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

Due date	Last edited	Edited by	Status
06/28/2024	06/28/2024	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.	06/28/2024

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2023
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2023
A6	**Program name** Auto-populated from report dashboard.	Hoosier Healthwise

Add plans (A.7)

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

Indicator	Response
Plan name	Managed Health Services CareSource MDwise Anthem Blue Cross Blue Shield

Add BSS entities (A.8)

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

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

Indicator	Response
BSS entity name	Maximus Health Services, Inc

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the 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.	2,153,497
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.	1,702,410

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.	The state has implemented a beneficiary verification plan (BVP) with each MCE and its reporting started on 1/1/2024. The MCEs are completing metrics on BVP on a monthly basis and continue reporting on other PI metrics on a quarterly basis. Throughout 2023, the OMPP PI team also assisted other OMPP areas with the 7/1/2024 launch date of the LTSS services.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	7.4 Program Integrity Overpayment Recovery (page 184)

BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether 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 contractor to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by the OMPP PI Unit. The OMPP PI unit may also take disciplinary action against any provider identified by the contractor or the OMPP PI unit as engaging in inappropriate or abusive billing or service provision practices. If the fraud referral from the MCE generates an action that results in a monetary recovery, the reporting MCE does get a share of the final monetary amount (the contracts allow for the State and MFCU to retrain the cost of pursuing the final action).
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment 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 the ongoing activities and status on overpayments. Additionally, members of the PI staff meet with each MCE monthly to discuss ongoing activities.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate	The Benefit Enrollment and Maintenance (834) file is sent to the health plans on a daily basis. Additionally, the state sends the health plans a weekly reconciliation file. The MCEs review the

	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).	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 the 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. The MCE must accept enrollment data in electronic format, currently via secure file transfer protocol ("FTP").
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state 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	No

	of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	No
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, 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.	https://www.in.gov/fssa/ompp/files/OMPP_Technical_Report_2023.pdf

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 (Contract #69649), MHS (Contract #69655), MDwise (#69654), CareSource (#69649)
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	1/1/2017
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-	Behavioral health Dental Transportation

	service should not be listed here.	
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	Since all members under 21 receive additional benefits due to EPSDT, there are few differences in dental coverage for HHW members.
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).	823,541
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.	The continuous enrollment provisions that Indiana Medicaid had been following since March 2020 ended as of March 31, 2023. Regular determinations of coverage began again and actions to adjust, reduce or eliminate coverage were allowed beginning April 1, 2023. Because of the end of the continuous enrollment provisions, Indiana was able to take adverse actions against members, impacting HHW enrollment counts. Regarding benefits, beginning April 1, 2024, OMPP aligned utilization management medical criteria hierarchy.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Overall data accuracy (as determined through data validation) Other, specify – completeness of 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	8.6. Encounter data submission and exhibit 2A (6) Encounter Data Quality Report

	section references, not page numbers.	
C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	6. Encounter Data Quality Report (part of exhibit 2A) 7. Non-compliance with Shadow/Encounter Claims Submission Requirements. (part of exhibit 2A)
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	Exhibit 2: Non-Financial Incentives
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting 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 MCO shall make a decision on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal.
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the	The MCO shall resolve expedited appeals within forty-eight (48) hours after the Contractor receives notice of the appeal.

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

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting 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 CY 2023, the HHW MCEs experienced difficulty meeting the orthodontia standards outlined in their contract.
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 network adequacy, Indiana provides the MCEs access to the state's IHCP portal. The portal allows the MCE to identify IHCP enrolled providers.

Access Measures

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

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

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

Access measure total count: 25

Complete

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

1 / 25

C2.V.2 Measure standard

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

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Member Access to Providers 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 contractors shall 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 and pediatric

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

C2.V.3 Standard type

Provider to enrollee ratios

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

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

C2.V.3 Standard type

Provider to enrollee ratios

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

C2.V.7 Monitoring Methods

Member Access to Providers 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

5 / 25

C2.V.2 Measure standard

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

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

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

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialty care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Member Access to Providers 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 and pediatric

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 and pediatric

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

9 / 25

C2.V.2 Measure standard

The Contractor shall 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 and pediatric

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

10 / 25

C2.V.2 Measure standard

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

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialty care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Member Access to Providers 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

11 / 25

C2.V.2 Measure standard

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

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialty care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

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

12 / 25

C2.V.2 Measure standard

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

C2.V.3 Standard type

Minimum number of network providers

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

C2.V.7 Monitoring Methods

Member Access to Providers 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

13 / 25

C2.V.2 Measure standard

Two (2) home health providers shall be available to provide services to the Contractor's members

C2.V.3 Standard type

Minimum number of network providers

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

C2.V.7 Monitoring Methods

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

14 / 25

C2.V.2 Measure standard

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

C2.V.3 Standard type

Minimum number of network providers

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

C2.V.7 Monitoring Methods

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

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

C2.V.3 Standard type

Minimum number of network providers

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

C2.V.7 Monitoring Methods

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 Contractor 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 and pediatric

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

C2.V.3 Standard type

Minimum number of network providers

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

C2.V.7 Monitoring Methods

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

18 / 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 and pediatric

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

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

C2.V.3 Standard type

Maximum distance to travel

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

C2.V.7 Monitoring Methods

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 20 / 25

C2.V.2 Measure standard

The Contractor shall ensure the availability of a dentist practicing in general, family, and pediatric dentistry within thirty (30) miles of the member's residence.

