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

Due date	Last edited	Edited by	Status
06/29/2025	06/27/2025	Cinthia Gonzales Cruz	Submitted

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

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Indiana
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Cinthia Gonzales
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	cinthia.gonzalescruz@fssa.in.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Cinthia Gonzales Cruz
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	cinthia.gonzalescruz@fssa.in.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	06/27/2025

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2024
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2024
A6	**Program name** Auto-populated from report dashboard.	Healthy Indiana Plan

Add plans (A.7)

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

Indicator	Response
Plan name	Anthem Managed Health Services MDwise CareSource

Add BSS entities (A.8)

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

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for 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

Add In Lieu of Services and Settings (A.9)

Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** Guidance on In Lieu of Services on Medicaid.gov.

Indicator	Response
ILOS name	

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	1,984,569
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	1,576,598

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. If no PI activities were performed, enter “No PI activities were performed during the reporting period” as your response. “N/A” is not an acceptable response.	Since the state implemented a beneficiary verification plan (BVP) with each HIP MCE on 1/1/2024, the MCE's complete monthly and quarterly metrics. The MCEs are required to have a verification process to determine whether services fulfilled by their network providers were received by enrollees. For reporting, the MCEs shall track all attempted verifications and completed verifications.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Section 7.4 Program Integrity Overpayment Recovery
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	In cases involving wasteful or abusive provider billing or service practices (including overpayments) identified by the OMPP PI Unit, FSSA may recover any identified overpayment directly from the provider or may require the MCE to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by the OMPP PI Unit. The OMPP PI Unit may also take disciplinary action against any provider identified by the MCE or the OMPP PI Unit as engaging in inappropriate or abusive billing or service provision practices. If the fraud referral from the MCE generates an

		action that results in a monetary recovery, the reporting MCE does get a share of the final monetary amount (the contract does allow for the State and MFCU to retain the cost of pursuing the final action) . If the State makes a recovery from a fraud investigation and/or corresponding legal action where the MCE has sustained a documented loss but the case did not result from a referral made by the MCE, the State shall not be obligated to repay any monies recovered to the MCE, but may do so at its discretion.
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	The MCEs submit monthly, quarterly, and yearly reports that detail ongoing activities and status of overpayments. Additionally, PI officials meet with each MCE monthly to discuss ongoing activities.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	The Benefit Enrollment and Maintenance (834) file is sent to the health plans on a daily basis to account for changes in status. Additionally, the state sends the health plans a weekly reconciliation file. The MCEs review the files to identify any discrepancies in enrollment. The MCEs are responsible for verifying member eligibility data and reconciling with capitation payments for each eligible member on a monthly basis. If an MCE discovers a discrepancy in eligibility or capitation information, the MCE must notify FSSA and the State fiscal agent within thirty (30) calendar days of discovering the discrepancy and no more than ninety (90) calendar days after FSSA delivers the eligibility records.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider “for cause” terminations in a	Yes

	timely manner under 42 CFR 438.608(a)(4)? Select one.	
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.	No
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter "No such audits were conducted during the reporting year" as your response. "N/A" is not an acceptable response.	FSSA recognizes the importance of monitoring MCE performance throughout the calendar year, and as a result the MCEs are required to submit quarterly encounter data quality reports. Each quarterly report includes year-to-date information and must be verified to a degree of at least ninety-eight percent (98%) completeness for all claims. State actuaries, in collaboration with their MCE officer, review the report to reconcile whether results differ more than (+/-) 2%, which may result in financial penalties.

Topic XIII. Prior Authorization

Beginning June 2026, Indicators B.XIII.1a-b–2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?**	Yes
BXIII.1a	**Timeframes for standard prior authorization decisions** Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and within state-established timeframes. For rating periods that start before January 1, 2026, a state's time frame may not exceed 14 calendar days after receiving the request. For rating periods that start on or after January 1, 2026, a state's time frame may not exceed 7 calendar days after receiving the request. Does the state set timeframes shorter than these maximum timeframes for standard prior authorization requests?	Yes
BXIII.1b	**State's timeframe for standard prior authorization decisions** Indicate the state's maximum timeframe, as number of days, for plans to provide notice of their decisions on standard prior authorization requests.	5
BXIII.2a	**Timeframes for expedited prior authorization decisions** Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and no later than 72 hours after receipt of the request for service. Does the state set timeframes shorter than the maximum timeframe for expedited prior authorization requests?	Yes
BXIII.2b	**State's timeframe for expedited prior authorization decisions** Indicate the state's maximum timeframe, as number of hours, for plans to provide notice of	48

their decisions on expedited
prior authorization requests.

