Hoosier CARE CONNECT

Hoosier Healthwise Health Care Program

HIP HEALTHY INDIANA PLAN

External Quality Review of Indiana's Care Programs: Hoosier Healthwise, Hoosier Care Connect and HIP Review Year Calendar 2017

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FINAL REPORT
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ABBREVIATIONS LIST

Abbreviation	Meaning
AAP	Adult Ambulatory and Preventive Care
ADHD	Attention Deficit Hyperactivity Disorder
ADT	Admission/Discharge/Transfer
ADV	Annual Dental Visit
AMB	Ambulatory Care
AMB-ED	Ambulatory Emergency Department Visit Rate
AOD	Alcohol or Other Drug Dependence
APR-DRG	All Patient Refined Diagnostic Related Grouping
ASM	Use of Appropriate Medications for Members with Asthma
AWP	Average Wholesale Price
B&A	Burns & Associates, Inc.
CCM	Complex Case Management
CDC	Comprehensive Diabetes Care
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHL	Chlamydia Screening
CLAS	Culturally and Linguistically Appropriate Services
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
Core MMIS	Core Medicaid Management Information System
CPT	Current Procedural Terminology
CSR	Customer Service Representative
CY	Calendar Year
DRG	Diagnosis-Related Group
DXC	DXC Technology (OMPP's fiscal agent)
DUR	Drug Utilization Review
ED	Emergency Department
EDW	Enterprise Data Warehouse
EOB	Explanation of Benefits
EPSDT	Early Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ER	Emergency Room
ESI	Express Scripts Inc.
ESSR	EDW Encounter Summary Report
FFS	Fee-For-Service
FPL	Federal Poverty Level
FSSA	Family and Social Services Administration
FUA	Follow-Up Visit After ER Visit
FUH	Follow-Up Visit After Inpatient Psychiatric Hospitalization
FPC	Frequency of Ongoing Prenatal Care
FTE	Full-time Equivalent
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set

Abbreviation	Meaning
IHIE	Indiana Health Information Exchange
HCC	Hoosier Care Connect
HHW	Hoosier Healthwise
HIP	Healthy Indiana Plan 2.0
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HNS	Health Needs Screening
ICD-10	International Statistical Classification of Diseases & Related Health Problems 10th Ed.
IET	Initiation and Engagement of Alcohol & Drug Dependence Treatment
IHCP	Indiana Health Coverage Programs
LPI	Legacy Provider Identifier
MAC	Maximum Allowable Cost
MCE	Managed Care Entity
MCO	Managed Care Organization
MHIN	Michiana Health Information Network
MHS	Managed Health Services
MRO	Medicaid Rehabilitation Option
MTM	Medication Therapy Management
NCPDP	National Council for Prescription Drug Program
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NOP	Notification of Pregnancy
NPI	National Provider Identifier
NR	Not Reported
OB	Obstetrician
OMPP	Office of Medicaid Policy and Planning
P&T	Pharmacy and Therapeutics
P4O	Pay For Outcomes
P4P	Pay for Performance
PA	Prior Authorization
PAD	Physician Administered Drug
PBM	Pharmacy Benefit Manager
PDL	Preferred Drug List
PIPs	Performance Improvement Projects
PMP	Primary Medical Provider
POWER	Personal Wellness and Responsibility Account
QIP	Quality Improvement Project
RCP	Right Choices Program
RID	Medicaid Recipient ID
SAS	Statistical Analysis System
SLA	Service Level Agreement
U&C	Usual and Customary
UCC	Urgent Care Centers
UM	Utilization Management

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EXECUTIVE SUMMARY

The Indiana Family and Social Services Administration's (FSSA's) Office of Medicaid Policy and Planning (OMPP) has responsibility for the administration and oversight of Indiana's Medicaid program under waiver and state plan authorities. There are three risk-based managed care programs in place and each serves a targeted population—Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC).

The **Hoosier Healthwise (HHW)** program began in 1994 with members having the option to voluntarily enroll with a managed care entity (MCE)[1] in 1996. By 2005, enrollment with an MCE was mandatory for select populations, namely, low income families, pregnant women, and children. Most enrollees in Indiana's Children's Health Insurance Program (CHIP), which covers children in families up to 250 percent of the Federal Poverty Level (FPL)[2], are also enrolled in HHW. This program is authorized by a 1932(a) state plan amendment.

The **Healthy Indiana Plan (HIP)** was first created in January 2008 under a separate Section 1115 waiver authority. This program covered two groups of adults with family income up to 200 percent of the FPL. The first group was uninsured custodial parents and caretaker relatives of children eligible for Medicaid or CHIP who were not otherwise eligible for Medicaid or Medicare. The second group was uninsured noncustodial parents and childless adults ages 19 through 64 who were not otherwise eligible for Medicaid or Medicare.

In January 2015, the State received a new Section 1115 demonstration waiver authority from the Centers for Medicare & Medicaid Services (CMS) to change the design of HIP (the original version now referred to as HIP 1.0) to a non-traditional Medicaid model (the new version called HIP 2.0) that effectively terminated HIP 1.0 on January 31, 2015. The HIP 2.0 model is a health insurance program for uninsured adults under 138 percent of the FPL between the ages of 19 and 64. The **Healthy Indiana Plan 2.0 (HIP)** program began February 1, 2015. In addition to the existing HIP 1.0 enrollees, adults from the HHW program (with some exceptions) were transitioned into HIP 2.0. Additionally, individuals in the federal marketplace under 138 percent FPL were allowed to join HIP 2.0 at this time.

The **Hoosier Care Connect (HCC)** program was implemented April 1, 2015 under a 1915(b) waiver authority. Enabling state legislation in Calendar Year (CY) 2013 tasked the FSSA with considering a managed care model for the aged, blind and disabled Medicaid enrollees. This new program means that its predecessor program, Care Select, expired June 30, 2015. Whereas HCC is administered by MCEs, the Care Select program was administered by Care Management Organizations who were not at full risk.

Effective January 1, 2017, the OMPP executed new contracts for the HHW and HIP. Four MCEs are under contract in both these programs. Anthem Insurance Companies, Inc. (Anthem) has been under contract with Indiana Medicaid since 2007. Coordinated Care Corporation, Inc. d/b/a Managed Health Services (MHS) is a subsidiary of the Centene Corporation and has been under contract with Indiana Medicaid since the inception of HHW in 1994. MDwise, Inc. has also been participating in HHW since its inception. MDwise subcontracts the management of services to eight delivery systems. The newest MCE, CareSource, began contracting with the State in January 2017. Anthem and MHS serve members

[1] In Indiana, the term MCE is synonymous with the term managed care organization and will be used as such throughout this report. It refers to those entities that Indiana Medicaid contracts with under a full-risk arrangement. Each MCE is a health maintenance organization (HMO) authorized by the Indiana Department of Insurance.
[2] CHIP children in families up to 150% FPL do not pay a premium. Children in families whose income is between 151% and 250% FPL pay a premium on a sliding scale.

in all three of the OMPP's managed care programs. CareSource and MDwise serve members in the HHW and HIP programs. MDwise had previously been under contract in HCC, but it withdrew from the program effective March 31, 2017. The HCC members enrolled with MDwise transitioned to Anthem and MHS.

Net enrollment in Indiana Medicaid's program grew by almost 27,000, or 1.8 percent, from the end of CY 2016 to the end of CY 2017, but this is due more specifically to an 8.7 percent increase in enrollment in HHW and a 2.5 percent increase in enrollment in HIP. Enrollment in HCC fell 4.2 percent during CY 2017 as did enrollment in fee-for-service (-9.1%). At the end of CY 2017, 78.5 percent of Indiana Medicaid's 1.48 million members were enrolled in one of the State's three managed care programs while 21.5 percent were enrolled in fee-for-service[3].

EQRO Activities in CY 2018

Burns & Associates (B&A) has served as the External Quality Review Organization (EQRO) and has conducted annual EQRs for the OMPP each year since 2007. B&A has relied on the EQR protocols defined by CMS to conduct its reviews. This year was no exception. B&A utilized the protocols released by CMS in September 2012 to serve as the basis for the format of the EQR this year.

The focus of the CY 2018 EQR is MCE activities that occurred in CY 2017. The three mandatory EQR activities as required by CMS were included in this year's EQR:

- Review to Determine MCE Compliance with Federal Medicaid Managed Care Regulations
- Validation of Performance Measures
- Validation of MCE Performance Improvement Projects

In cooperation with the OMPP, B&A also developed focus studies in addition to the mandatory activities. This year's topics include the following:

- Optional EQR Activity: Focus Study on Encounter Validation
- Optional EQR Activity: Focus Study on Pharmacy Management

All of this year's EQR tasks were conducted during April through September, 2018. For all activities in the EQR, a desk review was conducted first. Then, an onsite meeting was conducted with each MCE individually. In total, 32 onsite meetings were held with the MCEs (eight meetings for each of the four MCEs). There were nine individuals on B&A's EQR Review Team this year.

Review to Determine MCE Compliance with Federal Medicaid Managed Care Regulations and OMPP Contract Provisions

In total, B&A scored 350 review items which were derived from language in the MCE contracts with the OMPP for HHW and HIP that became effective January 1, 2017 and the contract for HCC that became effective April 1, 2015. Most of the review items tied to a specific provision within the Medicaid managed care regulations identified in the Code of Federal Regulations. Some items, however, were added to the reviews that are specific to Indiana's contract. These review items are primarily related to the tracking and reporting on the Personal Wellness and Responsibility Account (POWER) that is specific to Indiana's HIP.

[3] Source: Optum, OMPP's data warehouse vendor, provided enrollment data to B&A on May 1, 2018.

With the release of the EQR Review Guide on March 29, 2018 (refer to Appendix B), B&A requested 130 documents from each MCE for the desk audit. These items were delivered in installments over the course of three months. The B&A EQR Review Team conducted the desk review prior to the onsite interviews. B&A team members completed the preliminary scoring of items if they could be assessed from desk review materials. Each review item was given a score of either: Fully Met (2 points), Partially Met (1 point), or Not Met (0 points).

The 350 review items were consolidated into 11 modules. An onsite interview was conducted with each MCE for all 11 modules (some modules were combined into a single MCE meeting). The same team members assigned to review desk materials were also responsible for leading the interviews with MCE staff that were knowledgeable about the functional area to be scored.

The impact of each review item on managed care operations varies. Therefore, B&A assigned a weight to each review item which sometimes included sub-items as well. The weight values assigned were in the range of one to five depending upon the level of impact on operations or service delivery (although some sub-items could be assigned a score of 0.25 or 0.50). When the weighting of scored items is factored in, the total available points were 1,100.

The scores by functional area are shown below. The detailed scoring of individual review items is provided for each MCE in Appendix D of this report.

Summary of Scores Related to MCE Compliance with Managed Care Regulations and OMPP Contracts

Review Topic Area	Number of Scored Items	Maximum Score	Anthem Score	CareSource Score	MDwise Score	MHS Score
Administrative Oversight	24	80	80	80	80	77
Subdelegation Oversight	6	60	60	60	60	55
Member Services and Enrollee Rights	77	140	134	133	140	134
Grievances and Appeals	21	80	80	80	80	80
Provider Network Management, Contracting, and Relations	53	120	119	116	120	119
Utilization Management	35	140	137	137	140	140
Program Integrity	13	60	60	60	60	60
Disease, Care and Complex Case Management	34	120	118	116	120	120
Quality Management	15	100	96	92	90	96
Information Systems	26	120	112	118	102	119
POWER Account Tracking and Reporting	46	80	75	76	78	78
TOTAL	**350**	**1100**	**1071**	**1068**	**1070**	**1078**
			97.4%	**97.0%**	**97.2%**	**98.0%**

In Section V, B&A provides more information on the construct of the review of each topic area. Tables are presented to summarize the number of items that were fully met, partially met or not met for each MCE in each topic area. At the end of the Section, B&A offers recommendations to each MCE so that

each can meet fully met status on all review items in the future. B&A also offers recommendations to the OMPP related to the oversight of managed care operations in each topic area.

Validation of Performance Measures

B&A selected performance measures to validate from among the various reports that the MCEs submit to the OMPP on a regular (usually quarterly) basis. This year's reports selected for validation are reports designed by the OMPP to track utilization in preventive care:

- Adults' Access to Preventive/Ambulatory Services
- Chlamydia Screening for Women
- Use of Appropriate Medication for Members with Asthma
- Comprehensive Diabetes Care

These are quarterly reports that are submitted by each MCE to the OMPP for the HHW, HIP and HCC programs separately. Data is tabulated using the administrative (claims-based) method with no medical record abstraction used. The entire potential population is included in each measure. Since there are 10 MCE/program combinations, B&A reviewed the results from 160 measures (10 MCE/programs x 4 measures x 4 quarters). B&A focused its validation on the 4th Quarter submissions, so 40 measures were validated.

To conduct the validation, B&A made a data request for records from the FSSA's Enterprise Data Warehouse (EDW) for enrollment data representing the enrollment period January 1, 2016 through December 31, 2017 and encounter data representing dates of service for the same time period. B&A reviewed the report specifications for each of the OMPP reports. The specifications for each report resemble, but are not identical to, a HEDIS®[4] measure specification. The OMPP has deviated from the HEDIS specifications in two key areas for most of these measures, namely, the continuous enrollment requirement and the age bands to report on. A member of B&A's EQR Analytics Team programmed the HEDIS specifications, as adjusted by the OMPP, in an attempt to replicate the logic used by the MCEs in the computation of the results that they submitted in their quarterly reports.

When meeting with each MCE about preliminary results, it was learned that there was some confusion in the specification requirements for, among other things, the continuous enrollment criteria. B&A tested to see if its results for the 4th Quarter 2017 experience period were closer to the MCE result using one method over another. Interestingly, even though the OMPP specified not to apply continuous enrollment for three of the four measures, B&A's computed results were more often closer to the MCE's results when B&A did apply continuous enrollment. This was consistent for all OMPP programs tested or the there was no real distinction in B&A's results if the continuous enrollment was applied or not.

Across all MCEs/programs, a total of 140 measures were validated (this accounts for situations where a given utilization measure is further broken down into discrete age bands). B&A was within +/- five percentage points of the value reported by MCEs only 58 percent of the time. This finding did vary by MCE, however. B&A's results were much closer to the results reported by MHS than the other MCEs. The "match rate"—that is, the percentage of time that B&A's result was within five percentage points of the MCE's result, was found to be: for Anthem, 63%; for CareSource, 33%; for MDwise, 57%; and for MHS, 86%.

[4] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

Detailed results are shown in Section III of this report. At the end of the section, B&A offers recommendations to the OMPP to clarify its specifications to the MCEs for reporting each measure. B&A also offers recommendations to the MCEs to audit its own specifications for each measure.