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental	Statewide	Pediatric

C2.V.7 Monitoring Methods

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

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

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

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

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialty care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

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

23 / 25

C2.V.2 Measure standard

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

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

24 / 25

C2.V.2 Measure standard

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

C2.V.3 Standard type

Minimum number of network providers

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

C2.V.7 Monitoring Methods

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

Contract with a minimum of 90% of IHCP enrolled Community Mental Health Centers (CMHC) located in the State of Indiana.

C2.V.3 Standard type

Minimum number of network providers

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

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)

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

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).	**Managed Health Services** 189,498 **CareSource** 80,758 **MDwise** 223,547 **Anthem Blue Cross Blue Shield** 329,737
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Managed Health Services** 8.8% **CareSource** 3.8% **MDwise** 10.4% **Anthem Blue Cross Blue Shield** 15.3%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a	**Managed Health Services** 11.1% **CareSource**

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

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

4.7%

MDwise

13.1%

Anthem Blue Cross Blue Shield

19.4%

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.	**Managed Health Services** 90% **CareSource** 89% **MDwise** 93% **Anthem Blue Cross Blue Shield** 98%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Managed Health Services** Program-specific statewide **CareSource** Program-specific statewide **MDwise** Program-specific statewide **Anthem Blue Cross Blue Shield** Program-specific statewide
D1II.2	**Population specific MLR description**	**Managed Health Services**

	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.	N/A **CareSource** N/A **MDwise** N/A **Anthem Blue Cross Blue Shield** N/A
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Managed Health Services** Yes **CareSource** Yes **MDwise** Yes **Anthem Blue Cross Blue Shield** Yes
N/A	Enter the start date.	**Managed Health Services** 01/01/2021 **CareSource** 01/01/2021 **MDwise**

		01/01/2021 **Anthem Blue Cross Blue Shield** 01/01/2021
N/A	Enter the end date.	**Managed Health Services** 12/31/2021 **CareSource** 12/31/2021 **MDwise** 12/31/2021 **Anthem Blue Cross Blue Shield** 12/31/2021

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Managed Health Services** The Contractor shall submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week. **CareSource** The Contractor shall submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week. **MDwise** The Contractor shall submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week. **Anthem Blue Cross Blue Shield** The Contractor shall submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week.

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 from the managed care plan for the reporting year.	**Managed Health Services** N/A **CareSource** N/A **MDwise** N/A **Anthem Blue Cross Blue Shield** N/A
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting 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.	**Managed Health Services** N/A **CareSource** N/A **MDwise** N/A **Anthem Blue Cross Blue Shield** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved 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.	**Managed Health Services** 563 **CareSource** 210 **MDwise** 531 **Anthem Blue Cross Blue Shield** 751
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.	**Managed Health Services** 24 **CareSource** 0 **MDwise** 21 **Anthem Blue Cross Blue Shield** 23
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the	**Managed Health Services** N/A

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).

CareSource

N/A

MDwise

N/A

Anthem Blue Cross Blue Shield

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 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

Managed Health Services

N/A

CareSource

N/A

MDwise

N/A

Anthem Blue Cross Blue Shield

N/A

	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.	**Managed Health Services** 552 **CareSource** 195 **MDwise** 517 **Anthem Blue Cross Blue Shield** 724
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	**Managed Health Services** 11 **CareSource** 12

	requirements related to timely resolution of standard appeals.	**MDwise** 14 **Anthem Blue Cross Blue Shield** 22
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Managed Health Services** 518 **CareSource** 152 **MDwise** 531 **Anthem Blue Cross Blue Shield** 738
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.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem Blue Cross Blue Shield** 13

D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Managed Health Services** 45 **CareSource** 58 **MDwise** 0 **Anthem Blue Cross Blue Shield** 0
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem Blue Cross Blue Shield** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's	**Managed Health Services** 0 **CareSource** 0

failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

MDwise

0

Anthem Blue Cross Blue Shield

0

D1IV.6f

Resolved appeals related to plan denial of an enrollee's right to request out-of-network care

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).

Managed Health Services

0

CareSource

0

MDwise

0

Anthem Blue Cross Blue Shield

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.