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 separate contract with each MCE: Anthem (#69649), MHS (#69655), MDwise (#69654), CareSource (#69651)
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2017
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-service should not be listed here.	Behavioral health Dental Transportation
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.	For HIP members, only non-expansion population members receive state plan level benefits, including transportation. This includes pregnant members, medically frail, low income-parent caretakers (LIPC) and transitional medical assistance (TMA). These members also receive additional dental coverage over what the expansion population receives. Differences in dental coverage for non-expansion members include oral exams, x-rays, and restorative/corrective services. HIP plus

		beneficiaries receive additional coverage, including dental, vision, chiropractic, over what the HIP basic population receives.
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	704,853
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. If there were no major changes, please enter “There were no major changes to the population or benefits during the reporting year” as your response. “N/A” is not an acceptable response.	During 2024, all cost sharing, including POWER Account Contributions and copays, remains suspended. All members who apply, and are eligible for HIP, will continue to automatically enroll in HIP Plus during this time. Lastly, the COVID-19 PHE unwind was complete effective May 2024.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Overall data accuracy (as determined through data validation) Other, specify – Completeness of encounter claims data
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	8.6. Encounter Data Submission and Exhibit 2B Section 6. Encounter Data Quality Report

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.	Exhibit 2B Section 6. Encounter Data Quality Report and Section 7. Non-compliance with Shadow/Encounter Claims Submission Requirements
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	Exhibit 2B Section 8. 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 year. If there were no barriers, please enter "The state did not experience any barriers to collecting or validating encounter data during the reporting year" as your response. "N/A" is not an acceptable response.	The State did not experience any barriers to collecting or validating encounter data during the reporting year.

Topic IV. Appeals, State Fair Hearings & Grievances

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

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

Topic 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 access standards. If the state and MCPs did not encounter any challenges, please enter "No challenges were encountered" as your response. "N/A" is not an acceptable response.	During 2024, the HIP MCEs encountered challenges maintaining network adequacy for dental specialists, such as orthodontists. Additionally, the MCEs noted that recruiting providers in rural areas, ensuring that specialty providers (including OB/GYNs) and pharmacies meet time/distance standards, and ensuring that providers are updating their availability information have been challenges to maintaining adequate networks and meeting access standards.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	To assist with gaps in the provider networks, Indiana provides the MCEs with access to the State's IHCP portal. The portal allows the MCEs to identify IHCP enrolled providers. Additionally, the State meets with the MCEs on a monthly basis to address and discuss network matters.

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: 25

Complete

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

1 / 25

C2.V.2 Measure standard

The MCEs must meet or exceed the following provider-to-member ratio: 1:1,000 for PMPs

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

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit , Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

2 / 25

C2.V.2 Measure standard

The MCEs must meet or exceed the following provider-to-member ratio, 1:1,000 for Behavioral Health Providers

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

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit, Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

3 / 25

C2.V.2 Measure standard

The MCEs must 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
Primary care	Statewide	Adult

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit, Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

4 / 25

C2.V.2 Measure standard

The MCEs contract with a minimum of 90% of IHCP enrolled Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) within the state

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

C2.V.7 Monitoring Methods

Geomapping, Member Access to Providers Report, Provider Directory Audit

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

5 / 25

C2.V.2 Measure standard

The MCE must 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

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit, Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

6 / 25

C2.V.2 Measure standard

The MCE must 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

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit, Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

7 / 25

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

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit, Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

8 / 25

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

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit, Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

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C2.V.2 Measure standard

The MCEs 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, 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

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit, Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

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C2.V.2 Measure standard

The MCEs 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

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit, Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

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C2.V.2 Measure standard

Two (2) durable medical equipment providers shall be available to provide services to the MCEs members

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Ancillary provider	County (regardless of size)	Adult

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit, Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

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C2.V.2 Measure standard

The MCEs shall contract with 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
Ancillary provider	County (regardless of size)	Adult

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit, Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

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C2.V.2 Measure standard

The MCE or its Pharmacy Benefits Manager (PBM) shall 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 providers or maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacy	County	Adult

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit , Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

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C2.V.2 Measure standard

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

C2.V.3 Standard type

Maximum time to travel

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

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit, Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

15 / 25

C2.V.2 Measure standard

The MCEs 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

Maximum distance to travel

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

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit, Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

16 / 25

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

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit, Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

17 / 25

C2.V.2 Measure standard

The MCEs shall ensure the availability of a Medication-assisted treatment 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

C2.V.7 Monitoring Methods

Geomapping, Member Access to Providers Report, Provider Directory Audit

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

18 / 25

C2.V.2 Measure standard

The MCE shall ensure the availability of a dentist practicing in general, family, and pediatric dentistry 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
Dental	Statewide	Adult

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit, Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

19 / 25

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

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit , Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

20 / 25

C2.V.2 Measure standard

The MCEs 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
Ancillary providers	Statewide	Adult

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit , Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

21 / 25

C2.V.2 Measure standard

The MCEs shall ensure the availability of at least two OB/GYNs practicing within sixty (60) miles of the member's residence and 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
Primary care	Statewide	Adult

C2.V.7 Monitoring Methods

Member Access to Providers Report, Provider Directory Audit, Geomapping

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

22 / 25

C2.V.2 Measure standard

The MCEs must contract with a minimum of 90% of IHCP enrolled acute care hospitals

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

C2.V.7 Monitoring Methods

Geomapping, Member Access to Providers Report, Provider Directory Audit

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

23 / 25

C2.V.2 Measure standard

The MCEs must contract with a minimum of 90% of IHCP enrolled Community Mental Health Centers (CMHCs).