Validation of Performance Improvement Projects

The OMPP uses the term "Quality Improvement Project" (QIP) to describe the projects in this review. B&A reviewed 13 QIPs in this year's EQR as follows:

Inventory of the Quality Improvement Programs Reviewed in the 2018 EQR

	Anthem			Caresource		MDwise		MHS		
QIP Topic	**HHW**	**HCC**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HCC**	**HIP**
AOD Treatment								x	x	x
Adult Preventive Care Visit		x	x							
Annual Dental Visit	x									
ED Utilization		x	x					x	x	x
Follow-up Psychiatric Hospitalization	x	x	x				x			
Health Needs Screening	x	x	x	x	x	x	x	x	x	x
Job Connect Program				x	x					
Notification of Pregnancy						x				

Throughout this report, references to "QIPs" means the same thing as "PIPs" in CMS's EQR Protocol 3. The MCEs are required to submit an annual report on each QIP to the OMPP using a pre-defined format. The QIP reporting template was created in cooperation with the OMPP, the MCEs and B&A during the CY 2016 EQR. B&A used this template to review the annual QIP reports for this year's validation study.

The B&A EQR team members first reviewed the QIP report as part of a desk review. Later, onsite meetings were conducted with each MCE to discuss the QIPs under review. This included follow-up questions from our desk review as well as a discussion with the relevant staff who had primary responsibility for the interventions that were put in place for the QIPs that were selected.

A one-page summary related to each QIP appears in Section IV of this report. At the end of this section, B&A makes specific recommendations to each of the MCEs about their own QIPs as well as recommendations to the OMPP more generally. The recommendations to the OMPP relate to clarifications pertaining to the tabulating and tracking of Health Needs Screenings (HNSs) which is a required QIP for all MCEs. Other recommendations pertain to establishing or re-establishing benchmarks for other HEDIS measures which are being used as the basis for MCE QIPs.

B&A also makes the following recommendations to all MCEs related to QIP development:

1. Analyze data by cohort populations. These could be by program, by geographic region, by age, by ethnicity or other designation. This analysis could assist with targeting intervention resources where they will generate the most impact.

2. Provide comparison metric for each intervention metric. There needs to be a way to determine if an intervention improved the measure or if it was something else.

3. It is not necessary to repeat the same information if it is relevant to all OMPP programs.

4. Compute measures and intervention rates more often than annually. Monthly or quarterly measurements allow for program changes sooner than waiting an entire year.

Focus Study on Encounter Validation

In this year's EQR, B&A conducted a focus study of the validation of the encounters submitted by the MCEs to the OMPP. The objectives of the study were as follows:

1. To track the pace at which encounters are being submitted timely to the OMPP by the MCEs for the HHW, HIP and HCC programs.
2. To track the accuracy of key variables on the encounters that are being submitted to the OMPP and to determine if certain key variables are what are causing an encounter to be rejected.
3. To track the rate of completeness of the encounters that are being submitted that are deemed accepted and those deemed rejected.
4. To assist the OMPP in defining what is a "successful" encounter submission encompassing factors pertaining to timeliness, accuracy and completeness.
5. To identify process improvements that can be completed by all parties that are involved in the encounter collection and validation process.
6. To identify specific areas of opportunity within each MCE to assist them with successful encounter submissions.
7. To provide recommendations to the OMPP to strengthen the oversight and the accountability of the MCEs related to successful encounter submissions.

Currently, there are multiple parties involved in the encounter validation process and the type of validation varies between the parties. DXC, the OMPP fiscal agent, intakes encounters submitted by the MCEs and runs a series of edits on the encounters that are the same as or similar to the edits run on the fee-for-service claims submitted by providers to DXC. Optum is the entity that manages the FSSA's EDW. Optum runs validations on encounters submitted for pharmacy claims from all three programs as well as encounters for medical claims for HIP. The validation that Optum completes does not mimic the editing logic applied in the fee-for-service program.

After the validations occur, response files are sent to the MCE from both DXC and Optum that show the results of their validations completed. The encounters are ultimately populated into the EDW.

The State transitioned to a new information system, *Core*MMIS, in February 2017. With this transition, the encounter submission process was disrupted. All of the parties that work on encounter submission and validation have been working diligently to correct issues that manifested from the transition to the new system. This independent encounter validation study was intended to highlight the priority areas that could be most impactful on improving encounter submissions as well as to test MCE compliance with existing OMPP benchmarks.

The OMPP has outlined the following requirements in its contracts with the MCEs related to encounters:

- With respect to timeliness, the MCEs must submit 100 percent of adjudicated claims within 30 calendar days of adjudication.

- With respect to accuracy, the MCEs must adhere to compliance with pre-cycle (HIPAA) edits.

B&A utilized data from three sources to conduct this study:

- Each MCE delivered four files in Excel that showed claim information at the header level. One file was for each of the four claim types UB-04/837I, CMS-1500/837P, Pharmacy and Dental. The MCEs were instructed to submit information on any claim that they adjudicated during the time period of July 1, 2017 through September 30, 2017.

- B&A obtained from Optum all encounters with dates of service from January 1, 2016 through December 31, 2017 as received in the EDW by March 31, 2018.

- B&A also obtained from Optum all weekly response files (called ESSRs) delivered to each MCE related to their encounter submission for the time period July 1, 2017 through June 30, 2018.

When comparing the claims that the MCEs adjudicated in the third quarter of CY 2017 against what was submitted as encounters, it was found that, in the aggregate across all MCEs and programs, 97.3 percent of institutional claims and 97.2 percent of professional claims had been submitted by the MCEs. For institutional claims, the encounter completion rate range was from a low of 92.5 percent for CareSource HHW to a high of 99.9 percent for MHS HIP. For professional claims, the encounter completion range was from a low of 91.5 percent for CareSource HHW to a high of 100.0 percent for MHS HIP.

Although B&A observed that encounters may not have been submitted as timely as the OMPP was expecting, it does appear that the MCEs are meeting the requirement that all adjudicated claims be submitted as encounters within 15 months of the earliest date of service on the claim. For the claims adjudicated by the MCEs in the 3rd Quarter of 2017, B&A tracked the average days from service date to receipt by the MCE, from receipt by the MCE to adjudication, and then from adjudication to submission as an encounter. With the exception of Anthem's HIP claims, for all other MCEs the total duration of these three events was, on average, less than 90 days. For Anthem HIP, the institutional claim average was closer to 120 days.

When reviewing each event in isolation, the greatest commonality across the MCEs was seen in the average time from end date of service to submission to the MCE by the provider (typically between 20 and 35 days). The average days from receipt to adjudication was also low (less than 10 days) with the exception of MDwise and Anthem HIP institutional claims. There was variance seen in the average days from MCE adjudication to encounter submission

With respect to accuracy, B&A reviewed just over 18.3 million encounters that were submitted by the MCEs for paid services that were rendered during CY 2017 and billed on institutional or professional claims for all three programs. B&A reviewed if values were populated for eight key variables on each encounter and, if so, if the value shown was a valid value. The results of this validation appear in Exhibit VI.7 appearing on the next page and are summarized below. For five of the eight variables, accuracy was high. For three variables (valid rendering NPI, valid DRG, valid primary diagnosis code), improvements can be made.

B&A also reviewed the adjudication edits (EOBs) that DXC assigns to all HHW and HCC medical claims. For the six months of data reviewed for the second half of CY 2017, there was 8.1 percent of all detail lines reported on ESSRs where DXC would have denied when the MCE paid for the service. These detail lines represent 11.6 percent of all payments made by the MCEs. The variance across the MCEs when measuring the percentage of detail lines is small (from a low of 7.2% for MHS to a high of 9.4% for Anthem). When DXC did assign a denial EOB, it was found that the EOBs are concentrated. In the July to December 2017 ESSR period, the top 10 EOBs statewide represent 72.4 percent of all DXC denial EOBs. B&A then reviewed the January to June 2018 ESSR period and found the percentage to be 75.0 percent.

Based on these findings, B&A offers a number of recommendations to the OMPP related to process improvements for the intake and submission of encounters to the State's data warehouse. In Section VI of this report, additional information is provided on the results of this study including root cause analyses pertaining to the denial EOBs. B&A makes recommendations to the MCEs related to conducting root cause analyses on the denial EOBs as well as building internal dashboards to meet OMPP benchmarks on encounter validations. Lastly, B&A recommends to the OMPP to prioritize its requirements for encounter submissions and, in turn, to strengthen its contractual requirements to the MCEs in this regard.

Focus Study on Pharmacy Management

To evaluate each MCE's compliance and effectiveness with the requirements set forth in the OMPP contracts, B&A conducted both a desk review of materials requested from each MCE as well as a facilitated onsite interview with key staff responsible for pharmacy management at each MCE. The desk review was conducted by two members of the B&A review team in advance of the onsite interviews. From this review, the team members created a standardized interview questionnaire. The onsite interviews were conducted with each MCE individually.

Related to this review, B&A performed data analytics at the request of the OMPP on pharmacy claims with service dates in CY 2017 to analyze two specific aspects of pharmacy management:

- First, to assess the rate at which the MCEs are including national drug codes (NDCs) on professional and institutional claims for physician-administered drugs (PADs). The OMPP is requiring the NDC in these situations because a HCPCS alone is not at the level of granularity that is appropriate for reporting rebate information directly to manufacturers.

- Second, to analyze the range of dispensing fees paid to pharmacies. There was interest from the OMPP in this study to ensure sufficient access to pharmacies throughout the state, particularly in areas where the pharmacy chain stores are not present.

For both of these analyses, B&A utilized a data extract from the FSSA's EDW that included all paid and denied pharmacy encounters submitted by the MCEs for scripts filled in CY 2017 as received in the EDW by March 31, 2018. For the study of NDC reporting on PAD encounters, B&A used the guidance from the State titled "Procedure Codes That Require National Drug Codes (NDCs)" published April 17, 2018.

With respect to the responsibilities pertaining to pharmacy management, each MCE subdelegates much of the responsibility to a Pharmacy Benefits Manager (PBM). Both CareSource and MHS use CVS as their PBM. Anthem uses Express Scripts (ESI) as its PBM and MDwise uses MedImpact (Walgreens). The MCEs outlined the responsibilities that each of them delegates to the PBM, which tasks are retained at the MCE, and which tasks are shared. In general, the MCEs generally employ the same approaches to managing this benefit.

In Section VII of this report, B&A discusses in depth other aspects of the review of pharmacy benefit management that were reviewed including:

- Initial readiness and ongoing monitoring of the PBMs;
- Education and communication related to pharmacy benefits management to pharmacies, prescribers and members;
- Development and maintenance of preferred drug lists (PDLs);
- Utilization management;

- Claims adjudication and encounter submissions; and
- Pharmacy pricing

In the interviews conducted with each MCE, it was evident to the B&A review team that each MCE has extensive documentation and sophisticated data analytics driving their management of the pharmacy benefit on behalf of their members. In fact, in some of the areas mentioned above, the MCEs perform, in the review team's opinion, above the minimum contractual requirements. Given this finding, B&A offers at the end of Section VII four recommendations to the MCEs and five recommendations in the spirit of continuous quality improvement.

For the specific study of NDCs submitted on PAD encounters, B&A identified just over 1.34 million PAD detail lines and just over $236 million in payments on these lines from professional and outpatient hospital encounters submitted by the MCEs to the FSSA's EDW for CY 2017 services. In the aggregate across all MCEs and all managed care programs, the NDCs were missing on 12.5 percent of all detail lines in CY 2017. This average is heavily weighted, however, by the Anthem HIP (22.3% of details) and Anthem HHW (13.0% of details) programs which represent almost half of all of the PAD details missing NDCs. CareSource also had a high percentage of detail lines missing NDCs, but their volume was very low in CY 2017. Although there were 12.5 percent of PAD detail lines missing an NDC, this represented only 5.1 percent of all PAD payments made by the MCEs. Anthem's programs represented $10.9 million of the $12.0 million shown on PAD detail lines with a missing NDC. The payments for the other three MCEs when a missing NDC was found were nominal. B&A did find situations where there was a PAD detail line was missing an NDC, the line had a status of paid, but the MCE paid amount was $0. This could be one of the reasons why the 5.1 percent of paid PAD details with missing NDCs is so much lower than the percentage of detail lines missing an NDC.

For the specific study of dispensing fees, B&A received all retail pharmacy encounters submitted by the MCEs for scripts filled in CY 2017 from the FSSA's EDW to analyze the variation in dispensing fees paid. Although the average dispensing fee paid in CY 2017 across all MCEs and programs was $0.97, there was variation seen by MCE. There was consistency found within each MCE, however. Anthem's average dispensing fee was between $1.43 and $1.45 for all three programs that it under contract with the OMPP. CareSource and MDwise were between $0.62 and $0.66 for its programs, while MHS was between $0.48 and $0.50 for its programs. There was a limited spread in the actual dispensing fee values found. Among the 14.6 million scripts analyzed, the encounter data analyzed showed that 97.7 percent of the scripts were paid one of the following eight dispensing fees: $0.00 (3.3% of the total), $0.50 (23.2%), $0.70 (26.2%), $1.02 (1.9%), $1.11 (4.4%), $1.41 (11.0%), $1.51 (26.2%) or $1.99 (1.6%).

Of the 14.6 million encounters reported for pharmacy scripts in CY 2017, 13.8 million encounters had a dispensing fee reported on the encounter. Among these, 85.3 percent came from the top 10 providers. A total of 68.0 percent came from the top three pharmacies alone (CVS, Walgreens and Wal-Mart). B&A found that the average dispensing fee for the top 10 providers was an even $1.00. Seven of the top ten had an average payment between $0.97 and $1.10. The two low outliers were Walgreens ($0.72) and Rite Aid ($0.82). The one high outlier was Genoa ($1.19).

Examination of Provider Network Adequacy

The OMPP requires that each MCE submit geoaccess maps to ensure that its members in each OMPP program have access to providers. The OMPP has set benchmarks for each MCE to meet with respect to the maximum driving distance miles for members to access over 40 provider specialties. In this EQR, B&A examined members in HHW, HIP and HCC and their access to 17 of these provider specialties.

B&A conducted a stricter interpretation than what the OMPP requires by using the member utilization from claims for dates of service in CY 2017 for each of the 17 provider specialties as opposed to just finding the closest provider to each member. B&A tested the accessibility of each MCE's provider network by measuring the average driving distance for members to each specialty type. It is understood that members have access to the full array of providers in the MCE's network. Members may choose to access a provider that is a further distance to their home than the provider that is the closest proximity to their home.

The rendering provider ID was used on each claim and the provider's address was found. Geocoding software was used to map the driving distance (not crow flies) from the member's home to the provider's office. Some exclusions were applied due to exclude missing latitude/longitude coordinates or distances deemed to short (less than 0.2 miles) or too far (more than 100 miles) that would skew average distance calculations. After exclusions were applied, B&A examined 2,220,530 trips during CY 2017—for HHW, there were 1,116,557 trips; for HIP, there were 821,870 trips; and for HCC, there were 282,103 trips.