Managed Health Services

0

CareSource

0

MDwise

0

Anthem Blue Cross Blue Shield

0

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Managed Health Services** 41 **CareSource** 23 **MDwise** 5 **Anthem Blue Cross Blue Shield** 17
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Managed Health Services** 257 **CareSource** 115 **MDwise** 4 **Anthem Blue Cross Blue Shield** 22
D1IV.7c	**Resolved appeals related to inpatient behavioral health services**	**Managed Health Services** 49

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

CareSource

3

MDwise

26

Anthem Blue Cross Blue Shield

111

D1IV.7d

Resolved appeals related to outpatient behavioral health services

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

Managed Health Services

66

CareSource

0

MDwise

1

Anthem Blue Cross Blue Shield

47

D1IV.7e

Resolved appeals related to covered outpatient prescription drugs

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

Managed Health Services

88

CareSource

46

MDwise

302

Anthem Blue Cross Blue Shield

170

D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem Blue Cross Blue Shield** 0
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	**Managed Health Services** N/A **CareSource** N/A **MDwise** N/A **Anthem Blue Cross Blue Shield** N/A
D1IV.7h	**Resolved appeals related to dental services**	**Managed Health Services** 62

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

CareSource

23

MDwise

167

Anthem Blue Cross Blue Shield

200

D1IV.7i

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

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

Managed Health Services

0

CareSource

0

MDwise

0

Anthem Blue Cross Blue Shield

0

D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i paid primarily by Medicaid, enter "N/A".	**Managed Health Services** 0 **CareSource** 0 **MDwise** 26 **Anthem Blue Cross Blue Shield** 184

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.	**Managed Health Services** 3 **CareSource** 0 **MDwise** 1 **Anthem Blue Cross Blue Shield** 5
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem Blue Cross Blue Shield** 1
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered	**Managed Health Services** 1 **CareSource**

	during the reporting year that were adverse for the enrollee.	0 **MDwise** 1 **Anthem Blue Cross Blue Shield** 3
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Managed Health Services** 2 **CareSource** 0 **MDwise** 0 **Anthem Blue Cross Blue Shield** 0
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A".	**Managed Health Services** 8 **CareSource** 6 **MDwise** 0 **Anthem Blue Cross Blue Shield**

	External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	30
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Managed Health Services** 19 **CareSource** 16 **MDwise** 15 **Anthem Blue Cross Blue Shield** 35

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Managed Health Services** 68 **CareSource** 2,198 **MDwise** 229 **Anthem Blue Cross Blue Shield** 887
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.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem Blue Cross Blue Shield** 20
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the	**Managed Health Services** N/A **CareSource**

	reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	N/A **MDwise** N/A **Anthem Blue Cross Blue Shield** N/A
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting 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.	**Managed Health Services** N/A **CareSource** N/A **MDwise** N/A **Anthem Blue Cross Blue Shield** N/A

	Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Managed Health Services** 68 **CareSource** 2,198 **MDwise** 228 **Anthem Blue Cross Blue Shield**

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem Blue Cross Blue Shield** 12
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem Blue Cross Blue Shield** 352
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan	**Managed Health Services** 0 **CareSource**

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

0

MDwise

0

Anthem Blue Cross Blue Shield

1

D1IV.15d

Resolved grievances related to outpatient behavioral health services

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

Managed Health Services

0

CareSource

3

MDwise

1

Anthem Blue Cross Blue Shield

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".

Managed Health Services

5

CareSource

35

MDwise

0

Anthem Blue Cross Blue Shield

D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem Blue Cross Blue Shield** 0
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Health Services** N/A **CareSource** N/A **MDwise** N/A **Anthem Blue Cross Blue Shield** N/A
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan	**Managed Health Services** 7

during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".

CareSource

0

MDwise

8

Anthem Blue Cross Blue Shield

55

D1IV.15i

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

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

Managed Health Services

5

CareSource

5

MDwise

31

Anthem Blue Cross Blue Shield

6

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".

Managed Health Services

51

CareSource

2,155

MDwise

189

Anthem Blue Cross Blue Shield

438

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Managed Health Services** 7 **CareSource** 2 **MDwise** 0 **Anthem Blue Cross Blue Shield** 11
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem Blue Cross Blue Shield** 6

D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Managed Health Services** 4 **CareSource** 94 **MDwise** 71 **Anthem Blue Cross Blue Shield** 84
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Managed Health Services** 1 **CareSource** 2 **MDwise** 7 **Anthem Blue Cross Blue Shield** 50
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that	**Managed Health Services** 2 **CareSource** 164

	were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**MDwise** 0 **Anthem Blue Cross Blue Shield** 16
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.	**Managed Health Services** 7 **CareSource** 997 **MDwise** 35 **Anthem Blue Cross Blue Shield** 331
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,	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0

	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 Blue Cross Blue Shield** 0
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.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem Blue Cross Blue Shield** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved 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).	**Managed Health Services** 5 **CareSource** 0 **MDwise** 0 **Anthem Blue Cross Blue Shield**

9

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.	**Managed Health Services** 0 **CareSource** 0 **MDwise** 0 **Anthem Blue Cross Blue Shield** 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.	**Managed Health Services** 42 **CareSource** 939 **MDwise** 116 **Anthem Blue Cross Blue Shield** 380

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: 48

Complete

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

1 / 48

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0058

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-USING HEDIS

Measure results

Managed Health Services

76.41

CareSource

80.84

MDwise

75.07

Anthem Blue Cross Blue Shield

74.85

Complete

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

D2.VII.2 Measure Domain

Maternal and perinatal health

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

1517

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Timeliness Prenatal Care: 82.48; Postpartum Care: 85.16

CareSource

Timeliness Prenatal Care: 87.59; Postpartum Care: 85.40

MDwise

Timeliness Prenatal Care: 81.92; Postpartum Care: 86.15

Anthem Blue Cross Blue Shield

Timeliness Prenatal Care: 86.86; Postpartum Care: 85.64

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Follow up 30-day: 70.83; Follow up 7-day: 45.53