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult

C2.V.7 Monitoring Methods

Geomapping, Member Access to Providers Report, Provider Directory Audit

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

24 / 25

C2.V.2 Measure standard

The MCEs must ensure access to PMPs within at least 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
Primary care	Statewide	Adult

C2.V.7 Monitoring Methods

Geomapping, Member Access to Providers Report, Provider directory audit

C2.V.8 Frequency of oversight methods

Member Access to Providers Report (Annual), Provider directory audit (Annual), Geomapping (Adhoc), All completed during contract renewals (readiness review)

Complete

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

25 / 25

C2.V.2 Measure standard

The MCEs shall ensure that members have telephone access to their PMP (or appropriate designate such as a covering physician) in English and Spanish 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

C2.V.7 Monitoring Methods

24-Hour Availability Audit

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(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://www.in.gov/medicaid/partners/medicaid-partners/maximus/
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? 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. 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 their contract manager. The contract manager ensures that Maximus is completing all the deliverables outlined in the contract and reviews quarterly reports submitted with performance metrics. 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).	No

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	**Does this program include MCOs?** If "Yes", please complete the following questions.	Yes
C1XII.5	**Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?** (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	Yes
C1XII.6	**Did the State or MCOs complete the most recent parity analysis(es)?**	State
C1XII.7a	**Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?** (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	No
C1XII.8	**When was the last parity analysis(es) for this program completed?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	11/01/2020
C1XII.9	**When was the last parity analysis(es) for this program**	11/12/2021

	submitted to CMS? States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	
C1XII.10a	**In the last analysis(es) conducted, were any deficiencies identified?**	No
C1XII.12a	**Has the state posted the current parity analysis(es) covering this program on its website?** The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.	No
C1XII.12c	**When will the state post the current parity analysis(es) on its State Medicaid website in accordance with 42 CFR § 438.920(b)(1)?**	07/14/2025

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Anthem** 328,583 **Managed Health Services** 135,425 **MDwise** 158,355 **CareSource** 82,490
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Anthem** 16.6% **Managed Health Services** 6.8% **MDwise** 8% **CareSource** 4.2%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a 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)	**Anthem** 20.8% **Managed Health Services** 8.6% **MDwise** 10% **CareSource** 5.2%

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. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Anthem** 92% **Managed Health Services** 92% **MDwise** 95% **CareSource** 90%
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.	**Anthem** Program-specific statewide **Managed Health Services** Program-specific statewide **MDwise** Program-specific statewide **CareSource** Program-specific statewide
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific 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.	**Anthem** N/A **Managed Health Services** N/A **MDwise** N/A **CareSource** N/A
D1II.3	**MLR reporting period discrepancies**	**Anthem**

	Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	Yes **Managed Health Services** Yes **MDwise** Yes **CareSource** Yes
N/A	Enter the start date.	**Anthem** 01/01/2022 **Managed Health Services** 01/01/2022 **MDwise** 01/01/2022 **CareSource** 01/01/2022
N/A	Enter the end date.	**Anthem** 12/31/2022 **Managed Health Services** 12/31/2022 **MDwise** 12/31/2022 **CareSource** 12/31/2022

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Anthem** The MCE 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. **Managed Health Services** The MCE 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. **MDwise** The MCE 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. **CareSource** The MCE 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.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received	**Anthem** N/A **Managed Health Services** N/A **MDwise** N/A **CareSource** N/A

	from the managed care plan for the reporting year.	
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	**Anthem** N/A **Managed Health Services** N/A **MDwise** N/A **CareSource** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Beginning June 2025, Indicators D1.IV.1a-c must be completed. Submission of this data before June 2025 is optional; if you choose not to respond prior to June 2025, enter "N/A".

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Anthem** 2,153 **Managed Health Services** 1,716 **MDwise** 2,306 **CareSource** 1,109
D1IV.1a	**Appeals denied** Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**Anthem** 1,599 **Managed Health Services** 1,091 **MDwise** 1,383 **CareSource** 863
D1IV.1b	**Appeals resolved in partial favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**Anthem** 50 **Managed Health Services** 13 **MDwise** 5 **CareSource** 8
D1IV.1c	**Appeals resolved in favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee. If you	**Anthem** 504 **Managed Health Services** 612

	choose not to respond prior to June 2025, enter "N/A".	**MDwise** 918 **CareSource** 238
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**Anthem** 105 **Managed Health Services** 64 **MDwise** 111 **CareSource** 0
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter "N/A" if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	**Anthem** 1 **Managed Health Services** N/A **MDwise** N/A **CareSource** N/A
D1IV.4	**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the	**Anthem** N/A **Managed Health Services** N/A **MDwise** N/A **CareSource** N/A

reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A".
The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.
To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

D1IV.5a

Standard appeals for which timely resolution was provided

Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year.
See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.

Anthem

2,049

Managed Health Services

1,662

MDwise

2,283

CareSource

1,058

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 within the reporting year.
See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.