B&A reviewed MCE compliance with the OMPP driving distance standards at the program, specialty and county level. For most provider specialties reviewed, the members are, on average, travelling to providers below the OMPP mileage standard for the provider specialty. There are a few counties where neurology, urology and cardiology have high average driving distances (greater than 60 miles). A similar trend was found for behavioral health providers where the OMPP has set a standard of 45 miles. There are a number of counties where the MCEs have exceeded the 30-mile standard for dental services, but they are most all rural counties since the total dentist trips in these counties is approximately eight percent of the total dentist trips statewide. There does appear to be opportunity to improve access among primary care providers, particularly for Anthem and CareSource (all programs) and for MDwise and MHS in the HIP program.

Follow-Up from the EQR in the Previous Year

In addition to the Validation of Performance Measures and Performance Improvement Projects, B&A conducted four focus studies in the EQR conducted in CY 2017. One of these studies was related to lead testing for children. The OMPP, the MCEs and the State Department of Health have been working to improve the rate of lead tests reported to the health department's data reporting system. B&A reviewed lead testing results conducted in CY 2017 and compared these to the results in the original study for CY 2016. Over two-thirds of the counties saw a higher rate of 1-year-old and 2-year-old Medicaid children with lead tests in CY 2017 than in CY 2016. This was also true for members enrolled with each MCE. Additionally, each MCE had a higher number of counties that had more than 30 percent of their members age 1 and 2 that have evidence of a lead test.

B&A also examined the results of the lead tests that were submitted to the Department of Health. In CY 2016, there were 1.1 percent of tests with results above five micrograms per deciliter. In CY 2017, the result was 1.5 percent of the total. In CY 2018, to date the result is 1.8 percent of the total.

SECTION I: OVERVIEW OF INDIANA'S MEDICAID MANAGED CARE PROGRAMS

Introduction

The Family and Social Services Administration's (FSSA's) Office of Medicaid Policy and Planning (OMPP)[5] have responsibility for the administration and oversight of Indiana's Medicaid program under waiver and state plan authorities. There are three risk-based managed care programs in place and each serves a targeted population—Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC).

The **Hoosier Healthwise (HHW)** program began in 1994 with members having the option to enroll with a managed care entity (MCE)[6] in 1996. By 2005, enrollment with an MCE was mandatory for select populations, namely, low income families, pregnant women, and children. Enrollees in Indiana's Children's Health Insurance Program (CHIP), which covers children in families up to 250 percent of the Federal Poverty Level (FPL)[7], are also enrolled in HHW. This program is authorized by a 1932(a) state plan amendment.

The **Healthy Indiana Plan (HIP)** was first created in January 2008 under a separate Section 1115 waiver authority. This program covered two groups of adults with family income up to 200 percent of the FPL. The first group was uninsured custodial parents and caretaker relatives of children eligible for Medicaid or CHIP who were not otherwise eligible for Medicaid or Medicare. The second group was uninsured noncustodial parents and childless adults ages 19 through 64 who were not otherwise eligible for Medicaid or Medicare.

The HHW and HIP were aligned in Calendar Year (CY) 2011 under a family-focused model such that the programs were aligned to allow a seamless experience for Hoosier families and to establish a medical home model for continuity of care. The same MCEs were contracted to serve both the HHW and HIP populations.

In January 2015, the State received a new Section 1115 demonstration waiver authority from the Centers for Medicare & Medicaid Services (CMS) to change the design of HIP (the original version now called HIP 1.0) to a non-traditional Medicaid model (the new version called HIP 2.0) that effectively terminated HIP 1.0 on January 31, 2015. The HIP 2.0 model is a health insurance program for uninsured adults between the ages of 19 and 64. The **HIP 2.0** program began February 1, 2015. In addition to the existing HIP 1.0 enrollees, adults from the HHW program (with some exceptions) were transitioned into HIP 2.0. Additionally, the marketplace was open for new uninsured Hoosiers who met the enrollment criteria to join HIP 2.0 at this time.

HIP is a State-sponsored health insurance program where monthly contributions are required of each enrolled member. The Personal Wellness and Responsibility (POWER) Account is the feature of HIP that makes it unique among programs developed nationally for the low-income uninsured. The POWER

[5] FSSA and OMPP are collectively referred to as Indiana Medicaid throughout this report.

[6] In Indiana, the term MCE is synonymous with the term managed care organization and will be used as such throughout this report. It refers to those entities that Indiana Medicaid contracts with under a full-risk arrangement. Each MCE is a health maintenance organization (HMO) authorized by the Indiana Department of Insurance.

[7] CHIP children in families up to 150% FPL do not pay a premium. Children in families whose income is between 151% and 250% FPL pay a premium on a sliding scale.

Account was used in HIP 1.0 and continued to be used in the HIP 2.0 program. A $2,500 deductible is provided to each member annually.

Individuals eligible for HIP can opt to pay a modest POWER Account contribution in order to receive HIP Plus benefits. This includes enhanced benefits such as dental and vision. There are no co-payments. Contributions to the member's POWER Account may also come from the State (with federal matching dollars) and, in some cases, the member's employer. HIP members who do not choose this option will be placed in HIP Basic. Members enrolled here are charged co-payments and dental and vision benefits are not included. Members with certain medical conditions or criteria may eb eligible for the HIP State Plan package which offers additional benefits.

There is a financial incentive for members to seek the required preventive care for their age, gender and health status. If a HIP member is deemed to be eligible upon redetermination 12 months after enrolling and there are funds remaining in the member's POWER Account, the funds are rolled over into the next year's account if the member met program requirements in the prior year. This will effectively reduce the amount of the member's monthly POWER Account contribution in the next year.

The **Hoosier Care Connect (HCC)** program was implemented April 1, 2015 under a 1915(b) waiver authority. Enabling state legislation in CY 2013 tasked the FSSA with managing the care for the aged, blind and disabled Medicaid enrollees. After convening a task force of key FSSA divisions, the FSSA developed the HCC program. The HCC is a risk-based program that contracts with MCEs to administer and to deliver services to members. The HCC replaced a predecessor program, Care Select, which ended June 30, 2015. Two of the MCEs who administered HCC in CY 2017 are the same ones that administered HHW and HIP.

Traditional Medicaid is comprised of the remaining Medicaid enrollees who are not members of HHW, HIP or HCC. Specifically, the following populations are covered under Traditional Medicaid under a fee-for-service environment:

- Individuals dually enrolled receiving Medicare and Medicaid benefits;
- Individuals receiving home- and community-based waiver benefits;
- Individuals receiving care in a nursing facility or other State-operated facility;
- Individuals in specific aid categories (e.g., refugees); and
- Individuals awaiting an assignment to an MCE.

Applicants to HHW, HIP and HCC are asked to select the MCE they would like to join if determined eligible for the program. If a member does not select an MCE within 14 days of obtaining eligibility, then Indiana Medicaid auto-assigns the member to an MCE. Once assigned, the MCE then has 30 days to work with the member to select a primary medical provider (PMP). If the member does not make a selection within this time frame, the MCE will auto-assign the member to a PMP.

In CY 2017, which is the focus of this External Quality Review (EQR), there were four MCEs that contracted with the OMPP to administer services to its managed care programs. Anthem Insurance Companies, Inc. (Anthem) has been under contract with Indiana Medicaid since 2007. Coordinated Care Corporation, Inc. d/b/a Managed Health Services (MHS) is a subsidiary of the Centene Corporation and has been under contract with Indiana Medicaid since the inception of HHW in 1994. MDwise, Inc. has also been participating in HHW since its inception. MDwise subcontracts the management of services to eight delivery systems. The newest MCE, CareSource, began contracting with the State in January 2017.

Anthem and MHS serve members in all three of the OMPP's managed care programs—HHW, HIP and HCC. CareSource and MDwise serve members in the HHW and HIP programs. MDwise had previously been under contract with the HCC program, but MDwise terminated its HCC contract effective March 31, 2018. The members enrolled with MDwise in the HCC program were transitioned to Anthem and MHS.

It is important to note some programmatic changes which occurred at the beginning of CY 2017. A new contract was executed with the MCEs for the HHW and HIP programs. The contract for HCC which began April 1, 2015 is still in effect. With respect to covered services, both pharmacy and dental were added to the MCE contract for HHW effective January 1, 2017 (these services were already in the HIP and HCC contracts). This change aligned the contracts such that the covered services under all three contracts are almost identical.

With respect to enrollment, prior to January 1, 2017 there remained some adults enrolled in HHW, more specifically pregnant women and some parents. With few exceptions, adults that had previously been eligible and enrolled in HHW have been transitioned to HIP as of February 1, 2018.

Enrollment at a Glance

As seen in Exhibit I.1 below, net enrollment in Indiana Medicaid's program grew by almost 27,000, or 1.8 percent, from the end of CY 2016 to the end of CY 2017, but this is due more specifically to an 8.7 percent increase in enrollment in HHW and a 2.5 percent increase in enrollment in HIP. Enrollment in HCC fell 4.2 percent during CY 2017 as did enrollment in fee-for-service (-9.1%). At the end of CY 2017, 78.5 percent of all of Indiana Medicaid members were enrolled in one of the three managed care programs while 21.5 percent were enrolled in fee-for-service.

Exhibit I.1
Change in Enrollment Across Indiana Medicaid's Programs, Dec 2016 to Dec 2017

	Managed Care Programs				
	Hoosier Healthwise	**Healthy Indiana Plan**	**Hoosier Care Connect**	**Fee-for-Service**	**All Combined**
December 2016	602,768	404,151	94,438	349,737	1,451,094
	41.5%	27.9%	6.5%	24.1%	100.0%
	75.9%			24.1%	100.0%
December 2017	655,138	414,263	90,462	317,881	1,477,744
	44.3%	28.0%	6.1%	21.5%	100.0%
	78.5%			21.5%	100.0%
Change from Dec 16 to Dec 17	**52,370**	**10,112**	**-3,976**	**-31,856**	**26,650**
	8.7%	**2.5%**	**-4.2%**	**-9.1%**	**1.8%**

Source: OMPP Enterprise Data Warehouse.
Data provided to B&A by Optum (OMPP's vendor) on May 1, 2018.

Exhibit I.2 shows that Anthem and MDwise have a similar proportion (32%-34%) of managed care members in HHW, but Anthem is more predominant in both HIP and HCC. As a result, the total enrollment across all three programs at the end of CY 2017 is 38 percent for Anthem, 30 percent for MDwise, 23 percent for MHS and just under 10 percent for CareSource.

Exhibit I.2
Managed Care Program Enrollment by MCE
As of December 2017

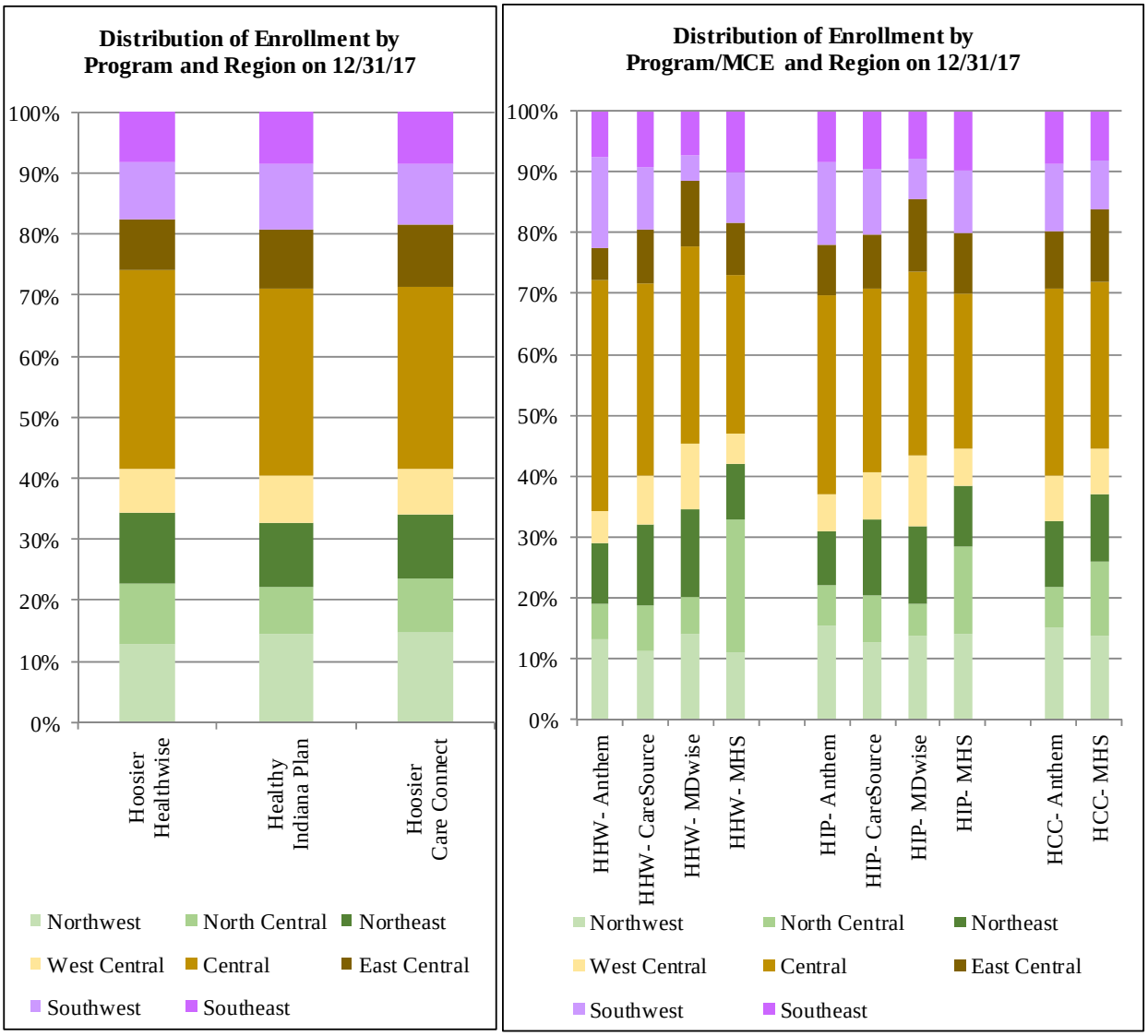
	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect	All Combined
Anthem	32%	43%	63%	38%
CareSource	10%	10%	0%	9%
MDwise	34%	29%	0%	30%
MHS	23%	18%	37%	23%

Source: OMPP Enterprise Data Warehouse
Data provided to B&A by Optum (OMPP's vendor) on May 1, 2018.

Exhibit I.3 on the next page illustrates the enrollment patterns of the three managed care programs across the eight regions defined by the OMPP. Each of the 92 counties in Indiana has been mapped to one of eight MCE regions. The county-to-region mapping appears in Appendix A. There are three regions in the northern part of the state (shown in the green colors), three regions in the central part of the state (shown in the gold/brown colors), and two regions in the southern part of the state (shown in the purple colors).