CareSource

Follow up 30-day: 75.49; Follow up 7-day: 50.11

MDwise

Follow up 30-day: 64.83; Follow up 7-day: 41.89

Anthem Blue Cross Blue Shield

Follow up 30-day: 73.43; Follow up 7-day: 49.95

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

NA

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

Program-specific rate

D2.VII.6 Measure Set

CAHPS

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

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

Measure results

Managed Health Services

73.3

CareSource

76.4

MDwise

77.8

Anthem Blue Cross Blue Shield

75.14

Complete

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

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

Managed Health Services

62.29

CareSource

62.53

MDwise

62.53

Anthem Blue Cross Blue Shield

74.21

Complete

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

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

Managed Health Services

Age 46-50: 14.28

CareSource

Age 46-50: 14.29; Age 51-75: 50.00

MDwise

Age 46-50: 18.18

Anthem Blue Cross Blue Shield

Age 46-50: 21.62; Age 51-75: 75.00

Complete

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

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

Managed Health Services

Age 16-20: 47.85; Age 21-24: 58.49

CareSource

Age 16-20: 41.96; Age 21-24: 56.30

MDwise

Age 16-20: 40.14 ; Age 21-24: 51.42

Anthem Blue Cross Blue Shield

Age 16-20: 44.62; Age 21-24: 58.53

Complete

D2.VII.1 Measure Name: Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)

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

Managed Health Services

0.30

CareSource

0.15

MDwise

0.33

Anthem Blue Cross Blue Shield

0.11

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life (W30)

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

Managed Health Services

Age 15 months: 61.8; Age 15 to 30 months: 71.87

CareSource

Age 15 months: 61.19; Age 15 to 30 months: 70.55

MDwise

Age 15 months: 62.09; Age 15 to 30 months: 66.65

Anthem Blue Cross Blue Shield

Age 15 months: 69.03; Age 15 to 30 months: 70.84

Complete

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

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

Managed Health Services

54.89

CareSource

52.18

MDwise

48.52

Anthem Blue Cross Blue Shield

54.16

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

Managed Health Services

Influenza: 22.84; Tdap: 57.79; Combination: 19.75

CareSource

Influenza: 28.87; Tdap: 68.55; Combination: 26.94

MDwise

Influenza: 26.88; Tdap: 62.13; Combination: 23.09

Anthem Blue Cross Blue Shield

Influenza: 25.08 ; Tdap: 62.43; Combination: 21.37

Complete

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

Managed Health Services

Screening: 13.46; Follow up: 22.73

CareSource

Screening: 56.13; Follow up: 18.75

MDwise

Screening: 0.39; Follow up: 50

Anthem Blue Cross Blue Shield

Screening: 6.54; Follow up: 58.54

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

Managed Health Services

Screening: 4.73; Follow up: 27.78

CareSource

Screening: 32.59; Follow up: 40

MDwise

Screening: 0.12

Anthem Blue Cross Blue Shield

N/A

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

Managed Health Services

Age 13 -17: Initiation: 41.1; Engagement: 13.26 ;Age 18 -64: Initiation: 34.31 ;Engagement: 14.96

CareSource

Age 13 -17: Initiation: 54.82; Engagement: 16.87; Age 18 -64: Initiation: 52.20; Engagement: 23.27

MDwise

Age 13 -17: Initiation: 47.81; Engagement: 15.35; Age 18 -64: Initiation: 40.91; Engagement: 15.50

Anthem Blue Cross Blue Shield

Age 13 -17: Initiation: 51.02; Engagement: 16.07 ;Age 18 -64: Initiation: 37.34; Engagement: 15.80

Complete

D2.VII.1 Measure Name: Asthma Medication Ratio (AMR)

15 / 48

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

Managed Health Services

67.17

CareSource

74.55

MDwise

64.86

Anthem Blue Cross Blue Shield

72.68

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

Managed Health Services

58.90

CareSource

46.94

MDwise

60.18

Anthem Blue Cross Blue Shield

65.19

Complete

D2.VII.1 Measure Name: Hemoglobin A1c Control for Patients With Diabetes (HBD

17 / 48

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0575

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Adequate HbA1c Control: 23.18; Poor HbA1c Control: 71.24