Anthem

96

Managed Health Services

54

MDwise

21

CareSource

42

D1IV.6a

Resolved appeals related to denial of authorization or

Anthem

	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).	2,076 **Managed Health Services** 1,284 **MDwise** 2,303 **CareSource** 631
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Anthem** 77 **Managed Health Services** 260 **MDwise** 0 **CareSource** 1
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Anthem** 0 **Managed Health Services** 170 **MDwise** 1 **CareSource** 477
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Anthem** 0 **Managed Health Services** 0 **MDwise** 0 **CareSource** 0

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

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter “N/A”.	**Anthem** 42 **Managed Health Services** 173 **MDwise** 1 **CareSource** 148
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”.	**Anthem** 380 **Managed Health Services** 711 **MDwise** 48 **CareSource** 197
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter “N/A”.	**Anthem** 288 **Managed Health Services** 144 **MDwise** 16 **CareSource** 33
D1IV.7d	**Resolved appeals related to outpatient behavioral health services**	**Anthem** 410 **Managed 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".	116 **MDwise** 20 **CareSource** 1
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**Anthem** 896 **Managed Health Services** 538 **MDwise** 1,875 **CareSource** 311
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Anthem** 6 **Managed Health Services** 3 **MDwise** 14 **CareSource** 7
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".	**Anthem** 1 **Managed Health Services** N/A **MDwise** N/A **CareSource** N/A
D1IV.7h	**Resolved appeals related to dental services**	**Anthem** 130

	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”.	**Managed Health Services** 31 **MDwise** 214 **CareSource** 11
D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter “N/A”.	**Anthem** 0 **Managed Health Services** 0 **MDwise** 0 **CareSource** 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 paid primarily by Medicaid, enter “N/A”.	**Anthem** 0 **Managed Health Services** 0 **MDwise** 118 **CareSource** 401

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**Anthem** 12 **Managed Health Services** 11 **MDwise** 0 **CareSource** 2
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Anthem** 1 **Managed Health Services** 0 **MDwise** 0 **CareSource** 0
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Anthem** 14 **Managed Health Services** 1 **MDwise** 1 **CareSource** 0
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Anthem** 4 **Managed Health Services** 5 **MDwise** 0 **CareSource**

		2
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Anthem** 20 **Managed Health Services** 24 **MDwise** 3 **CareSource** 1
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Anthem** 381 **Managed Health Services** 40 **MDwise** 29 **CareSource** 91

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.	**Anthem** 3,015 **Managed Health Services** 799 **MDwise** 657 **CareSource** 4,432
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Anthem** 96 **Managed Health Services** 48 **MDwise** 33 **CareSource** 0
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Anthem** 4 **Managed Health Services** N/A **MDwise** N/A **CareSource** N/A
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number	**Anthem** N/A **Managed Health Services** N/A **MDwise**

	of critical incidents filed within the reporting year 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. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	N/A **CareSource** N/A
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was	**Anthem** 3,012 **Managed Health Services** 799

	provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**MDwise** 656 **CareSource** 4,430

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter “N/A”.	**Anthem** 154 **Managed Health Services** 13 **MDwise** 16 **CareSource** 0
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”.	**Anthem** 1,173 **Managed Health Services** 102 **MDwise** 48 **CareSource** 0
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter “N/A”.	**Anthem** 10 **Managed Health Services** 0 **MDwise** 5 **CareSource** 0
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	**Anthem** 30 **Managed Health Services** 0

	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".	**MDwise** 7 **CareSource** 6
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 112 **Managed Health Services** 29 **MDwise** 9 **CareSource** 233
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 1 **Managed Health Services** 0 **MDwise** 5 **CareSource** 0
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 4 **Managed Health Services** N/A **MDwise** N/A **CareSource** N/A
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does	**Anthem** 492 **Managed Health Services** 25

	not cover this type of service, enter “N/A”.	**MDwise** 98 **CareSource** 0
D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter “N/A”.	**Anthem** 82 **Managed Health Services** 53 **MDwise** 149 **CareSource** 82
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 paid primarily by Medicaid, enter “N/A”.	**Anthem** 957 **Managed Health Services** 577 **MDwise** 320 **CareSource** 4,111

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan’s Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Anthem** 126 **Managed Health Services** 103 **MDwise** 49 **CareSource** 19
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Anthem** 28 **Managed Health Services** 33 **MDwise** 2 **CareSource** 1

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.	**Anthem** 602 **Managed Health Services** 47 **MDwise** 421 **CareSource** 171
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.	**Anthem** 477 **Managed Health Services** 41 **MDwise** 100 **CareSource** 62
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Anthem** 53 **Managed Health Services** 0 **MDwise** 2 **CareSource** 227

D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**Anthem** 927 **Managed Health Services** 47 **MDwise** 82 **CareSource** 1,914
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Anthem** 21 **Managed Health Services** 0 **MDwise** 1 **CareSource** 49
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Anthem** 0 **Managed Health Services** 0 **MDwise** 0 **CareSource** 1
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal**	**Anthem** 47 **Managed Health Services**