In general, as seen in the left box of the exhibit, the distribution of the enrollment for HHW, HIP and HCC is consistent across the regions. In the right box of the exhibit, the enrollment is further distributed by both managed care program and MCE. When comparing the left box (statewide) against the right box (by MCE), there is some variation at the MCE level. MHS tends to have a higher percentage of the enrollment the northern regions, MDwise tends to have a higher percentage of the enrollment in the central regions, and Anthem tends to have a higher percentage of the enrollment in the southern regions. This is true for all programs that each of these MCEs is contracted under.

Exhibit I.3
Managed Care Program Enrollment by Region and MCE
As of December 2017



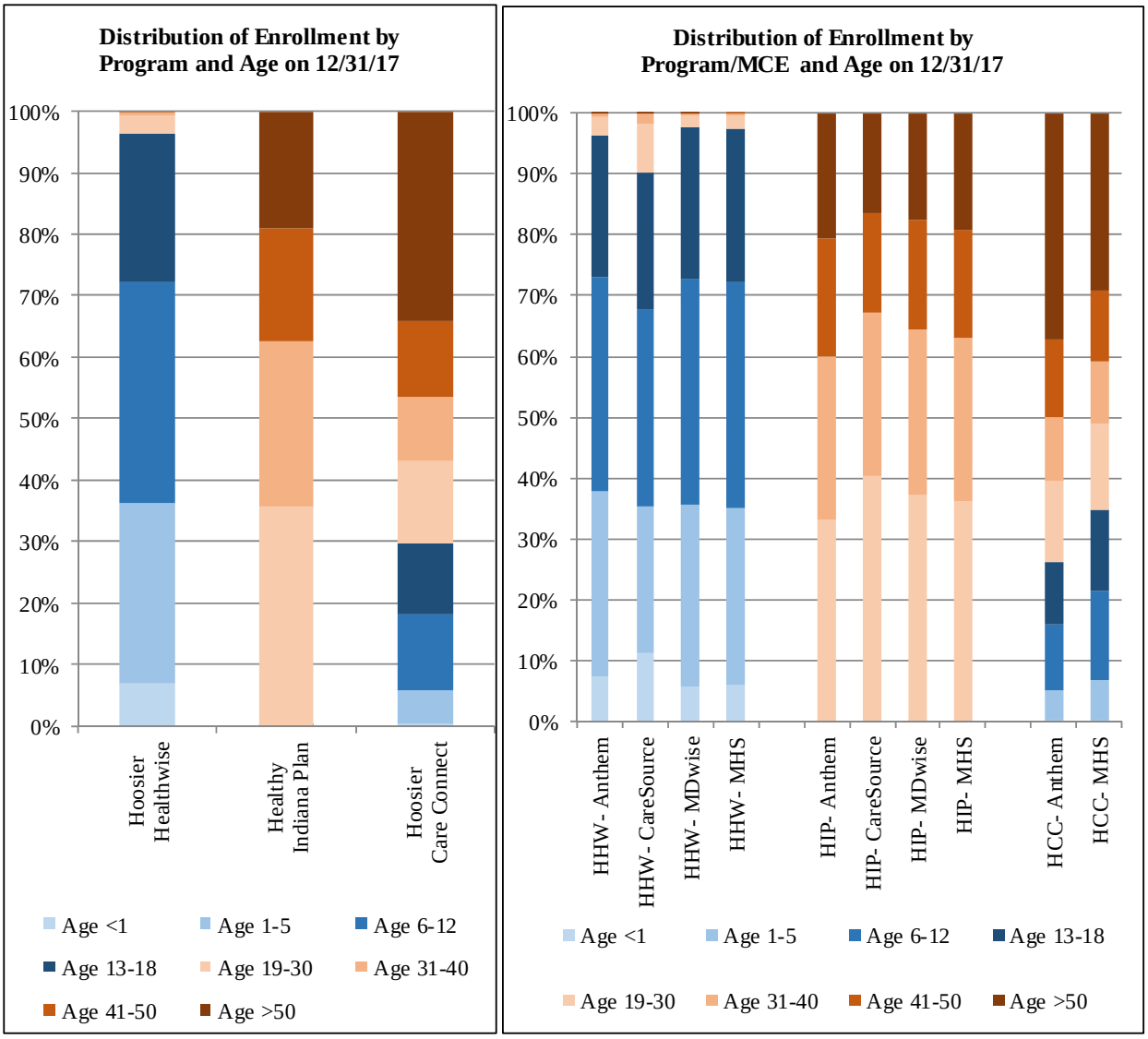
Source: OMPP Enterprise Data Warehouse
Data provided to B&A by Optum (OMPP's vendor) on May 1, 2018.

The display for Exhibit I.4 is similar to what was shown in Exhibit I.3, but instead of distributing the enrollment by region, the enrollment is distributed by the age of the members. In this exhibit, the blue colors represent different age groups among children while the peach/orange colors represent different age groups among adults.

Exhibit I.4 illustrates the targeted populations of each of Indiana's managed care programs. As of December 2017, over 96 percent of the HHW population is children. Conversely, all of the HIP population is adults. The HCC program is mixed with 30 percent children and 70 percent adults. Even within HCC, the children that are enrolled are mostly older children.

As shown in the box on the right, there are no significant differences in the distribution of the enrollment by age group across the MCEs in any of the three managed care programs.

Exhibit I.4
Managed Care Program Enrollment by Age and MCE
As of December 2017



Source: OMPP Enterprise Data Warehouse
Data provided to B&A by Optum (OMPP's vendor) on May 1, 2018.

Indiana Medicaid's CY 2017 Quality Strategy Plan

The OMPP, like other State Medicaid Agencies, develops a Quality Strategy Plan. In its 2017 Plan, Indiana outlined specific initiatives for the HHW, HIP and HCC programs as well as the Traditional Medicaid program. The initiatives for the managed care programs are shown on the next page in Exhibit I.5. Most of the initiatives carried forward from what was released in the 2015 Quality Strategy Plan. The items that are new in 2017 are identified in italics.

The initiatives outlined stem from four global aims that the OMPP has identified that support the objectives for all of its programs. These are[8]:

1. Quality – Monitor quality improvement measures and strive to maintain high standards.
    a. Improve health outcomes
    b. Encourage quality, continuity and appropriateness of medical care

2. Prevention – Foster access to primary and preventive care services with a family focus.
    a. Promote primary and preventive care
    b. Foster personal responsibility and healthy lifestyles

3. Cost – Ensure medical coverage in a cost-effective manner.
    a. Deliver cost-effective coverage
    b. Ensure the appropriate use of health care services
    c. Ensure utilization management best practices

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

The Quality Strategy Committee meets quarterly throughout the year. The subcommittees also meet quarterly in different sessions from the main Committee meetings. MCEs are involved with the Quality Strategy Committee in multiple ways. Most importantly, the MCEs are required to submit to OMPP quarterly updates to their quality improvement projects that were identified in their annual work plan. The Quality Strategy Committee is briefed on these updates by the MCEs.

[8] From the Indiana Medicaid Managed Care Quality Strategy Plan 2017, page 4. www.in.gov/fssa/hip/files/2017_IN_Medicaid_Qual_Strategy_Plan.pdf

Exhibit I.5
OMPP Quality Strategy Initiatives for 2017

Area of Focus	Goal	HHW	HIP	HCC
Improvements in Children and Adolescent Well-Care	Achieve at or above the 90th percentile for improvements in children and adolescent well-child visits (HEDIS).	✓		
Early Periodic Screening, Diagnosis and Treatment (EPSDT)	Achieve at or above 80% participation rate in the EPSDT program.	✓		
Improvement in Behavioral Health	Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders (HEDIS).	✓	✓	
Ambulatory Care	Achieve at or above the HEDIS percentile (for HHW, the 75th percentile, for HIP, the 90th percentile) of Ambulatory Outpatient Care Visits.	✓	✓	
	Continue to establish baseline data.			✓
Emergency Room Visits	Achieve at or below the 10th percentile of Ambulatory Emergency Department Care Visits (HEDIS).	✓	✓	
	Achieve at or below 75 visits per 1000 member months.		✓	
Pregnant Women Smoking Cessation	Achieve an increase in the percentage who are referred to and have one contact with the Indiana Tobacco Quitline.	✓	✓	
Freqency of Prenatal and Post-Partum Care	Achieve at or above the 90th percentile for the frequency of prenatal and at or above the 90th percentile for post-partum care (HEDIS).	✓		
Right Choices Program (RCP)	Achieve at or above 96% of the RCP periodic reviews that are completed on time.	✓		
	A minimum of 90% of the findings of appeals filed by members to be removed from RCP will be upheld because the member was correctly assessed as requiring RCP services. (*new in 2017*)		✓	
Access to Care	90% of all HIP members shall have access to primary care within a minimum of 30 miles of a member's residence and at least two providers of each specialty type within 60 miles of their residence.		✓	
Access to Care	90% of all HIP members shall have access to dental and vision care within a minimum of 60 miles of a member's residence and at least two providers of each type within 60 miles of their residence.		✓	
POWER Account Rollover	Achieve at or above 85% of the number of members who receive a preventive exam during the year.		✓	
Medically Frail	Identify individuals who meet the medically frail criteria and offer access to enhanced services. (*new in 2017*)		✓	
Preventive Care (HEDIS AAP-like)	Continue to establish baseline data.			✓
Completion of Health Needs Screen	Percentage of newly enrolled MCE members, net of terminated members, that have had a health screen assessment completed within 90 days will be greater than or equal to 70% of total.			✓
Completion of Comprehensive Health Assessment Tool	Exceed baseline percentage of newly enrolled MCE members, net of terminated members, that have had a comprehensive health assessment completed within 150 days.			✓
Identification of Hoosier Care Connect Members	Exceed baseline of the number of members identified by stratification level, program participation length and average contacts per month.			✓
Complex Case Management	Exceed baseline of the number of CCM members by disease state, total contacts and average contacts per reporting period.			✓

Source: Indiana Medicaid Managed Care Quality Strategy Plan 2017

The OMPP also has a robust Pay for Outcomes (P4O) program as part of its contracts with the MCEs for each of the three managed care programs. Most measures used in the P4O program are based on HEDIS®[9] measures and are focused to the populations within each of the three programs. The P4O measures for CY 2017 are listed in Exhibit I.6 below.

Exhibit I.6
OMPP Pay for Outcomes Program in Effect for CY 2017

HEDIS Code	Description	HHW	HIP	HCC
AMB	Ambulatory Care	✓		
AMB	ER Admissions per 1000 Member Months		✓	✓
W15	Well-Child Visits in the First 15 Months of Life - Six or More Visits	✓		
W34	Well-Child Annual Visit in the Third, Fourth, Fifth and Sixth Years of Life	✓		
AWC	Adolescent Well-Child Visit	✓		
FUH	Follow-up After Hospitalization for Mental Illness: 7-Day Follow-up	✓	✓	✓
FUH	Follow-up After Hospitalization for Mental Illness: 30-Day Follow-up			✓
FPC	Frequency of Ongoing Prenatal Care	✓		
PPC	Postpartum Care- Percentage of Deliveries with Post-Partum Visit	✓		
AAP	Adult Ambulatory and Preventive Care		✓	✓
n/a	OMPP Measure: Health Needs Screener Completion		✓	✓
n/a	OMPP Measure: Comprehensive Health Assessment Tool Completion			✓
n/a	OMPP Measure: Referral to Quitline for Pregnant Members who Smoke		✓	

Source: Indiana Medicaid Managed Care Quality Strategy Plan 2017

[9] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

SECTION II: APPROACH TO THIS YEAR'S EXTERNAL QUALITY REVIEW

Background

Burns & Associates, Inc. (B&A) has served as the External Quality Review Organization (EQRO) and has conducted annual External Quality Reviews (EQRs) for Indiana Medicaid each year since 2007. B&A is a Phoenix-based health care consulting firm whose clients almost exclusively are state Medicaid agencies or sister state agencies. In the State of Indiana, B&A is contracted only with the Indiana Medicaid program.

The Centers for Medicare & Medicaid Services (CMS) require that EQROs complete three mandatory activities on a regular basis as part of the EQR:

1) A review to determine managed care entity (MCE) compliance with federal Medicaid managed care regulations;
2) Validation of performance measures produced by an MCE; and
3) Validation of performance improvement projects (PIPs) undertaken by the MCEs

All three of these activities were completed in the EQR conducted in Calendar Year (CY) 2018. For the first activity, B&A utilized the CMS EQR Protocol 1: *Assessment of Compliance with Medicaid Managed Care Regulations* that was published in September 2012 to complete this review. For the second activity, B&A utilized the framework outlined in CMS EQR Protocol 2: *Validation of Measures Reported by the MCO*. Likewise, for the third activity, B&A utilized the framework outlined in CMS Protocol 3: *Validation of Performance Improvement Projects*.

In other years, B&A has worked with the OMPP to develop focus studies covering specific aspects of the HHW, HIP and HCC programs. Since 2011, B&A has completed 26 focus studies as part of the annual EQR. The functional areas where focus studies have been completed in the last six years appears in Exhibit II.1 on the next page.

For the mandatory activity related to the validation of performance measures, B&A has selected a sample of reports that the MCEs are required to submit to the OMPP on a regular basis in order to validate the performance measures reported.

For the mandatory activity related to the validation of performance improvement projects, B&A worked with the OMPP during the EQR conducted in CY 2014 by convening a workgroup with all of the MCEs to develop a streamlined and standardized reporting tool for Quality Improvement Projects (in Indiana, PIPs are referred to as QIPs). This tool was further refined at the conclusion of the CY 2016 EQR. The review of QIPs in this year's EQR included information reported by the MCEs in the latest QIP reporting template.

