **CareSource**

	by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	0.44:1,000 **MDwise Inc** 0.1:1,000 **Anthem Blue Cross Blue Shield** 0.29:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations have been resolved by the plan in the past year?	**Managed Health Services (MHS)** 120 **CareSource** 21 **MDwise Inc** 6 **Anthem Blue Cross Blue Shield** 79
D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**Managed Health Services (MHS)** 0.59:1,000 **CareSource** 0.24:1,000 **MDwise Inc** 0.03:1,000 **Anthem Blue Cross Blue Shield**

0.23:1,000

D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Managed Health Services (MHS)** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **CareSource** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **MDwise Inc** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Anthem Blue Cross Blue Shield** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals	**Managed Health Services (MHS)** 6 **CareSource** 3 **MDwise Inc** 1 **Anthem Blue Cross Blue Shield** 3

D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.1) as the denominator.	**Managed Health Services (MHS)** 0.03:1,000 **CareSource** 0.03:1,000 **MDwise Inc** 0:1,000 **Anthem Blue Cross Blue Shield** 0.01:1,000
D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2).	**Managed Health Services (MHS)** 1. Date: 01/01/2022-12/31/2022 2. Dollar amount: $230,516. Please note that this amount is the overpayment recovered from MHS for HIP, Hoosier Care Connect, and HHW. MHS serves three of IN's managed care programs and the amounts are not differentiated by program as typically providers who commit fraud, waste, or abuse will do so across plans. This also applies to the count of staff, open investigations, resolved investigations, and referrals to the state. 3. The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR: 0 **CareSource** 1. Date: 01/01/2022-12/31/2022 2. Dollar amount: $31,000. Please note that this amount is the overpayment recovered from CareSource for HIP, and HHW. CareSource serves two of our managed care programs and the amounts

are not differentiated by program as typically providers who commit fraud, waste, or abuse will do so across plans. This also applies to the count of staff, open investigations, resolved investigations, and referrals to the state. 3. The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR: 0

MDwise Inc

1. Date: 01/01/2022-12/31/2022 2. Dollar amount: $918,890.05. Please note that this amount is the overpayment recovered from MDwise for HIP and HHW. MDwise serves two of our managed care programs and the amounts are not differentiated by program as typically providers who commit fraud, waste, or abuse will do so across plans. This also applies to the count of staff, open investigations, resolved investigations, and referrals to the state. 3. The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR: 0

Anthem Blue Cross Blue Shield

1. Date: 01/01/2022-12/31/2022 2. Dollar amount: $659,073.53 Please note that this amount is the overpayment recovered from Anthem for HIP, Hoosier Care Connect, and HHW. Anthem serves three of IN's managed care programs and the amounts are not differentiated by program as typically providers who commit fraud, waste, or abuse will do so across plans. This also applies to the count of staff, open investigations, resolved investigations, and referrals to the state. 3. The ratio of the dollar amount of overpayments

		recovered as a percent of premium revenue as defined in MLR: 0
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Managed Health Services (MHS)** Daily **CareSource** Daily **MDwise Inc** Daily **Anthem Blue Cross Blue Shield** Daily

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

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