	(including requests to expedite or extend appeals) Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	1 **MDwise** 0 **CareSource** 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Anthem** 0 **Managed Health Services** 0 **MDwise** 0 **CareSource** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Anthem** 734 **Managed Health Services** 553 **MDwise** 0 **CareSource** 1,988

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: 50

Complete

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

1 / 50

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0033

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA- using HEDIS

Measure results

Anthem

55.77

Managed Health Services

58.06

MDwise

49.45

CareSource

56.51

Complete

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

2 / 50

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Program-specific rate

D2.VII.6 Measure Set
HEDIS

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

D2.VII.8 Measure Description
NA-HEDIS

Measure results

Anthem
Follow up 30 Day: 41.55; Follow up 7 day: 30.34

Managed Health Services
Follow up 30 Day: 38.26; Follow up 7 day: 29.24

MDwise
Follow up 30 Day: 36.02; Follow up 7 day: 26.16

CareSource
Follow up 30 Day: 44.54; Follow up 7 day: 32.78

Complete

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

3 / 50

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

D2.VII.3 National Quality Forum (NQF) number
N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
CAHPS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2023 - 12/01/2023

D2.VII.8 Measure Description
Rating of Personal (Primary Care) Doctor (9 + 10)

Measure results

Anthem

61.87

Managed Health Services

70.9

MDwise

69.8

CareSource

72.3

Complete

D2.VII.1 Measure Name: Cervical Cancer Screening (CCS)

4 / 50

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0032

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

61.8

Managed Health Services

58.88

MDwise

50.85

CareSource

50.36

Complete

D2.VII.1 Measure Name: Colorectal Cancer Screening (COL-E)

5 / 50

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0034

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

41.72

Managed Health Services

40.47

MDwise

31.97

CareSource

30.19

Complete

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

6 / 50

D2.VII.2 Measure Domain

Primary care access and preventative care

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

2372

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

52.61

Managed Health Services

52.77

MDwise

48.94

CareSource

50.86

Complete

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

D2.VII.2 Measure Domain

Maternal and perinatal health

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

3484

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

Influenza: 24.35; Tdap: 60.09; Combination: 20.84

Managed Health Services

Influenza: 21.37; Tdap: 57.98; Combination: 18.84

MDwise

Influenza: 21.57; Tdap: 58.95; Combination: 18.34

CareSource

Influenza: 24.36; Tdap: 65.74; Combination: 21.88

Complete

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

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0018

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

70.8

Managed Health Services

69.59

MDwise

61.61

CareSource

66.42

Complete

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

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0058

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

43.82

Managed Health Services

42.04

MDwise

47.39

CareSource

47.56

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

0004

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

(Alcohol- Initiation: 47.07, Engagement: 23.12) (Opioid- Initiation: 72.96, Engagement: 53.61) (Other- Initiation: 40.38, Engagement: 20.29) (Total- Initiation: 48.19, Engagement: 26.96)

Managed Health Services

(Alcohol- Initiation: 40.02, Engagement: 19.41) (Opioid- Initiation: 72.6, Engagement: 54.94) (Other- Initiation: 37.89, Engagement: 19.17) (Total- Initiation: 43.30, Engagement: 24.18)

MDwise

(Alcohol- Initiation: 38.78, Engagement: 18.68) (Opioid- Initiation: 65.86, Engagement: 47.39) (Other- Initiation: 35.39, Engagement: 18.35) (Total- Initiation: 41.05, Engagement: 22.84)

CareSource

(Alcohol- Initiation: 42.92, Engagement: 20.51) (Opioid- Initiation: 73.24, Engagement: 56.81) (Other- Initiation: 36.35, Engagement: 21.48) (Total- Initiation: 44.94, Engagement: 27.56)

Complete

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

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

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

Program-specific rate

0071

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

56.83

Managed Health Services

61.54

MDwise

44.12

CareSource

44.19

Complete

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

12 / 50

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0061

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

74.21

Managed Health Services

76.64

MDwise

70.32

CareSource

70.07

Complete

D2.VII.1 Measure Name: Asthma Medication Ratio: Ages 19 to 64 (AMR) 13 / 50

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

1800

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

60.61

Managed Health Services

59.64

MDwise

51.20

CareSource

59.89

Complete

D2.VII.1 Measure Name: Antidepressant Medication Management (AMM)