CareSource

Adequate HbA1c Control: 50.82; Poor HbA1c Control: 44.26

MDwise

Adequate HbA1c Control: 38.27; Poor HbA1c Control: 53.37

Anthem Blue Cross Blue Shield

Adequate HbA1c Control: 47.69; Poor HbA1c Control: 42.82

Complete

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

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

Managed Health Services

70.18

CareSource

73.77

MDwise

70.08

Anthem Blue Cross Blue Shield

81.75

Complete

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

19 / 48

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

Managed Health Services

52.63

CareSource

50.82

MDwise

50.94

Anthem Blue Cross Blue Shield

52.55

Complete

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

20 / 48

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

Managed Health Services

Age 18-64: 25.86

CareSource

Age 18-64: 28.33

MDwise

Age 18-64: 22.99

Anthem Blue Cross Blue Shield

Age 18-64: 27.13

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

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

Managed Health Services

Received Therapy: 44.44; Adherence: 75.00

CareSource

Received Therapy: 50.00; Adherence: 0.00

MDwise

Received Therapy: 69.23 ; Adherence: 33.33

Anthem Blue Cross Blue Shield

Received Therapy: 46.15; Adherence: 66.67

Complete

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

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

Managed Health Services

Age 1-17: 23.27; Age 18-64: 26.97

CareSource

Age 1-17: 20.98 ; Age 18-64: 24.96

MDwise

Age 1-17: 25.03; Age 18-64: 24.86

Anthem Blue Cross Blue Shield

Age 1-17: 24.62; Age 18-64: 29.71

Complete

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

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

Managed Health Services

Acute: 57.62; Continuation: 33.97

CareSource

Acute: 48.89; Continuation: 24.44

MDwise

Acute: 50.56; Continuation: 30.59

Anthem Blue Cross Blue Shield

Acute: 60.17; Continuation: 39.52

Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed ADHD Medication (ADD) 24 / 48

D2.VII.2 Measure Domain

Behavioral health care

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

0108

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Initiation: 44.10; Continuation: 50.15

CareSource

Initiation: 48.35; Continuation: 55.73

MDwise

Initiation: 54.90; Continuation: 64.89

Anthem Blue Cross Blue Shield

Initiation: 44.16; Continuation: 52.40

Complete

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

25 / 48

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

Managed Health Services

Age 6-17: Follow up 30 day: 66.40; Follow up 7 day: 46.24; Age 18-64: Follow up 30 day: 51.32 Follow up 7 day: 38.16;

CareSource

Age 6-17: Follow up 30 day: 74.63; Follow up 7 day: 53.73; Age 18-64: Follow up 30 day: 41.67 ;Follow up 7 day: 25

MDwise

Age 6-17: Follow up 30 day: 71.37 ;Follow up 7 day: 56.65; Age 18-64: Follow up 30 day: 53.51; Follow up 7 day: 38.60

Anthem Blue Cross Blue Shield

Age 6-17: Follow up 30 day: 67.59 ;Follow up 7 day: 51.94; Age 18-64: Follow up 30 day: 53.05; Follow up 7 day: 40.24

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

NA-using HEDIS

Measure results

Managed Health Services

(Age 13-17: Alcohol: 0.27 Opioid: 0.06 Other: 1.21 Any: 1.35) (Age 18-64: Alcohol: 0.89 Opioid: 0.61 Other: 2.57 Any: 3.36)

CareSource

(Age 13-17: Alcohol: 0.34 Opioid: 0.06 Other: 1.40 Any: 1.53)(Age 18-64: Alcohol: 0.97 Opioid: 0.63 Other: 2.16 Any: 3.05)

MDwise

(Age 13-17: Alcohol: 0.24 Opioid: 0.04 Other: 1.08 Any: 1.22)(Age 18-64: Alcohol: 0.78 Opioid: 0.50 Other: 2.11 Any: 2.75)

Anthem Blue Cross Blue Shield

(Age 13-17: Alcohol: 0.28 Opioid: 0.06 Other: 1.16 Any: 1.30) (Age 18-64: Alcohol: 0.95 Opioid: 0.74 Other: 2.68 Any: 3.46)

Complete

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

27 / 48

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

Managed Health Services

(Age 13-17: Follow up 30 day: 40.91 Follow up 7 day: 18.18) (Age 18-64: Follow up 30 day: 59.77 Follow up 7 day: 41.38)

CareSource

(Age 13-17: Follow up 30 day: 100) (Age 18-64: Follow up 30 day: 68.42 Follow up 7 day: 52.63)

MDwise

(Age 13-17: Follow up 30 day: 14.29 Follow up 7 day: 7.14) (Age 18-64: Follow up 30 day: 67.42 Follow up 7 day: 52.81)

Anthem Blue Cross Blue Shield

(Age 13-17: Follow up 30 day: 29.17 Follow up 7 day: 4.17) (Age 18-64: Follow up 30 day: 65.82 Follow up 7 day: 53.06)

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use (FUA) 28 / 48

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-using HEDIS

Measure results

Managed Health Services

Follow up 30 day: 33.48 ; Follow up 7 day: 20.60

CareSource

Follow up 30 day: 34.78; Follow up 7 day: 24.64

MDwise

Follow up 30 day: 21.04; Follow up 7 day: 13.59

Anthem Blue Cross Blue Shield

Follow up 30 day: 31.48; Follow up 7 day: 23.97

Complete

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

29 / 48

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

Managed Health Services

Age 16-64: 10

CareSource

Age 16-64: 19.23

MDwise

Age 16-64: 9.09

Anthem Blue Cross Blue Shield

Age 16-64: 12.29

Complete

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

30 / 48

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

Managed Health Services

75.82

CareSource

74.55

MDwise

70.05

Anthem Blue Cross Blue Shield

75.86

Complete

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

31 / 48

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

Managed Health Services

28.57

CareSource

55.56

MDwise

37.14

Anthem Blue Cross Blue Shield

47.83

Complete

D2.VII.1 Measure Name: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

32 / 48

D2.VII.2 Measure Domain

Behavioral health care

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

2800

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Blood Glucose testing: 50.25 Cholesterol testing: 31.86 Blood Glucose testing - Cholesterol testing: 30.04