Exhibit II.1
EQR Focus Studies Conducted of MCE Operations in HHW, HIP and HCC, 2012 - 2017

Review Conducted	Review Year	HHW	HIP	HCC	Functional Area	Review Topic
CY 2012	CY 2011	x	x		Utilization Management Behavioral Health	Review of Inpatient Psychiatric Stays
CY 2012	CY 2011	x	x		Utilization Management	Review of the Right Choices Program
CY 2013	CY 2012	x	x		Access to Care	Review of member access to care and provider perceptions of the MCEs
CY 2013	CY 2012	x	x		Mental Health Utilization and Care Coordination	Clinical review of care plans and review of care coordination for members with co-morbid physical health and behavioral health ailments
CY 2014	CY 2013	x			Access to Care	Review of Non-Emergency Medical Transportation Services
CY 2014	CY 2013	x	x		Member Services	New Member Activities
CY 2014	CY 2013	x	x		Provider Relations	Review of MCE Provider Services Staff and Communication with Providers
CY 2014	CY 2013	x	x		Program Integrity	Review of Processes Related to Third Party Liability
CY 2015	CY 2014	x	x		Utilization Management	Review of Service Authorization Processes including sample review
CY 2015	CY 2014	x	x		Inpatient Hospital Readmissions	Assessment of Potentially Preventable Hospital Readmissions
CY 2015	CY 2014	x	x		Emergency Services	Assessment of Potentially Preventable Emergency Department Visits
CY 2016	CY 2015	x	x	x	Access to Care	Audit of MCE Provider Directories
CY 2016	CY 2015	x	x	x	Access to Care	Review of Beneficiary Access to Providers
CY 2016	CY 2015		x	x	Dental Care	Review of the Utilization and Access to Dental Services
CY 2016	CY 2015	x	x	x	Mental Health Utilization	Review of the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
CY 2016	CY 2015	x	x		Prenatal Care	Review of the Delivery of Prenatal Care
CY 2016	CY 2015	x		x	Well Child Visits and Primary Care	Review of the Delivery of Well Care and Primary Care to Children
CY 2017	CY 2015-CY 2016	x	x	x	Inpatient Hospital Readmissions	Assessment of Potentially Preventable Hospital Readmissions
CY 2017	CY 2016	x	x	x	Claims Processing	Review of Claims Adjudication and Pricing
CY 2017	CY 2016	x	x	x	Children's Health	Study of Lead Testing and Related Outreach
CY 2017	CY 2016	x	x	x	Pharmacy	Study of MCE Medication Adherence Programs

EQRO Activities in CY 2018

B&A met with the OMPP in early 2018 and developed the following topics for this year's EQR:

- Review to Determine MCE Compliance with Federal Medicaid Managed Care Regulations
- Validation of Performance Measures
- Validation of MCE Performance Improvement Projects (Quality Improvement Projects, QIPs)
- Optional EQR Activity: Focus Study on Encounter Validation
- Optional EQR Activity: Focus Study on Pharmacy Management

In addition to the CMS guidance for the mandatory activities, B&A worked with the OMPP Quality Director to develop the construct and elements to be included in the two focus studies.

The details pertaining to each aspect of this year's EQR were released to the MCEs in an EQR Guide on March 29, 2018. The EQR Guide appears in Appendix B of this report. It contains information about the focus of each review topic in the EQR, the expectations of MCEs in the review, a document request list, and a schedule of events. For all review topics, a desk review, onsite reviews and post-onsite follow-up occurred. All of this year's EQR tasks were conducted during April through September, 2018.

In preparation for the study, B&A received data from the FSSA's Enterprise Data Warehouse (EDW) with the transfer of data facilitated by OMPP's EDW vendor, Optum. A data request specific to this EQR was given to Optum and the data was delivered to B&A in an agreed upon format. All data delivered to B&A from the OMPP came directly from the EDW. B&A leveraged all data validation techniques used by Optum before the data is submitted to the EDW. When additional data was deemed necessary, B&A outreached directly to the MCEs to obtain this data for the study and ran validations of this data. Specific data received from the EDW included:

- An enrollment file that contained demographic information about each Medicaid enrollee;
- A member month file that tracked a Medicaid member's enrollment in any of the three programs (HHW, HIP or HCC) as well as Traditional Medicaid on a monthly basis for CYs 2016 and 2017;
- A provider roster file that contained demographic information about each provider enrolled with Indiana Medicaid (a provider must be enrolled with Indiana Medicaid before the provider can contract with an MCE for any Medicaid managed care program); and
- A dataset of managed care encounters and fee-for-service claims with dates of service in CYs 2016 and 2017 for individuals who moved from fee-for-service to a managed care program (or back to fee-for-service).

For both the fee-for-service claims and encounter data, services included institutional services, professional services, dental services and pharmacy scripts.

Sections III through VII of this report describe in detail the methodology and findings of each of the EQR activities stated above. Because the MCEs that contract with the OMPP serve all three programs (HHW, HIP and HCC), the review of all three programs was conducted simultaneously. This report, therefore, serves as the EQR study for all three of Indiana's managed care programs for CY 2017. Throughout the report, where applicable, information is presented for each program individually. The two focus studies conducted reviewed information on all three of OMPP's managed care programs.

A series of onsite meetings were held with each MCE individually at their home office in Indianapolis over the course of the EQR period. Multiple members of the EQR Review Team participated in these meetings either in person or telephonically based on their role in this year's EQR. The Project Director

facilitated all of the onsite meetings in person. The focus of all meetings was to interview MCE staff appropriate to the study topic. Most onsite meetings were between two and three hours in length. B&A also conducted a webinar with each MCE individually to review preliminary findings completed by B&A related to the validation of performance measures and encounters. A summary of the onsite meeting schedule is shown below:

- May 15-16: In-person interviews were held to walk through the MCE's information systems and processes to administer, track and report on Personal Wellness and Responsibility (POWER) Account reporting in the HIP.

- May 17-18: In-person interviews were held to interview MCE staff on their procedures to intake, validate and submit encounters to the OMPP for all three programs. B&A reviewed initial reports on encounter submissions with each MCE during this session.

- May 22-23: In-person interviews were held to interview MCE staff on how they manage the pharmacy benefit in each of the OMPP programs.

- June 26-27: In-person interviews were held to interview MCE staff on administrative oversight at each MCE, subdelegated entity oversight, utilization management functions, the prior authorization process, and program integrity functions.

- July 17-20: Two different in-person sessions were held with each MCE during this week to review other functional areas of MCE management and service delivery. In one session, B&A staff held interviews with staff responsible for member services, grievances and appeals, provider contracting and relations, and provider network management. In the other session, B&A staff held interviews with staff responsible for disease, care and complex case management and also quality management.

- August 1-2: B&A hosted a webinar to review the initial results from the validation of performance measures as well as a second round of reports related to the validation of encounters reporting.

- August 15-16: In-person interviews were held to discuss and ask questions related to each MCE's QIP reports.

The EQR Review Team

This year's review team included the following staff:

- Mark Podrazik, Project Director, Burns & Associates, Inc. Mr. Podrazik provided project oversight and participated in all onsite reviews for this year's EQR. He led the B&A team responsible for all analytics pertaining to this year's focus studies. He has worked with the OMPP in various capacities since 2000. Previously, Mr. Podrazik led the EQRs in CYs 2007-2017. Although it was not required since the program was not a managed care program, Mr. Podrazik also conducted an external review of Indiana's Care Select program (the predecessor to HCC) at OMPP's request in CY 2009.

- Dr. Linda Gunn, AGS Consulting, Inc. Dr. Gunn participated as a team member in the review of MCE adherence to managed care regulations related to enrollee rights, member services,

grievances and appeals, provider contracting and network management, utilization management, program integrity, administrative oversight and subdelegated entity oversight. Dr. Gunn also participated in B&A's EQRs for Indiana programs in CYs 2009-2017.

- Kristy Lawrance, Lawrance Policy Consulting, LLC. Ms. Lawrence participated as a team member in the review of MCE adherence to managed care regulations related to disease, care and case management, quality management and information systems. She also reviewed the MCE's administration of POWER accounts. She also shared responsibility with Mark Podrazik conducting the validation of QIPs. Lastly, Ms. Lawrance conducted onsite interviews and was part of the analytics team for the focus study on encounter validation. Ms. Lawrance also participated in B&A's EQRs for Indiana programs in CYs 2013-2017.

- Kara Suter, Project Manager, Burns & Associates, Inc. Ms. Suter joined the EQR team this year with a focus on co-leading the focus study on pharmacy management with Mr. Podrazik. She participated in the review of desk materials, conducting the onsite interviews and the design of analytics related to the study. Ms. Suter has a Master of Science in Pharmaceutical Science and had previously consulted with clients on drug pricing reforms. She also has three years of experience as the Director of Payment Reform and Reimbursement for Vermont Medicaid.

- Karl Matzinger, Project Manager, Burns & Associates, Inc. Mr. Matzinger joined the EQR team this year with a focus on the review of MCE adherence to managed care regulations. His areas of focus included enrollee rights, member services, grievances and appeals, provider contracting and network management, utilization management, program integrity, administrative oversight and subdelegated entity oversight, disease, care and case management, and quality management. Prior to joining B&A in 2015, Mr. Matzinger served in management positions for 21 years within Arizona's state government working in human services agencies.

- Ryan Sandhaus, SAS Programmer, Burns & Associates, Inc. Mr. Sandhaus conducted analytical support in SAS for the focus study related to encounter validation. He also served as the programmer responsible for the validation of performance measures. Mr. Sandhaus participated in all MCE meetings where the data analytics related to these projects was discussed. Mr. Sandhaus also participated in B&A's EQRs for Indiana programs in CYs 2016 and 2017.

- Jesse Eng, SAS Programmer, Burns & Associates, Inc. Mr. Eng conducted analytical support in SAS for the focus study related to encounter validation. He has conducted analytic support on B&A's engagements with the OMPP since 2009, in particular, the annual EQR and B&A's annual independent evaluation of Indiana's Children's Health Insurance Program.

- Akhilesh Pasupulati, SAS Programmer, Burns & Associates, Inc. Mr. Pasupulati completed the analytic support for this year's focus study on pharmacy management. In last year's EQR, he served as the lead programmer for B&A's focus study related to medication adherence. He leveraged his experience working for a national pharmacy benefit manager to inform the analytics for this study.

- Barry Smith, Analyst, Burns & Associates, Inc. Mr. Smith conducted analytical support related to the validation performance measures as well as the encounter validation focus study. Mr. Smith has previously worked on the Data Analysis Team for the EQRs conducted in CYs 2009-2017.

SECTION III: VALIDATION OF PERFORMANCE MEASURES

Introduction

In previous External Quality Reviews (EQRs), Burns & Associates, Inc. (B&A) has selected performance measures to validate from among the various reports that the managed care entities (MCEs) submit to the Office of Medicaid Policy and Planning (OMPP) on a regular basis. The OMPP has created an MCE Reporting Manual for each of the three managed care programs—Hoosier Healthwise (HHW), Healthy Indiana Plan 2.0 (HIP) and Hoosier Care Connect (HCC). The MCEs are required to submit results in pre-set reporting templates in Excel. Most reports must be submitted on a quarterly basis. In addition to the report template, the OMPP provides instructional guidance to the MCEs on how to complete each report.

For this year's EQR, in consultation with the OMPP, the following reports were selected for validation:

- QR-PCC1: Adults' Access to Preventive/Ambulatory Services
- QR-PCC5: Chlamydia Screening for Women
- QR-PCC6: Use of Appropriate Medication for Members with Asthma
- QR-PCC8: Comprehensive Diabetes Care

These are quarterly reports that are submitted by each MCE to the OMPP for the HHW, HIP and HCC programs separately. Since there are 10 MCE/program combinations, B&A reviewed the results from 160 measures (10 MCE/programs x 4 measures x 4 quarters). B&A focused it validation on the 4th Quarter submissions, so 40 measures were validated.

The reports within each measure were first analyzed for trends. Specifically, B&A looked for:

- How the results compared across the four quarters *within an MCE's program* (e.g. the results within MHS HHW)
- How the results compared across MCEs *within an OMPP program* (e.g., the results for HHW comparing Anthem, CareSource, MDwise and MHS to each other)
- How the results compared *across MCE programs* (e.g., the results in HHW compared to HIP and HCC)

B&A then validated the results reported by each MCE for one set of quarterly reports for each measure against B&A's own calculations for each measure. B&A selected the results submitted by the MCEs on reports delivered in Q1 2018 because each of the four measures selected this year are on a 90-day claims lag. With an anchor date of December 31, 2017, the results submitted in Q1 2018 represent the results for each measure from Calendar Year (CY) 2017.

In conducting this validation, B&A considered the elements for review suggested in the CMS EQR *Protocol 2: Validation of Performance Measures Reported by the MCO, Version 2.0* released in September 2012. This included the three main activities as outlined in the protocol:

- Activity 1: Pre-Onsite Visit Activities
- Activity 2: Onsite Visit Activities
- Activity 3: Post-Onsite Visit Activities

Due to the nature of this year's selected measures, some items in the protocol were not applicable. For example, medical records were not applicable and there was no sampling process since the measures validated represented the entire population. Factoring in the intent of the EQR protocol, B&A created a methodology specific to validating these reports and measures as outlined in the section below.

Methodology Related to the Validation Process

An overview of B&A's methodology is as follows:

1. B&A tabulated the results submitted by the MCEs for the four reports of interest for each program for the four quarters representing the experience period in CY 2017.

2. B&A examined the results of each report by MCE/program across the quarters for face validity.

3. B&A made a data request for records from the State's Enterprise Data Warehouse (EDW) for enrollment data representing the enrollment period January 1, 2016 through December 31, 2017 and encounter data representing dates of service for the same time period. The enrollment data is stored at the monthly segment level in the EDW. The encounters requested show data at the claim detail level. The reason why information from both CY 2016 and CY 2017 was requested is because some of the measures selected for this year's validation require a lookback to CY 2016.

4. B&A reviewed the report specifications for each of the OMPP QR-PCC reports. The specifications for each report resemble, but are not identical to, a HEDIS®[10] measure specification. A member of B&A's EQR Analytics Team programmed the HEDIS specifications, as adjusted by the OMPP, in an attempt to replicate the logic used by the MCEs in the computation of the results that they submitted in their quarterly reports.

5. B&A built detailed tables that showed the development of the denominator for each measure. The reports were specific to each MCE by measure/OMPP program and they provide a step-by-step accounting of MCE members included or excluded from the analysis.

6. Similarly, B&A built detailed tables that showed the development of the numerators for the adult access to preventive care and comprehensive diabetes care measures because these measures allow for multiple criteria used to count of members in the numerator for the measure.

7. B&A compared the results that it computed against the results reported by the MCEs for each of the measures submitted for the experience period with an anchor date of December 31, 2017.

8. The results compiled in Steps 1, 5, 6 and 7 were shared with each MCE in one-on-one meetings held August 1-2, 2018. Questions were posed to each MCE related to its reported results.

9. Because it was determined that some results found in the validation process were not matching between B&A and the MCE, B&A asked each MCE to complete a checklist that itemized all of the specification requirements for computing each measure. This was due to B&A on August 30.

[10] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

10. Based on feedback from the MCEs, B&A re-ran its results for the validation after receiving clarification on how the MCEs interpreted the OMPP's specifications for the selected measures.

11. The updated results were compared to the original submissions by the MCEs on the quarterly reports to the OMPP.

12. B&A compared the results submitted by the MCEs in the specifications checklist to determine if the MCEs have programmed the specifications for each measure in the same way.

How the OMPP Measure Specifications Differ from HEDIS

For the measures in this year's study, the OMPP requires that the MCEs provide results of measures using the administrative (claims-based) method as opposed to a hybrid (with medical records) method. There is no sampling involved. The entire potential population is included in each measure.