14 / 50

D2.VII.2 Measure Domain

Behavioral health care

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

0105

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

Acute: 65.84; Continuation: 47.07

Managed Health Services

Acute: 65.23; Continuation: 46.64

MDwise

Acute: 55.42; Continuation: 38.12

CareSource

Acute: 64.34; Continuation: 42.85

Complete

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

15 / 50

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

Follow up 30 Day: 51.99; Follow up 7 day: 32.51

Managed Health Services

Follow up 30 Day: 52.85; Follow up 7 day: 31.36

MDwise

Follow up 30 Day: 41.77; Follow up 7 day: 24.19

CareSource

Follow up 30 Day: 59.59; Follow up 7 day: 38.5

Complete

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

16 / 50

D2.VII.2 Measure Domain

Behavioral health care

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

3489

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

Follow up 30 Day: 47.30; Follow up 7 day: 35.42

Managed Health Services

Follow up 30 Day: 47.53; Follow up 7 day: 36.31

MDwise

Follow up 30 Day: 45.91; Follow up 7 day: 35.67

CareSource

Follow up 30 Day: 56.66; Follow up 7 day: 49.86

Complete

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

17 / 50

D2.VII.2 Measure Domain

Behavioral health care

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

1879

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

50.89

Managed Health Services

55.83

MDwise

45.78

CareSource

47.57

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

1932

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

83.68

Managed Health Services

83.38

MDwise

80.94

CareSource

83.52

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

1934

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

76.29

Managed Health Services

65.00

MDwise

68.00

CareSource

72.73

Complete

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

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0055

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

59.61

Managed Health Services

59.12

MDwise

54.01

CareSource

55.96

Complete

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

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

37.34

Managed Health Services

38.04

MDwise

33.38

CareSource

41.64

Complete

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

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0545

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA- using HEDIS

Measure results

Anthem

Received Therapy: 62.64; Adherence: 70.88

Managed Health Services

Received Therapy: 64.43; Adherence: 72.97

MDwise

Received Therapy: 62.84; Adherence: 50.80

CareSource

Received Therapy: 64.21; Adherence: 70.68

Complete

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

23 / 50

D2.VII.2 Measure Domain

Behavioral health care

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

3400

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

26.05

Managed Health Services

27.30

MDwise

25.67

CareSource

24.04

Complete

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

24 / 50

D2.VII.2 Measure Domain

Behavioral health care

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

1933

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

85.29

Managed Health Services

0

MDwise

66.67

CareSource

60.00

Complete

D2.VII.1 Measure Name: Appropriate Testing for Pharyngitis (CWP) 25 / 50

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0002

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

84.31

Managed Health Services

83.20

MDwise

83.83

CareSource

84.56

Complete

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

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0052

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

67.41

Managed Health Services

66.21

MDwise

66.36

CareSource

67.37

Complete

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

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0543

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

Received Therapy: 81.07; Adherence: 71.75

Managed Health Services

Received Therapy: 83.42; Adherence: 73.58

MDwise

Received Therapy: 83.81; Adherence: 56.16

CareSource

Received Therapy: 79.13; Adherence: 73.63

Complete

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

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0549

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

Systemic Corticosteroid: 74.11; Bronchodilator: 83.48

Managed Health Services

Systemic Corticosteroid: 77.92; Bronchodilator: 84.08

MDwise

Systemic Corticosteroid: 75.60; Bronchodilator: 80.12

CareSource

Systemic Corticosteroid: 75.00; Bronchodilator: 80.56

Complete

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

29 / 50

D2.VII.2 Measure Domain

Primary care access and preventative care

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

3620

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

Influenza: 12.59; Tdap: 44.47; Zoster: 9.95; Pneumococcal: 66.67

Managed Health Services

Influenza: 8.24; Tdap: 37.89; Zoster: 7.11; Pneumococcal: 100

MDwise

Influenza: 10.43; Tdap: 29.22; Zoster: 8.97; Pneumococcal: 33.33

CareSource

Influenza: 11.32; Tdap: 33.67; Zoster: 12.68; Pneumococcal: 0

Complete

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

30 / 50

D2.VII.2 Measure Domain

Maternal and perinatal health

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

Screening: 16.27; Follow up: 51.20

Managed Health Services

Screening: 12.38; Follow up: 56.57

MDwise

Screening: 0.95; Follow up: 56.52

CareSource

Screening: 60.77; Follow up: 61.73

Complete

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

D2.VII.2 Measure Domain

Maternal and perinatal health

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

Screening: 8.17; Follow up: 66.42

Managed Health Services

Screening: 5.00; Follow up: 86.27

MDwise

Screening: 0.74; Follow up: 58.33

CareSource

Screening: 32.94; Follow up: 79.17

Complete

D2.VII.1 Measure Name: Plan All-Cause Readmissions (PCR)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1768