CareSource

Blood Glucose testing: 28.10 Cholesterol testing: 34.65 Blood Glucose testing - Cholesterol testing: 32.19

MDwise

Blood Glucose testing: 45.88 Cholesterol testing: 28.01 Blood Glucose testing - Cholesterol testing: 26.77

Anthem Blue Cross Blue Shield

Blood Glucose testing: 50.70 Cholesterol testing: 30.43 Blood Glucose testing - Cholesterol testing: 29.41

Complete

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

33 / 48

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

Managed Health Services

Covered 15 or More Days: 0.78 Covered 31 or More Days:0.07

CareSource

Covered 15 or More Days: 1.43

MDwise

Covered 15 or More Days: 0.29 Covered 31 or More Days:0.19

Anthem Blue Cross Blue Shield

Covered 15 or More Days: 0.78 Covered 31 or More Days:0.39

Complete

D2.VII.1 Measure Name: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

34 / 48

D2.VII.2 Measure Domain

Behavioral health care

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

2801

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

55.52

CareSource

59.53

MDwise

60.66

Anthem Blue Cross Blue Shield

57.51

Complete

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

35 / 48

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

Managed Health Services

Age 12-17: Screening: 0.27 Follow up: 33.33 Age 18-64: Screening: 1.94 Follow Up: 36

CareSource

Age 12-17: Screening: 4.16 Follow up: 60 Age 18-64: Screening: 10.75 Follow Up: 15.38

MDwise

Age 12-17: Screening: 0.01 Follow up: 100 Age 18-64: Screening: 0.02 Follow Up: 100

Anthem Blue Cross Blue Shield

N/A

Complete

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

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

Managed Health Services

45.96

CareSource

39.58

MDwise

46.49

Anthem Blue Cross Blue Shield

43.43

Complete

D2.VII.1 Measure Name: Topical Fluoride for Children (TFC)

37 / 48

D2.VII.2 Measure Domain

Dental and oral health services

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

Managed Health Services

10.11

CareSource

8.86

MDwise

10.43

Anthem Blue Cross Blue Shield

9.64

Complete

D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

38 / 48

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0024

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

BMI Percentile: 67.40 Nutrition Counseling: 65.69 Physical Activity Counseling: 61.80

CareSource

BMI Percentile: 68.61 Nutrition Counseling: 61.31 Physical Activity Counseling: 54.99

MDwise

BMI Percentile: 54.74 Nutrition Counseling: 67.88 Physical Activity Counseling: 61.31

Anthem Blue Cross Blue Shield

BMI Percentile: 90.27 Nutrition Counseling: 74.21 Physical Activity Counseling: 70.56

D2.VII.1 Measure Name: Lead Screening in Children (LSC)

Complete

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

Managed Health Services

56.45

CareSource

69.34

MDwise

64.55

Anthem Blue Cross Blue Shield

62.42

Complete

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

40 / 48

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

Managed Health Services

87.7

CareSource

88.36

MDwise

86.53

Anthem Blue Cross Blue Shield

87.90

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

Managed Health Services

65.11

CareSource

66.13

MDwise

67.13

Anthem Blue Cross Blue Shield

70.93

Complete

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

42 / 48

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

Managed Health Services

91.3

CareSource

91.38

MDwise

89.98

Anthem Blue Cross Blue Shield

90.51

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

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

Managed Health Services

100

CareSource

N/A

MDwise

50

Anthem Blue Cross Blue Shield

100

Complete

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

44 / 48

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

Managed Health Services

Age 3m-17: 34.05; Age 18-64: 24.38

CareSource

Age 3m-17: 31.17; Age 18-64: 23.09

MDwise

Age 3m-17: 31.82; Age 18-64: 22.98

Anthem Blue Cross Blue Shield

Age 3m-17: 33.63; Age 18-64: 25.37

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS)

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

Managed Health Services

Dtap: 68.86 IPV: 85.16 MMR: 80.29 HiB: 82 Hepatitis B: 85.16 VZV: 79.56 Pneumococcal Conjugate: 68.37 Hepatitis A: 79.81 Rotavirus: 69.34 Influenza: 33.33 Combo 3: 62.53 Combo 7: 56.20 Combo 10: 27.01

CareSource

Dtap: 72.02 IPV: 87.35 MMR: 85.64 HiB: 85.4 Hepatitis B: 88.08 VZV: 85.89 Pneumococcal Conjugate: 71.78 Hepatitis A: 85.89 Rotavirus: 70.56 Influenza: 33.33 Combo 3: 65.94 Combo 7: 60.10 Combo 10: 26.76

MDwise

Dtap: 63.50 IPV: 81.27 MMR: 79.56 HiB: 77.62 Hepatitis B: 81.51 VZV: 79.32 Pneumococcal Conjugate: 62.77 Hepatitis A: 78.59 Rotavirus: 61.31 Influenza: 29.68 Combo 3: 56.93 Combo 7: 50.36 Combo 10: 21.41