In its instructions for each measure, the OMPP suggests a HEDIS specification as reference for the starting point for computing the measure. However, the OMPP has deviated from the HEDIS specifications in two key areas for most of these measures, namely, the continuous enrollment requirement and the age bands to report on. Exhibit III.1 below cross-references the specifications in the HEDIS 2017 guidance compared to the OMPP CY 2017 Reporting Manual.

Exhibit III.1
Comparison Between HEDIS Specifications and OMPP Requirements for Performance Measures Reviewed

		Continuous Enrollment?		Age Group(s)			
Measure	**Abbrev-iation**	**NCQA**	**OMPP**	**NCQA**	**OMPP HHW**	**OMPP HIP**	**OMPP HCC**
Adults' Access to Preventive/ Ambulatory Services	AAP	Yes	No	20-44	20-44	20-44	20-44
				45-64	45-64	45-64	45-64
				65 +			65 +
Chlamydia Screening	CHL	Yes	No	16-20	16-20	19-25	16-20
				21-24	21-25		21-25
Use of Appropriate Medications for Members with Asthma	ASM	Yes (current and prior year)	No (neither current nor prior year)	5-11	5-9		5-9
				12-18	10-17		10-17
				19-50	18-56	19-56	18-56
				51-64			
Comprehensive Diabetes Care	CDC	Yes	Yes	18-75	18-75	18-64	18-75

When computing each measure, B&A used the age bands as referenced by the OMPP. B&A ran values for each measure in two ways—first with the continuous enrollment requirement in place, then again without the continuous enrollment requirement in place. The results using both methods were compared to what the MCE reported for the period with anchor date of December 31, 2017.

Findings

First, B&A examined the trends for each measure across the four quarters reported by each MCE within each program. The details of all results are shown in Appendix C. Within this appendix, there are five reports that are formatted in a similar manner. One report is for HHW, one report is for HCC, and three reports are for HIP. The HIP program is divided into three sub-components as this is how the OMPP directs the MCEs to report statistics on a quarterly basis. The three sub-programs are HIP Plus, HIP Basic and HIP State Plan.

Within each program, a median value was determined for each measure/age combination reported. For example, a median rate for the AAP measure for ages 20-44 was computed separate from the median value for ages 45-64. The median was computed by comparing all four MCEs (only two in HCC) and all four quarters reported. Then, B&A computed each MCE's rate and compared it to the median. As Exhibit III.2 below shows, CareSource is the only MCE who had results that consistently deviated from the median (either more than 10 percentage points above or below the statewide median value). This is expected given the fact that CareSource just began contracting with the OMPP in January 2017 and its enrollment was a gradual ramp up over the course of the year. Still, by the end of 2017, CareSource members represented approximately ten percent of the total HHW and HIP enrollment.

Exhibit III.2
Summary of Trend Reports for MCE Submissions in Four Experience Quarters in CY 2017

			Number of Occurrences		
Number of Unique Measures	**Total Across 4 Qtrs**	**MCE**	**More than 10 pct points below median**	**More than 10 pct points above median**	**Within 10 pct points of median**
Hoosier Healthwise					
10	40	Anthem	4	5	31
		CareSource	26	3	11
		MDwise	1	7	32
		MHS	1	0	39
Hoosier Care Connect					
12	48	Anthem	0	0	48
		MHS	1	0	47
Healthy Indiana Plan 2.0, HIP Plus					
8	30*	Anthem	0	0	30
		CareSource	23	0	7
		MDwise	1	2	27
		MHS	0	0	30
Healthy Indiana Plan 2.0, HIP Basic					
8	30*	Anthem	0	0	30
		CareSource	23	0	7
		MDwise	0	4	26
		MHS	3	3	24
Healthy Indiana Plan 2.0, HIP State Plan					
8	30*	Anthem	0	2	28
		CareSource	23	0	7
		MDwise	3	3	24
		MHS	0	0	30

*The OMPP suspended two measures starting in Q1 2018 so only three quarters are reported.

A summary of B&A's comparison of its calculation for each measure for the experience period ending December 31, 2017 to the MCE's reported result appears in summary format in Exhibit III.3 on the next page. After this page, the specific results comparing B&A's results to the MCE's results are shown for all measures validated by program. Five exhibits show the details of the comparison of measures as follows:

- In Exhibit III.4, results for HHW members
- In Exhibit III.5, results for HCC members
- In Exhibit III.6, results for HIP Plus members
- In Exhibit III.7, results for HIP Basic members
- In Exhibit III.8, results for HIP State Plan members

Two different methods are shown in Exhibit III.3 on how B&A summarized the results of its validation to the MCE-reported results. Because it was found that the HEDIS specification and the OMPP instructions deviated with respect to the application of continuous enrollment on three of the four measures studied, B&A tested to see if it was closer to the MCE result using one method over another. Interestingly, even though the OMPP specified not to apply continuous enrollment for three of the four measures, B&A's computed results were more often closer to the MCE's results when B&A did apply continuous enrollment. This was consistent for all OMPP programs tested or there was no real distinction in B&A's results if the continuous enrollment was applied or not.

The variation between B&A and the MCE on each measure within each program is shown in the details in Exhibits III.4 through III.8. In these exhibits, cells in yellow represent situations where the difference between B&A and the MCE was more than five percentage points (in either direction).

A summary of this level of variation is also shown in Exhibit III.3 on the next page. Across all MCEs/programs, a total of 140 measures were validated. B&A was within +/- five percentage points of the value reported by MCEs only 58 percent of the time. This finding did vary by MCE, however. B&A's results were much closer to the results reported by MHS than the other MCEs. The "match rate"—that is, the percentage of time that B&A's result was within five percentage points of the MCE's result, was found to be:

- For Anthem, 63%
- For CareSource, 33%
- For MDwise, 57%
- For MHS, 86%

Exhibit III.3
Comparison of B&A Validation of Performance Measures to Each MCE's Reported Values

		Number of Occurrences			Match Rate to the MCE	
Number of Measures Validated	**MCE**	**B&A Closer to MCE Using Continuous Enrollment**	**B&A Closer to MCE Not Using Continuous Enrollment**	**Results the Same or Not Tested***	**B&A Not Within +/- 5 Pct Points of MCE**	**B&A Within +/- 5 Pct Points of MCE**
Hoosier Healthwise						
9	Anthem	4	2	3	7	2
	CareSource	1	2	6	7	2
	MDwise	3	2	4	6	3
	MHS	2	3	4	3	6
Hoosier Care Connect						
10	Anthem	5	1	4	4	6
	MHS	5	2	3	1	9
Healthy Indiana Plan 2.0, HIP Plus						
7	Anthem	2	1	4	1	6
	CareSource	3	0	4	7	0
	MDwise	3	1	3	2	5
	MHS	4	0	3	0	7
Healthy Indiana Plan 2.0, HIP Basic						
7	Anthem	3	1	3	2	5
	CareSource	3	0	4	7	0
	MDwise	2	2	3	3	4
	MHS	3	1	3	1	6
Healthy Indiana Plan 2.0, HIP State Plan						
7	Anthem	2	1	4	1	6
	CareSource	0	3	4	5	2
	MDwise	2	2	3	2	5
	MHS	2	2	3	0	7

*The OMPP required continuous enrollment for the Comprehensive Diabetes Care measure and all MCEs applied continuous enrollment. Therefore, B&A did not test a non-continuous enrollment option.

Exhibit III.4

Validation of Performance Measures for the HHW Program

Cells in yellow indicate where the difference between the MCE-reported value and the B&A-computed value is greater than five percentage points.
X indicates that this application of continuous enrollment yeilded a result closer to the MCE's reported value.

Experience Period Ends on Last Day of Q4 2017				Continuous Enrollment Applied			No Continuous Enrollment Applied		
			MCE Report	B&A Calc	Difference from MCE		B&A Calc	Difference from MCE	
Report	**Data Description**								
QR-PCC1	Percentage of Preventive or Ambulatory visits, ages 20 - 44 years	Anthem	71.2%	79.6%	8.4%	x	58.7%	-12.5%	
		Caresource	34.0%	83.9%	49.9%		42.7%	8.7%	x
		MDwise	73.6%	77.6%	4.0%	x	52.1%	-21.5%	
		MHS	57.3%	80.9%	23.6%		55.3%	-2.0%	x
QR-PCC5	Percentage of women who had a chlamydia screening, ages 16-20 years	Anthem	42.9%	46.1%	3.2%		43.3%	0.4%	x
		Caresource	34.9%	48.8%	13.9%		40.1%	5.2%	x
		MDwise	41.3%	49.4%	8.1%		47.8%	6.5%	x
		MHS	50.2%	53.3%	3.1%		50.1%	-0.1%	x
	Percentage of women who had a chlamydia screening, ages 21-25 years	Anthem	47.4%	66.2%	18.8%		38.8%	-8.6%	x
		Caresource	75.5%	77.4%	1.9%	x	36.0%	-39.5%	
		MDwise	50.0%	76.1%	26.1%		39.1%	-10.9%	x
		MHS	56.9%	69.8%	12.9%	x	37.3%	-19.6%	
QR-PCC6	Percentage of members dispensed at least one prescription for a preferred therapy, ages 5-9 years	Anthem	89.1%	62.6%	-26.5%	x	62.2%	-26.9%	
		Caresource	61.0%	NR			NR		
		MDwise	87.3%	77.8%	-9.5%	x	74.6%	-12.7%	
		MHS	89.9%	86.0%	-3.9%	x	82.7%	-7.2%	
	Percentage of members dispensed at least one prescription for a preferred therapy, ages 10-17 years	Anthem	89.1%	75.0%	-14.1%	x	71.7%	-17.4%	
		Caresource	48.0%	NR			NR		
		MDwise	89.6%	69.5%	-20.1%		69.5%	-20.1%	
		MHS	79.8%	77.6%	-2.2%		77.6%	-2.2%	
	Percentage of members dispensed at least one prescription for a preferred therapy, ages 18-56 years	Anthem	78.7%	70.0%	-8.7%	x	64.7%	-14.0%	
		Caresource	19.0%	NR			NR		
		MDwise	94.0%	69.5%	-24.5%	x	61.9%	-32.1%	
		MHS	69.2%	77.6%	8.4%		76.0%	6.8%	x
QR-PCC8	Percentage of members with diabetes who had a HbA1c testing, ages 18-75 years	Anthem	74.2%	75.8%	1.6%		B&A did not test computing these measures with no continuous enrollment because the OMPP instructions state to apply continuous enrollment and every MCE indicated that they had done so.		
		Caresource	32.0%	75.0%	43.0%				
		MDwise	83.3%	79.5%	-3.8%				
		MHS	81.8%	83.1%	1.3%				
	Percentage of members who received an annual eye exam, ages 18-75 years	Anthem	24.2%	32.3%	8.1%				
		Caresource	0.0%	0.0%	0.0%				
		MDwise	45.6%	45.8%	0.2%				
		MHS	42.1%	40.7%	-1.4%				
	Percentage of members with diabetes who received medical attention for Nephropathy, ages 18-75 years	Anthem	96.8%	77.4%	-19.4%				
		Caresource	61.0%	100.0%	39.0%				
		MDwise	77.2%	62.7%	-14.5%				
		MHS	81.0%	74.6%	-6.4%				

Exhibit III.5
Validation of Performance Measures for the HCC Program

Cells in yellow indicate where the difference between the MCE-reported value and the B&A-computed value is greater than five percentage points.
X indicates that this application of continuous enrollment yeilded a result closer to the MCE's reported value.

Experience Period Ends on Last Day of Q4 2017				Continuous Enrollment Applied			No Continuous Enrollment Applied		
			MCE Report	B&A Calc	Difference from MCE		B&A Calc	Difference from MCE	
Report	**Data Description**								
QR-PCC1	Percentage of Preventive or Ambulatory visits, ages 20 - 44 years	Anthem	76.8%	75.7%	-1.1%	x	73.4%	-3.4%	
		MHS	70.1%	66.1%	-4.0%	x	62.0%	-8.1%	
	Percentage of Preventive or Ambulatory visit, ages 45 - 64 years	Anthem	89.0%	89.0%	0.0%	x	86.2%	-2.8%	
		MHS	85.1%	83.3%	-1.8%	x	78.4%	-6.7%	
QR-PCC5	Percentage of women who had a chlamydia screening, ages 16-20 years	Anthem	48.1%	47.3%	-0.8%	x	45.6%	-2.5%	
		MHS	46.8%	44.2%	-2.6%	x	42.1%	-4.7%	
	Percentage of women who had a chlamydia screening, ages 21-25 years	Anthem	51.3%	56.8%	5.5%		53.3%	2.0%	x
		MHS	54.0%	54.7%	0.7%	x	50.0%	-4.0%	
QR-PCC6	Percentage of members dispensed at least one prescription for a preferred therapy, ages 5-9 years	Anthem	94.3%	79.0%	-15.3%		79.0%	-15.3%	
		MHS	90.9%	88.2%	-2.7%		90.2%	-0.7%	x
	Percentage of members dispensed at least one prescription for a preferred therapy, ages 10-17	Anthem	88.2%	79.4%	-8.8%	x	77.6%	-10.6%	
		MHS	84.5%	86.4%	1.9%	x	87.7%	3.2%	
	Percentage of members dispensed at least one prescription for a preferred therapy, ages 18-56	Anthem	72.6%	47.8%	-24.8%	x	47.4%	-25.2%	
		MHS	71.7%	73.7%	2.0%		73.3%	1.6%	x
QR-PCC8	Percentage of members with diabetes who had a HbA1c testing, ages 18-75 years	Anthem	84.1%	84.1%	0.0%		B&A did not test computing these measures with no continuous enrollment because the OMPP instructions state to apply continuous enrollment. The MCEs indicated that they had done so.		
		MHS	83.4%	77.0%	-6.4%				
	Percentage of members who received an annual eye exam, ages 18-75 years	Anthem	50.5%	43.0%	-7.5%				
		MHS	45.0%	42.4%	-2.6%				
	Percentage of members with diabetes who received medical attention for Nephropathy, ages 18-75 years	Anthem	87.7%	88.3%	0.6%				
		MHS	87.4%	85.3%	-2.1%				

Exhibit III.6

Validation of Performance Measures for the HIP Plus Program

Cells in yellow indicate where the difference between the MCE-reported value and the B&A-computed value is greater than five percentage points.
X indicates that this application of continuous enrollment yeilded a result closer to the MCE's reported value.