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

1.0155

Managed Health Services

1.1373

MDwise

1.0481

CareSource

1.1459

Complete

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

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0642

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

Initiation: 12.95; Engagement 1: 11.50; Engagement 2: 7.83; Achievement: 3.48

Managed Health Services

Initiation: 12.5; Engagement 1: 10.66; Engagement 2: 7.35; Achievement: 3.68

MDwise

Initiation: 7.84; Engagement 1: 0; Engagement 2: 0; Achievement: 0

CareSource

Initiation: 17.09; Engagement 1: 15.19; Engagement 2: 9.49; Achievement: 3.8

Complete

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

34 / 50

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

39.18

Managed Health Services

37.11

MDwise

34.25

CareSource

34.89

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A-using HEDIS

Measure results

Anthem

Alcohol: 4.97; Opioid: 6.34; Other: 7.65; Any: 13.42

Managed Health Services

Alcohol: 4.18; Opioid: 4.82; Other: 6.59; Any: 11.31

MDwise

Alcohol: 3.88; Opioid: 5.03; Other: 6.20; Any: 10.91

CareSource

Alcohol: 5.20; Opioid: 6.43; Other: 8.28; Any: 13.80

Complete

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

36 / 50

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

Follow up 30 Days: 69.74; Follow up 7 days: 49.30

Managed Health Services

Follow up 30 Days: 60.88; Follow up 7 days: 35.34

MDwise

Follow up 30 Days: 67.77; Follow up 7 days: 47.65

CareSource

Follow up 30 Days: 69.66; Follow up 7 days: 49.65

Complete

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

37 / 50

D2.VII.2 Measure Domain

Behavioral health care

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

2940

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

2.23

Managed Health Services

2.27

MDwise

1.49

CareSource

1.87

Complete

D2.VII.1 Measure Name: Use of Opioids From Multiple Providers (UOP) 38 / 50

D2.VII.2 Measure Domain

Behavioral health care

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

2950

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

Multiple Prescribers: 20.63; Multiple Pharmacies: 2.22; Multiple Prescribers/Multiple Pharmacies: 1.28

Managed Health Services

Multiple Prescribers: 19.98; Multiple Pharmacies: 1.96; Multiple Prescribers/Multiple Pharmacies: 1.24

MDwise

Multiple Prescribers: 22.41; Multiple Pharmacies: 1.63; Multiple Prescribers/Multiple Pharmacies: 1.19

CareSource

Multiple Prescribers: 22.12; Multiple Pharmacies: 1.59; Multiple Prescribers/Multiple Pharmacies: 1.09

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

Covered 15 or more days: 4.58; Covered 31 or more days: 2.94

Managed Health Services

Covered 15 or more days: 2.64; Covered 31 or more days: 1.19

MDwise

Covered 15 or more days: 2.59; Covered 31 or more days: 0.78

CareSource

Covered 15 or more days: 4.75; Covered 31 or more days: 3.02

Complete

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

40 / 50

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

Screening: 8.07; Follow-up: 69.43

Managed Health Services

Screening: 7.75; Follow-up: 73.82

MDwise

Screening: 0.04; Follow-up: 42.11

CareSource

Screening: 18.16; Follow-up: 62.79

Complete

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

41 / 50

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

11.07

Managed Health Services

12.8

MDwise

0.1

CareSource

9.48

Complete

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

42 / 50

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0069

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

77.02

Managed Health Services

79.50

MDwise

78.82

CareSource

81.47

Complete

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

43 / 50

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

28.02

Managed Health Services

28.29

MDwise

26.11

CareSource

25.37

Complete

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

44 / 50

D2.VII.2 Measure Domain

Primary care access and preventative care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Anthem

75.00

Managed Health Services

73.32

MDwise

70.31

CareSource

69.96

Complete

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

45 / 50

D2.VII.2 Measure Domain

Maternal and perinatal health

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

1517

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Anthem

Timeliness prenatal care: 91.73; Postpartum care: 88.32

Managed Health Services

Timeliness prenatal care: 86.37; Postpartum care: 82.97

MDwise

Timeliness prenatal care: 89.61; Postpartum care: 81.00

CareSource

Timeliness prenatal care: 86.86; Postpartum care: 86.13

Complete

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

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Anthem

Less than 8: 67.15; Greater than 9: 24.82

Managed Health Services

Less than 8: 63.75; Greater than 9: 26.52

MDwise

Less than 8: 56.45; Greater than 9: 33.82

CareSource

Less than 8: 59.61; Greater than 9: 31.14

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Anthem

Follow up: 33.93; Remission: 9.15; Response: 12.39

Managed Health Services

Follow up: 36.17; Remission: 5.24; Response: 9.44

MDwise

Follow up: 10.00; Remission: 10.00; Response: 10.00

CareSource

Follow up: 34.40; Remission: 8.16; Response: 13.83

Complete

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

48 / 50

D2.VII.2 Measure Domain

Dental and oral health services

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

2517

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Anthem

26.00

Managed Health Services

27.24

MDwise

26.37

CareSource

19.91

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Anthem

Screening: 0.12; Follow-up: 1.79

Managed Health Services

Screening: 0.16; Follow-up: 0.00

MDwise

Screening: 0.00; Follow-up: 0.00

CareSource

Screening: 0.00; Follow-up: 0.00

Complete

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

50 / 50

D2.VII.2 Measure Domain

Primary care access and preventative care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Anthem

24.02

Managed Health Services

25.39

MDwise

19.80

CareSource

23.79

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: 12

Complete

D3.VIII.1 Intervention type: Liquidated damages

1 / 12

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

MCE did not meet contract standards for appeals in the Q1 2024 priority reports

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$6,090

D3.VIII.7 Date assessed

06/05/2024

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

Yes, remediated 06/19/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

2 / 12

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

MCE did not meet contract standards for informal disputes (to be resolved within 30 days) and appeals in the Q2 2024 priority reports

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$6,930

D3.VIII.7 Date assessed

09/06/2024

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

Yes, remediated 09/20/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

3 / 12

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

MCE did not meet contract standards for appeals and grievances in the Q3 2024 priority reports