Anthem Blue Cross Blue Shield

Dtap: 71.78 IPV: 87.83 MMR: 85.37 HiB: 85.16 Hepatitis B: 89.54 VZV: 84.43 Pneumococcal Conjugate: 72.02 Hepatitis A: 84.91 Rotavirus:

70.07 Influenza: 29.68 Combo 3: 66.42 Combo 7: 59.12 Combo 10: 25.06

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents (IMA)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1407

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-using HEDIS

Measure results

Managed Health Services

Meningococcal: 84.43 Tdap: 86.13 HPV: 30.14 Combo 1: 83.94 Combo 2: 29.20

CareSource

Meningococcal: 82.48 Tdap: 85.40 HPV: 31.87 Combo 1: 82 Combo 2: 31.39

MDwise

Meningococcal: 85.64 Tdap: 89.05 HPV: 33.09 Combo 1: 85.40 Combo 2: 31.39

Anthem Blue Cross Blue Shield

Meningococcal: 83.72 Tdap: 86.23 HPV: 31.89 Combo 1: 83.22 Combo 2: 30.49

Complete

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

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

Managed Health Services

69.03

CareSource

67.1

MDwise

63.94

Anthem Blue Cross Blue Shield

71.84

Complete

D2.VII.1 Measure Name: Ambulatory Care (AMB)

48 / 48

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

Managed Health Services

Age <1: Outpatient: 8369.12 ED: 1106.75 Age 1-9 Outpatient: 3058.63 ED: 521.32 Age 10-19 Outpatient: 2469.6 ED: 397.06 Age 20-44 Outpatient: 2751.74 ED: 648.73 Age 45-64 Outpatient: 4072.29 ED: 722.89

CareSource

Age <1: Outpatient: 7833.14 ED: 1118.59 Age 1-9 Outpatient: 2747.15 ED: 527.51 Age 10-19 Outpatient: 2028.97 ED: 367.84 Age 20-44 Outpatient: 2558.90 ED: 612.35 Age 45-64 Outpatient: 3611.29 ED: 263.32

MDwise

Age <1: Outpatient: 8397.01 ED: 1105.37 Age 1-9 Outpatient: 2854.26 ED: 523.03 Age 10-19 Outpatient: 2312.76 ED: 393.19 Age 20-44 Outpatient: 2531.64 ED: 632.85 Age 45-64 Outpatient: 3634.07 ED: 435.33

Anthem Blue Cross Blue Shield

Age <1: Outpatient: 8583.35 ED: 1075.63 Age 1-9 Outpatient: 3327.80 ED: 494.24 Age 10-19 Outpatient: 2816.26 ED: 377.84 Age 20-44 Outpatient: 3056.99 ED: 645.82 Age 45-64 Outpatient: 5575.47 ED: 339.62

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: 21

Complete

D3.VIII.1 Intervention type: Liquidated damages

1 / 21

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
Anthem Blue Cross Blue Shield

D3.VIII.4 Reason for intervention

Did not meet metric requirements in the Q4 2022 priority report

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$6,710

D3.VIII.7 Date assessed
03/17/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 04/03/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

2 / 21

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
Anthem Blue Cross Blue Shield

D3.VIII.4 Reason for intervention

Did not meet metric requirements in the Q1 2023 priority report

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$14,700

D3.VIII.7 Date assessed

06/21/2023

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

Yes, remediated 07/05/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

3 / 21

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Anthem Blue Cross Blue Shield

D3.VIII.4 Reason for intervention

Did not meet metric requirements in the Q2 2023 priority report

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$9,240

D3.VIII.7 Date assessed

09/12/2023

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

Yes, remediated 09/26/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

4 / 21

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
CareSource

D3.VIII.4 Reason for intervention

Did not meet metric requirements in the Q4 2022 priority report

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$2,200

D3.VIII.7 Date assessed
03/24/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 04/07/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Warning

5 / 21

D3.VIII.2 Intervention topic
Timeliness

D3.VIII.3 Plan name
CareSource

D3.VIII.4 Reason for intervention

Did not meet timeliness response requirements for IQ

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount
$1,200

1

D3.VIII.7 Date assessed

05/12/2023

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

Yes, remediated 05/23/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

6 / 21

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

CareSource

D3.VIII.4 Reason for intervention

Did not meet metric requirements in the Q1 2023 priority report

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,090

D3.VIII.7 Date assessed

07/11/2023

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

Yes, remediated 07/25/2023

D3.VIII.9 Corrective action plan

Yes

D3.VIII.1 Intervention type: Liquidated damages

7 / 21

Complete

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
CareSource

D3.VIII.4 Reason for intervention

Did not meet metric requirements in the Q2 2023 priority report

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$4,620

D3.VIII.7 Date assessed
09/12/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 09/27/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

8 / 21

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
MDwise

D3.VIII.4 Reason for intervention

Did not meet requirements in the encounter data report Q2 2022

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$98,400

D3.VIII.7 Date assessed

02/03/2023

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

Yes, remediated 02/16/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Warning