Experience Period Ends on Last Day of Q4 2017				Continuous Enrollment Applied			No Continuous Enrollment Applied		
Report	Data Description		MCE Report	B&A Calc	Difference from MCE		B&A Calc	Difference from MCE	
QR-PCC1	Percentage of Preventive or Ambulatory visits, ages 20 - 44 years	Anthem	75.7%	80.0%	4.3%	x	69.6%	-6.1%	
		Caresource	16.0%	66.3%	50.3%		48.0%	32.0%	x
		MDwise	73.6%	71.9%	-1.7%	x	62.9%	-10.7%	
		MHS	75.4%	76.4%	1.0%	x	66.3%	-9.1%	
	Percentage of Preventive or Ambulatory visit, ages 45 - 64 years	Anthem	84.7%	87.4%	2.7%	x	80.6%	-4.1%	
		Caresource	27.0%	81.4%	54.4%		56.5%	29.5%	x
		MDwise	81.7%	80.8%	-0.9%	x	74.3%	-7.4%	
		MHS	83.0%	83.7%	0.7%	x	77.7%	-5.3%	
QR-PCC5	Percentage of women who had a chlamydia screening, ages 19-25	Anthem	47.9%	51.2%	3.3%		47.6%	-0.3%	x
		Caresource	21.7%	57.9%	36.2%		49.3%	27.6%	x
		MDwise	47.0%	55.8%	8.8%		50.8%	3.8%	x
		MHS	56.0%	56.4%	0.4%	x	51.4%	-4.6%	
QR-PCC6	Percentage of members dispensed at least one prescription for a preferred therapy, ages 19-56	Anthem	78.5%	57.4%	-21.1%		57.5%	-21.0%	
		Caresource	40.0%	NR			NR		
		MDwise	84.0%	59.7%	-24.3%	x	59.3%	-24.7%	
		MHS	75.6%	73.0%	-2.6%	x	72.5%	-3.1%	
QR-PCC8	Percentage of members with diabetes who had a HbA1c testing, ages 18-75 years	Anthem	87.5%	87.8%	0.3%		B&A did not test computing these measures with no continuous enrollment because the OMPP instructions state to apply continuous enrollment and every MCE indicated that they had done so.		
		Caresource	34.7%	84.8%	50.1%				
		MDwise	86.7%	86.5%	-0.2%				
		MHS	84.7%	86.4%	1.7%				
	Percentage of members who received an annual eye exam, ages 18-75 years	Anthem	47.2%	45.7%	-1.5%				
		Caresource	0.0%	26.1%	26.1%				
		MDwise	48.3%	37.3%	-11.0%				
		MHS	50.4%	45.7%	-4.7%				
	Percentage of members with diabetes who received medical attention for Nephropathy, ages 18-75 years	Anthem	83.9%	84.5%	0.6%				
		Caresource	46.4%	89.1%	42.7%				
		MDwise	84.4%	83.0%	-1.4%				
		MHS	86.2%	87.2%	1.0%				

Exhibit III.7

Validation of Performance Measures for the HIP Basic Program

Cells in yellow indicate where the difference between the MCE-reported value and the B&A-computed value is greater than five percentage points.
X indicates that this application of continuous enrollment yeilded a result closer to the MCE's reported value.

Experience Period Ends on Last Day of Q4 2017				Continuous Enrollment Applied			No Continuous Enrollment Applied		
Report	Data Description		MCE Report	B&A Calc	Difference from MCE		B&A Calc	Difference from MCE	
QR-PCC1	Percentage of Preventive or Ambulatory visits, ages 20 - 44 years	Anthem	50.8%	55.7%	4.9%	x	43.0%	-7.8%	
		Caresource	46.0%	31.3%	-14.7%	x	20.7%	-25.3%	
		MDwise	47.4%	45.5%	-1.9%	x	33.8%	-13.6%	
		MHS	48.2%	52.1%	3.9%	x	40.7%	-7.5%	
	Percentage of Preventive or Ambulatory visit, ages 45 - 64 years	Anthem	55.9%	55.9%	0.0%	x	49.6%	-6.3%	
		Caresource	58.0%	40.8%	-17.2%	x	22.9%	-35.1%	
		MDwise	49.1%	49.5%	0.4%	x	38.8%	-10.3%	
		MHS	51.4%	55.3%	3.9%	x	46.2%	-5.2%	
QR-PCC5	Percentage of women who had a chlamydia screening, ages 19-25	Anthem	45.1%	57.5%	12.4%		51.1%	6.0%	x
		Caresource	34.4%	42.9%	8.5%	x	51.2%	16.8%	
		MDwise	45.7%	61.0%	15.3%		54.3%	8.6%	x
		MHS	50.3%	57.6%	7.3%		52.7%	2.4%	x
QR-PCC6	Percentage of members dispensed at least one prescription for a preferred therapy, ages 19-56	Anthem	66.0%	44.0%	-22.0%	x	43.4%	-22.6%	
		Caresource	25.0%	NR			NR		
		MDwise	90.9%	52.4%	-38.5%		54.6%	-36.3%	x
		MHS	66.2%	71.4%	5.2%	x	74.1%	7.9%	
QR-PCC8	Percentage of members with diabetes who had a HbA1c testing, ages 18-75 years	Anthem	67.7%	72.0%	4.3%		B&A did not test computing these measures with no continuous enrollment because the OMPP instructions state to apply continuous enrollment and every MCE indicated that they had done so.		
		Caresource	26.3%	50.0%	23.7%				
		MDwise	67.6%	71.0%	3.4%				
		MHS	70.9%	72.0%	1.1%				
	Percentage of members who received an annual eye exam, ages 18-75 years	Anthem	22.1%	20.2%	-1.9%				
		Caresource	0.0%	0.0%	0.0%				
		MDwise	24.9%	15.2%	-9.7%				
		MHS	23.0%	22.1%	-0.9%				
	Percentage of members with diabetes who received medical attention for Nephropathy, ages 18-75 years	Anthem	73.1%	75.9%	2.8%				
		Caresource	39.0%	80.0%	41.0%				
		MDwise	75.1%	76.9%	1.8%				
		MHS	77.6%	77.7%	0.1%				

Exhibit III.8

Validation of Performance Measures for the HIP State Plan Program

Cells in yellow indicate where the difference between the MCE-reported value and the B&A-computed value is greater than five percentage points.
X indicates that this application of continuous enrollment yeilded a result closer to the MCE's reported value.

Experience Period Ends on Last Day of Q4 2017				Continuous Enrollment Applied			No Continuous Enrollment Applied		
Report	Data Description		MCE Report	B&A Calc	Difference from MCE		B&A Calc	Difference from MCE	
QR-PCC1	Percentage of Preventive or Ambulatory visits, ages 20 - 44 years	Anthem	80.0%	82.5%	2.5%	x	62.9%	-17.1%	
		Caresource	33.0%	57.4%	24.4%		35.8%	2.8%	x
		MDwise	79.2%	78.3%	-0.9%	x	63.9%	-15.3%	
		MHS	77.3%	78.1%	0.8%	x	63.6%	-13.7%	
	Percentage of Preventive or Ambulatory visit, ages 45 - 64 years	Anthem	92.2%	93.5%	1.3%	x	79.1%	-13.1%	
		Caresource	54.0%	78.6%	24.6%		52.5%	-1.5%	x
		MDwise	92.2%	91.9%	-0.3%	x	81.1%	-11.1%	
		MHS	90.9%	91.9%	1.0%	x	81.0%	-9.9%	
QR-PCC5	Percentage of women who had a chlamydia screening, ages 19-25	Anthem	50.9%	59.3%	8.4%		53.5%	2.6%	x
		Caresource	25.6%	85.7%	60.1%		46.4%	20.8%	x
		MDwise	57.7%	62.9%	5.2%		56.7%	-1.0%	x
		MHS	55.6%	62.7%	7.1%		56.4%	0.8%	x
QR-PCC6	Percentage of members dispensed at least one prescription for a preferred therapy, ages 19-56	Anthem	76.1%	54.8%	-21.3%		54.6%	-21.5%	
		Caresource	25.0%	NR			NR		
		MDwise	85.6%	52.2%	-33.4%		53.3%	-32.3%	x
		MHS	68.3%	70.5%	2.2%		69.6%	1.3%	x
QR-PCC8	Percentage of members with diabetes who had a HbA1c testing, ages 18-75 years	Anthem	85.2%	86.3%	1.1%		B&A did not test computing these measures with no continuous enrollment because the OMPP instructions state to apply continuous enrollment and every MCE indicated that they had done so.		
		Caresource	33.1%	88.9%	55.8%				
		MDwise	84.5%	83.4%	-1.1%				
		MHS	84.8%	84.5%	-0.3%				
	Percentage of members who received an annual eye exam, ages 18-75 years	Anthem	49.9%	45.4%	-4.5%				
		Caresource	0.0%	55.6%	55.6%				
		MDwise	51.8%	42.8%	-9.0%				
		MHS	53.3%	48.7%	-4.6%				
	Percentage of members with diabetes who received medical attention for Nephropathy, ages 18-75 years	Anthem	86.9%	87.5%	0.6%				
		Caresource	45.0%	72.2%	27.2%				
		MDwise	87.6%	86.7%	-0.9%				
		MHS	88.6%	87.1%	-1.5%				

Recommendations to the OMPP and the MCEs Related to the Validation of Performance Measures

B&A determined that many of the reasons why it could not match the results reported by MCEs for each of the measures selected in this year's review were due to differences in how the MCEs interpreted the instructions to compute the measures. Since none of the specifications are exactly HEDIS but more "HEDIS-like", there is room for variation in the interpretation of which aspects of the HEDIS specification should be included and which should be excluded from the OMPP measure.

With this in mind, B&A offers the following recommendations first to the OMPP and then to the MCEs on the validation of performance measures.

Recommendations to the OMPP

1. The OMPP should consider building more specificity in the instructions for each performance measure that it asks the MCEs to report on. For example,

    a. Instructions often cite the use of the "most current" HEDIS technical specification. The OMPP Reporting Manual is usually released as of January 1 of each year. The HEDIS technical specifications can change over the course of the calendar year. There is not clarity from the OMPP as to whether the MCEs should move to a new HEDIS specification as reference mid-way through the calendar year or not. B&A recommends keeping the same specification for an entire calendar year so that the four quarters reported on by the MCEs during year are computed in the same manner.

    b. Even if the verbiage in a HEDIS technical specification has not changed, the value sets or NDC lists that the NCQA often cites within its HEDIS technical specifications do change during the calendar year. It is unclear if the MCEs should move to updated value sets or NDC lists mid-way through the calendar year or not. B&A recommends keeping the same value sets and NDC lists throughout the year for the reason cited above.

    c. In lieu of incorporating the HEDIS specification in the OMPP instructions by reference, B&A recommends that the OMPP itemize specific elements within the specification in the instructions to ensure clarity of interpretation of the specification across all parties. For example, defining the anchor date for the study period, the use of continuous eligibility or not, the assignment of age and OMPP program if the member changes during the year, exclusions from the denominator, sources to count the numerator, etc.

2. With respect to the reporting templates themselves, B&A recommends that the OMPP build one template for each report that shows the results for all programs as columns going across so that both the MCE and the OMPP can review results for an MCE across multiple programs side-by-side. If an MCE does not participate in all of the OMPP's programs, the MCE can gray out the columns that do not pertain to them.

    This recommendation ensures alignment of the values required to be entered on each report are consistent across OMPP's programs. It also allows for more efficiency in tabulation for both the MCE and for the OMPP upon intake of all of the reports.

3. The OMPP may want to consider removing some of the reporting requirements in HHW for measures that, under the HEDIS definition, are limited to populations age 18 and over in light of the fact that the HHW enrollment at the end of CY 2017 for over age 18 was only 3.4 percent of the total enrollment. Some of the large variation in results between the MCEs and B&A on HHW measures may be attributable to the low denominators in the adult population.

4. For any measure that is reported as a rate rather than an absolute value, B&A strongly recommends that the OMPP require that the MCEs always report the numerator and denominator used to compute the rate on its report submission rather than just the rate itself.

5. Even if other aspects of a HEDIS specification are excluded from the OMPP specification for a measure (e.g., the granularity of exclusions applied in the numerator), B&A does recommend that the OMPP retain the continuous enrollment requirement specified in each HEDIS measure which is usually 12 months continuous enrollment with allowance for a one month gap in enrollment. Even though the quarterly results of measures are not equivalent to the final results from a HEDIS auditor, the inclusion of the continuous enrollment criteria will more closely align results during the year against the final audited results for measures that are computed using the administrative method.

<u>Recommendations to the MCEs</u>

1. If an MCE's self-reported results for a given measure deviate more than five percentage points in a given quarter against its own four-quarter average, the OMPP should require the MCE to provide a written summary of the root cause analysis that the MCE conducted to verify that the large deviation reported is valid.

2. It is recommended that the OMPP require each MCE to complete a checklist that validates the incorporation of all technical specifications into the measure on an annual basis. B&A recommends that this checklist be similar to one that B&A developed in this year's EQR for the four reports validated. The OMPP can require that these specifications be submitted by the MCE on an annual basis with the submission of Quarter 1 results. To the extent that specifications change at the start of a calendar year, the submission of the technical documentation after Quarter 1 will ensure that each MCE has appropriately made any programming changes necessary for measure calculations in the current year.

3. Related to the recommendation above, each MCE should conduct its own audit of the way it has programmed the specifications for the measures that are "HEDIS-like" to confirm that it has built its specification in the manner requested by the OMPP. Any open items related to the interpretation of specifications should be submitted to the OMPP for clarification. For the measures validated this year, it was found that each MCE had at least two instances where it deviated from all of its peers on how it handled a specific aspect of a measure specification.

4. When a measure controls for age, the results across OMPP programs should be similar for a given age group. The MCEs should be prepared on an ongoing basis to explain variances in the results for utilization measures across MCEs that vary significantly if controlled for age.

SECTION IV: VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

Introduction

The OMPP uses the term Quality Improvement Plan, or QIP, to define the Performance Improvement Projects that it requires of its managed care entities (MCEs). Therefore, in this report, references to "QIPs" mean the same thing as "PIPs" as described in the Centers for Medicare & Medicaid (CMS) External Quality Review (EQR) Protocol 3: *Validation of Performance Improvement Projects*. Burns & Associates, Inc. (B&A) utilized the guidance for this CMS Protocol to complete this year's validation which includes the following steps:

Activity 1: Assess the Study Methodology

1. Review the selected study topic(s)
2. Review the study question(s)
3. Review the identified study population
4. Review the selected study indicators
5. Review sampling methods
6. Review the data collection procedures
7. Review data analysis and interpretation of study results
8. Assess the MCO's improvement strategies
9. Assess the likelihood that reported improvement is "real" improvement
10. Assess sustainability of the documented improvement

Activity 2, Verify Study Findings (an optional activity not completed as part of this year's EQR)

Activity 3, Evaluate and Report Overall Validity and Reliability of QIP Results

B&A customized some of the components in the CMS Protocol's PIP Review Worksheet to better assess the specific QIPs at each MCE. In particular, more focus was spent on the MCE interventions for each QIP to determine if each intervention was measurable and how the results of interventions informed the MCE's assessment of the QIP.