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$8,610

D3.VIII.7 Date assessed

12/13/2024

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

Yes, remediated 01/03/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

4 / 12

D3.VIII.2 Plan performance issue

Contract noncompliance

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Processing of appeals within 30 days as contractually required was not met by MCE for five consecutive quarters

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

05/30/2024

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

Yes, remediated 02/25/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

5 / 12

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

CareSource

D3.VIII.4 Reason for intervention

MCE did not meet contract standards for appeals in the Q3 2024 priority reports

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,460

D3.VIII.7 Date assessed

12/28/2024

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

Yes, remediated 01/06/2025

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

6 / 12

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

CareSource

D3.VIII.4 Reason for intervention

MCE did not meet contract standards for appeals in the Q2 2024 priority reports

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$4,620

D3.VIII.7 Date assessed

09/06/2024

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

Yes, remediated 09/13/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

7 / 12

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

CareSource

D3.VIII.4 Reason for intervention

MCE did not meet metric standards for appeals and grievances in the Q1 2024 priority reports

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$2,310

D3.VIII.7 Date assessed

06/03/2024

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

Yes, remediated 06/11/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

8 / 12

D3.VIII.2 Plan performance issue

Contract noncompliance

D3.VIII.3 Plan name

CareSource

D3.VIII.4 Reason for intervention

MCE received a notice of noncompliance for responding late to internet quorum (IQ) inquiries for February 2024, which is not permitted by their contract.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$400

D3.VIII.7 Date assessed

03/13/2024

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

Yes, remediated 03/27/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

9 / 12

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

MCE did not meet contract standards for member call abandonment, informal disputes, appeals and grievances in the Q3 2024 priority reports

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$18,270

D3.VIII.7 Date assessed

12/18/2024

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

Yes, remediated 12/27/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

10 / 12

D3.VIII.2 Plan performance issue

Timeliness

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

MCE did not respond to State actuaries by the established deadline regarding the Q1 encounter data reconciliation report

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

10/18/2024

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

Yes, remediated 10/21/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

11 / 12

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

MCE did not meet contract standards for informal disputes (to be resolved within 30 days) and grievances in the Q2 2024 priority reports

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$8,610

D3.VIII.7 Date assessed

09/06/2024

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

Yes, remediated 09/19/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

12 / 12

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

MCE did not meet contract standards for informal disputes (to be resolved within 30 days) and appeals in the Q1 2024 priority reports

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$6,930

D3.VIII.7 Date assessed

06/03/2024

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

Yes, remediated 06/17/2024

D3.VIII.9 Corrective action plan

Yes

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Anthem** 10 **Managed Health Services** 4 **MDwise** 7 **CareSource** 4
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Anthem** 198 **Managed Health Services** 114 **MDwise** 15 **CareSource** 66
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Anthem** 0.6:1,000 **Managed Health Services** 0.84:1,000 **MDwise** 0.09:1,000 **CareSource** 0.8:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Anthem** 153 **Managed Health Services** 115 **MDwise** 11 **CareSource**

53

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 to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Anthem** 0.47:1,000 **Managed Health Services** 0.85:1,000 **MDwise** 0.07:1,000 **CareSource** 0.64:1,000
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.	**Anthem** Makes referrals to the SMA and MFCU concurrently **Managed Health Services** Makes referrals to the SMA and MFCU concurrently **MDwise** Makes referrals to the SMA and MFCU concurrently **CareSource** Makes referrals to the SMA and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals.	**Anthem** 9 **Managed Health Services** 4 **MDwise** 4 **CareSource** 1
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in	**Anthem** 0.03:1,000 **Managed Health Services**

	indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.	0.03:1,000 **MDwise** 0.03:1,000 **CareSource** 0.01:1,000
D1X.9a:	**Plan overpayment reporting to the state: Start Date** What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Anthem** 01/01/2024 **Managed Health Services** 01/01/2024 **MDwise** 01/01/2024 **CareSource** 01/01/2024
D1X.9b:	**Plan overpayment reporting to the state: End Date** What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Anthem** 12/31/2024 **Managed Health Services** 12/31/2024 **MDwise** 12/31/2024 **CareSource** 12/31/2024
D1X.9c:	**Plan overpayment reporting to the state: Dollar amount** From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	**Anthem** $722,059.69 **Managed Health Services** $682,306.37 **MDwise** $34,495,308.64 **CareSource** $1,475,837.22
D1X.9d:	**Plan overpayment reporting to the state: Corresponding premium revenue**	**Anthem** $0 **Managed Health Services**

	What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	$0 **MDwise** $0 **CareSource** $0
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Anthem** Daily **Managed Health Services** Daily **MDwise** Daily **CareSource** Daily

Topic XI: ILOS

Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if "Yes", which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter "0" for utilization.

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**Anthem** No ILOSs were offered by this plan **Managed Health Services** No ILOSs were offered by this plan **MDwise** No ILOSs were offered by this plan **CareSource** No ILOSs were offered by this plan

Topic XIII. Prior Authorization

Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If "Yes", please complete the following questions under each plan.	Not reporting data

Topic XIV. Patient Access API Usage

Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If "Yes", please complete the following questions under each plan.	Not reporting data

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

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