9 / 21

D3.VIII.2 Intervention topic

Timeliness

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

Member Electronic Inquiries Response Timeliness

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

03/21/2023

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

Yes, remediated 03/21/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

10 / 21

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
MDwise

D3.VIII.4 Reason for intervention

Did not meet requirements in the encounter data report Q3 2022

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$98,400

D3.VIII.7 Date assessed
04/21/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 05/05/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Warning

11 / 21

D3.VIII.2 Intervention topic
noncompliance

D3.VIII.3 Plan name
MDwise

D3.VIII.4 Reason for intervention

HIPAA password sharing

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$0

D3.VIII.7 Date assessed

05/25/2023

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

Yes, remediated 05/25/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

12 / 21

D3.VIII.2 Intervention topic

contract noncompliance

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

Noncompliance for IQ inquiries, March 2023

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$400

D3.VIII.7 Date assessed

04/04/2023

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

Yes, remediated 04/19/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

13 / 21

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
MDwise

D3.VIII.4 Reason for intervention

Did not meet metric requirements in the Q1 2023 priority report

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$2,310

D3.VIII.7 Date assessed
07/11/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 07/25/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

14 / 21

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
MDwise

D3.VIII.4 Reason for intervention

FQHC encounters- The MCE was submitting incorrect claims to the state, resulting in wrap payments not being paid to FQHCs

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$0

D3.VIII.7 Date assessed

12/01/2023

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

15 / 21

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

Pharmacy rebate refresh - The MCE was not submitting complete and timely reports to OMPPs Pharmacy team to ensure pharmacy rebates were being processed accordingly.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

12/01/2023

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

16 / 21

D3.VIII.2 Intervention topic

noncompliance

D3.VIII.3 Plan name

MDwise

D3.VIII.4 Reason for intervention

CMS complaint- CMS filed a complaint against the MCE regarding the MCEs provider payments. The MCE should have been paying at the NPI instead of the EIN.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

12/01/2023

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

17 / 21

D3.VIII.2 Intervention topic

noncompliance

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

MCE was not utilizing the new PA hierarchy that went into effect on 4/1/2023

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

05/24/2023

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

Yes, remediated 08/22/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

18 / 21

D3.VIII.2 Intervention topic

timeliness

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

Noncompliance for IQ inquiries, June 2023

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$400

D3.VIII.7 Date assessed

07/13/2023

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

Yes, remediated 07/27/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

19 / 21

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
Managed Health Services

D3.VIII.4 Reason for intervention

Did not meet metric requirements in the Q4 2022 priority report

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$4,510

D3.VIII.7 Date assessed
04/04/2023

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

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

20 / 21

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
Managed Health Services

D3.VIII.4 Reason for intervention

Did not meet metric requirements in the Q1 2023 priority report

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount
$6,930

1

D3.VIII.7 Date assessed

06/28/2023

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

Yes, remediated 07/13/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

21 / 21

D3.VIII.2 Intervention topic

noncompliance

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

Noncompliance for IQ inquiries

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$400

D3.VIII.7 Date assessed

12/12/2023

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

Yes, remediated 12/26/2023

D3.VIII.9 Corrective action plan

Yes

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Managed Health Services** 4 **CareSource** 3 **MDwise** 5 **Anthem Blue Cross Blue Shield** 10
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Managed Health Services** 137 **CareSource** 58 **MDwise** 20 **Anthem Blue Cross Blue Shield** 153
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened	**Managed Health Services** 0.72:1,000 **CareSource**

	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.	0.72:1,000 **MDwise** 0.09:1,000 **Anthem Blue Cross Blue Shield** 0.46:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Managed Health Services** 133 **CareSource** 58 **MDwise** 10 **Anthem Blue Cross Blue Shield** 145
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.	**Managed Health Services** 0.7:1,000 **CareSource** 0.72:1,000 **MDwise** 0.04:1,000 **Anthem Blue Cross Blue Shield**

0.44:1,000

D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Managed Health Services** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **CareSource** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **MDwise** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Anthem Blue Cross Blue Shield** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals made during the reporting year.	**Managed Health Services** 3 **CareSource** 4 **MDwise** 2 **Anthem Blue Cross Blue Shield** 9

D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in 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.	**Managed Health Services** 0.02:1,000 **CareSource** 0.05:1,000 **MDwise** 0.01:1,000 **Anthem Blue Cross Blue Shield** 0.03:1,000
D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, at minimum, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 42 CFR 438.8(f)(2).	**Managed Health Services** Date: 01/01/2023-12/31/2023 Overpayment amount: $1,132,375.32 (MCE retained due to capitation) Ratio: 0.0 **CareSource** Date: 01/01/2023-12/31/2023 Overpayment amount: $160,009 (MCE retained due to capitation) Ratio: 0.0 **MDwise** Date: 01/01/2023-12/31/2023 Overpayment Amount: $490,095.71 (MCE retained due to capitation) Ratio: 0.0 **Anthem Blue Cross Blue Shield**

		Date: 01/01/2023-12/31/2023 Overpayment amount: $1,466,789.07 (MCE retained due to capitation) Ratio: 0.0
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Managed Health Services** Daily **CareSource** Daily **MDwise** Daily **Anthem Blue Cross Blue Shield** Daily

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity 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