In the EQR conducted in Calendar Year (CY) 2014, B&A assisted the Office of Medicaid Policy and Planning (OMPP) in revising the format that the MCEs submit their annual QIP reports. The QIPs cover a calendar year period and the annual report on each QIP is due to the OMPP on August 1 of the following calendar year. The new QIP reporting tool took effect for QIPs in place in CY 2015.

After the EQR was completed in CY 2016, both B&A and the MCEs had proposed recommendations for further refining the tool after using it in practice for one year. At the OMPP's request, B&A convened a meeting with all of the MCEs on November 15, 2016 to discuss the proposed refinements to the tool. These refinements were agreed to and implemented for use in reporting the results from CY 2016 QIPs in the annual submissions due to the OMPP on August 1, 2017.

In response to a recommendation made by B&A in last year's EQR, the OMPP convened the MCEs in a QIP "pre-meeting" prior to the start of CY 2018 where each MCE gave a brief presentation of their QIPs for the upcoming year. This meeting was held on December 13, 2017. The MCEs presented their proposed 2018 QIPs and both the state and B&A provided suggestions and recommendations for enhancing the projects.

As part of the validation of QIPs conducted in the CY 2018 EQR, the B&A EQR team members reviewed the submissions on this updated QIP Reporting Tool as well as ancillary information either provided by the MCEs or requested by B&A to assist in supporting the results reported in the QIP Reporting Tool.

Methodology Related to the Validation Process

1. B&A verified with each MCE the QIPs in place for CY 2017 and the OMPP programs that each QIP pertained to.

2. B&A then selected QIPs from each MCE for inclusion in this year's validation.

3. The MCEs submitted the annual QIP reports to B&A for desk review that were due to the OMPP on August 1, 2018.

4. B&A team members Mark Podrazik and Kristy Lawrance independently conducted a desk review of each annual QIP report and the associated quarterly updates that had been submitted up to the annual submission. Specific elements conducted as part of the desk review included examining:

    a. The study question;
    b. The definition of performance measures;
    c. The definition of interventions;
    d. The method in which numerators and denominators are defined as ways to assess the effectiveness of interventions;
    e. The methods in which the MCEs assess their interventions;
    f. The qualitative summary provided by the MCE in its annual QIP report; and
    g. Indications of how the MCE is continually improving upon its QIP.

5. The B&A team members developed customized questions to pose to each MCE in an onsite meeting related to its CY 2017 QIPs.

6. One-on-one meetings were held with each MCE on August 15 or 16 to discuss their QIP reports. The MCEs had representatives from their team who were the leads for each QIP and those that could speak to the specific QIP interventions available for the onsite interviews. In some instances, the MCEs brought supplemental information to the meeting to explain more fully the analytics completed on QIP measure results.

7. The EQR team members considered the items from the desk review, the responses in onsite interviews and supplemental information provided by the MCEs to complete the assessment on each MCE QIP as part of a post-onsite evaluation.

Quality Improvement Projects Reviewed

The MCEs are required to have QIPs for all three programs that it administers—Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC). The MCEs have the option to conduct the same QIP across programs. Although the MCEs select their own QIPs, it is often the case that the choice of QIPs reflects measures in the OMPP's Pay for Outcomes (P4O) program. For this year's EQR, B&A validated the QIPs shown at the top of Exhibit IV.1 on the next page. The middle section of the exhibit states if the MCE indicated if the QIP would continue in CY 2018 or not. If it is going to continue, the MCE cited any improvements that are being made to the QIP.

Exhibit IV.1
Inventory of the Quality Improvement Programs Reviewed in the 2018 EQR

	Anthem			Caresource		MDwise		MHS		
QIP Topic	**HHW**	**HCC**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HCC**	**HIP**
AOD Treatment								x	x	x
Adult Preventive Care Visit		x	x							
Annual Dental Visit	x									
ED Utilization		x	x					x	x	x
Follow-up Psychiatric Hospitalization	x	x	x				x			
Health Needs Screening	x	x	x	x	x	x	x	x	x	x
Job Connect Program				x	x					
Notification of Pregnancy						x				

Will the QIP Continue in 2018?

	Anthem			Caresource		MDwise		MHS		
QIP Topic	**HHW**	**HCC**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HCC**	**HIP**
AOD Treatment								Yes	Yes	Yes
Adult Preventive Care Visit		Yes	Yes							
Annual Dental Visit	Yes									
ED Utilization		Yes	Yes					No	No	No
Follow-up Psychiatric Hospitalization	Yes	Yes	Yes				Yes			
Health Needs Screening	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Job Connect Program				Yes	Yes					
Notification of Pregnancy						Yes				

If Continuing, Were Improvements Cited to the QIP in the Coming Year?

	Anthem			Caresource		MDwise		MHS		
QIP Topic	**HHW**	**HCC**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HCC**	**HIP**
AOD Treatment								No	No	No
Adult Preventive Care Visit		Yes	Yes							
Annual Dental Visit	Yes									
ED Utilization		Yes	Yes					N/A	N/A	N/A
Follow-up Psychiatric Hospitalization	Yes	Yes	Yes				Yes			
Health Needs Screening	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Job Connect Program				No	No					
Notification of Pregnancy						No				

Summary of Findings

In Exhibits IV.2 and IV.3 on the next two pages, summary tables are presented of B&A's assessment of the validation of measures identified in each MCE's QIP (Exhibit IV.2) and the validation of interventions identified in each MCE's QIP (Exhibit IV.3). After these exhibits, a brief description of each MCE's QIP is presented.

In most cases, the measures defined by each MCE for its QIPs were valid. This is because in the majority of situations, the MCE is using a HEDIS measure as the measure in its QIP as well. There were some issues identified with non-HEDIS measures. Anthem cited that it was not that the measure for the rate of health needs screening (HNS) was an issue per se; rather, it was a matter of how Anthem was defining specifications for the calculation of the measure compared to how Optum (the OMPP contractor responsible for final HNS calculations) was calculating it.

Although not specifically identified by the other MCEs, B&A inferred that this may be the case with other MCEs as well since each of the MCEs went through a reconciliation process with Optum on HNS submissions. Anthem happened to be the first to do so.

CareSource created a QIP (at the request of OMPP) related to the number of jobs found for Indiana Medicaid members for its first year of operations. B&A recognizes that this is the baseline year for this measure, but the measures cited were indirectly related to actual jobs found.

The results were mixed with respect to improvements in the measures defined within each MCE's QIP compared to the prior year. One measure that must have a caveat is the HEDIS FUH measure (follow-up after a psychiatric hospitalization). The National Committee for Quality Assurance (NCQA) changed the specifications for this measure such that same-day appointments are no longer countable. As a result, every MCE's results are expected to be worse than the prior year. The question remains how Anthem and MDwise did compared to their peers nationally on this measure.

In the review of interventions, most interventions were well defined at the outset. That is, the intervention had a numerator and denominator defined to measure effectiveness. It was often observed that the MCE cited a control group to measure the effectiveness of the intervention. There are opportunities for both Anthem and MHS to better define its interventions related to ED utilization. CareSource could also improve its definitions of interventions for its QIPs.

Another finding is that not all interventions originally defined in the QIP were completed throughout the year. In some cases, the intervention was never even initiated. MCEs cited reasons for not completing interventions as a realization upon preparing the intervention that it was not feasible or a determination relatively early in the year that the intervention was not going to be effective given the level of effort it demanded.

When the interventions were implemented and could be measured for effectiveness, results were mixed as to whether the interventions were computed effectively. By the term effective, B&A means that in some cases it could easily be determined from the results used to measure the intervention that the intervention was effective. In other cases, this was less clear. Anthem's computations related to its interventions were most clear and could provide a direct causation to the intervention's effectiveness. MDwise also had effective analytics for the interventions in two of its QIPs. MHS had evidence of this in the interventions for one of its three QIPs. CareSource did not provide tangible results of the effectiveness of its interventions.

Exhibit IV.2

Summary of Findings Related to Validation of Measures in Each MCE's Quality Improvement Program

Were the Measure(s) Well Defined in the QIP?

	Anthem			Caresource		MDwise		MHS		
QIP Topic	**HHW**	**HCC**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HCC**	**HIP**
AOD Treatment								Yes	Yes	Yes
Adult Preventive Care Visit		Yes	Yes							
Annual Dental Visit	Yes									
ED Utilization		Yes	Yes					Yes	Yes	Yes
Follow-up Psychiatric Hospitalization	Yes	Yes	Yes				Yes			
Health Needs Screening	Yes*	Yes*	Yes*	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Job Connect Program				No	No					
Notification of Pregnancy						Yes				

Was Improvement Found in the Results for the Measure(s) from the Previous Year?

	Anthem			Caresource		MDwise		MHS		
QIP Topic	**HHW**	**HCC**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HCC**	**HIP**
AOD Treatment								No	Mixed	Mixed
Adult Preventive Care Visit		No	No							
Annual Dental Visit	1st year									
ED Utilization		Yes	Yes					Yes	Yes	Yes
Follow-up Psychiatric Hospitalization	No**	No**	No**				No**			
Health Needs Screening	No	No	No	1st year	1st year	Yes	Yes	No	No	Yes
Job Connect Program				1st year	1st year					
Notification of Pregnancy						Yes				

*The issue was not that the measure was not well defined; rather, that there was misalignment of data in the computation and interpretations of definitions compared to Optum's definitons (as learned through the HNS reconciliation project conducted with Optum).

**But this may more likely be driven by the change in the HEDIS spec to exclude same-day appointments. Both MCEs cited that they thought that they did better than expected (i.e. did not drop as much as they thought they would with spec change), but won't know for sure until Quality Compass release.

Exhibit IV.3

Summary of Findings Related to Validation of Interventions in Each MCE's Quality Improvement Program

Were the Intervention(s) Well Defined in the QIP?

	Anthem			Caresource		MDwise		MHS		
QIP Topic	**HHW**	**HCC**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HCC**	**HIP**
AOD Treatment								Yes	Yes	Yes
Adult Preventive Care Visit		Yes	Yes							
Annual Dental Visit	Yes									
ED Utilization		Mixed	Mixed					No	No	No
Follow-up Psychiatric Hospitalization	Yes	Yes	Yes				Yes			
Health Needs Screening	Yes	Yes	Yes	Mixed	Mixed	Yes	Yes	Yes	Yes	Yes
Job Connect Program				No	No					
Notification of Pregnancy						Yes				

Were the Intervention(s) Completed as Planned?

	Anthem			Caresource		MDwise		MHS		
QIP Topic	**HHW**	**HCC**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HCC**	**HIP**
AOD Treatment								2 out of 2	2 out of 2	2 out of 2
Adult Preventive Care Visit		1 out of 2	1 out of 2							
Annual Dental Visit	2 out of 3									
ED Utilization		2 out of 3	2 out of 3					1 out of 2	1 out of 2	1 out of 2
Follow-up Psychiatric Hospitalization	1 out of 1	1 out of 1	1 out of 1				1 out of 1			
Health Needs Screening	3 out of 3	3 out of 3	3 out of 3	1 out of 4	1 out of 4	2 out of 2	2 out of 2	3 out of 3	3 out of 3	3 out of 3
Job Connect Program				1 out of 1	1 out of 1					
Notification of Pregnancy						1 out of 1				

Were the Results from the Intervention(s) Computed Effectively?

	Anthem			Caresource		MDwise		MHS		
QIP Topic	**HHW**	**HCC**	**HIP**	**HHW**	**HIP**	**HHW**	**HIP**	**HHW**	**HCC**	**HIP**
AOD Treatment								No	No	No
Adult Preventive Care Visit		Yes (all LOB)								
Annual Dental Visit	Yes									
ED Utilization		Mixed	Mixed					No	No	No
Follow-up Psychiatric Hospitalization	Yes	Yes	Yes				Yes			
Health Needs Screening	Yes	Yes	Yes	no results	no results	No	No	Yes (2/3)	Yes (2/3)	Yes (2/3)
Job Connect Program				no results	no results					
Notification of Pregnancy						Yes				

Anthem QIP Findings

Adult Access to Preventive Care

Is the QIP related to an OMPP P4O initiative?	Yes
QIP in place in the following Program(s)	HIP, HCC
Year in which the QIP began	2016 (for HCC), 2017 (for HIP)
Will the QIP continue in the coming year?	Yes

Anthem utilizes the HEDIS measure for Adult Ambulatory and Preventive Care (AAP) to assess the impact of this QIP.

Interventions

1. Text outreach for completion of the annual preventive care visit.

In the previous year, Anthem had been conducting live outreach calls to members, but this did not prove to be cost effective. In CY 2017, Anthem redirected its intervention to utilize text or email outreach as the first mode of communication to members for reminders to seek a preventive visit.

Anthem stated that they receive affirmative responses from members who are texted or emailed. A system has been developed so that Anthem's claims system is swept to determine opportunities among members with no evidence of a preventive visit. When a member has the preventive care visit, they are given a member incentive.

Impact of the QIP

Measure Goal: 87.6% (HEDIS 90th percentile)

- HIP results: 82.2% in CY 2017 versus 82.3% in 2016
- HCC results: 85.4% in CY 2017 versus 85.9% in 2016

Lessons Learned / Next Steps

In early 2017, Anthem developed a more comprehensive tracking system related to this QIP. Examples of reports include a year-to-date running total of closed gaps (numerator adherence) for the AAP measure comparing CYs 2017 and 2016.

In 2017, Anthem changed the text script such that it is easier for a member to notify Anthem if they had received a preventive visit. Anthem as a corporate entity takes a strict position on adherence to the national Do Not Call list. They made the Do Not Call list specific to each test campaign.

Anthem initiated member incentives at the end of 2017. Some scripts sent to members are related to educating them about the incentives, while others are specific to AAP. Members are now getting texts all year long.

Annual Dental Visit

Is the QIP related to an OMPP P4O initiative?	No
QIP in place in the following Program(s)	HHW
Year in which the QIP began	2017
Will the QIP continue in the coming year?	Yes

Anthem utilizes the HEDIS measure for Annual Dental Visit (ADV) to assess the impact of this QIP.

Interventions

1. Text outreach for completion of the annual dental visit.
2. Live outbound calls in the 4th Quarter of 2017.

Impact of the QIP

Measure Goal: 65.9% (HEDIS 90th percentile)

- HHW results: 60.4% in CY 2017 (baseline year)

Lessons Learned / Next Steps

The intervention initially contemplated to outreach to members through community health workers was abandoned due to a low reach rate.

Anthem had conducted live outbound calls in the 2nd and 3rd Quarters of 2017 but they were discontinued. Their dental vendor offered to do outreach for Anthem, so Anthem looked at opportunities by age and worked with its vendor who made the outreach calls. Anthem identified the greatest opportunity to improve remains with the oldest and the youngest members of this population.

Anthem also enhanced their internal reporting to separate out children and adults to better inform about them about the engagement of the two groups.

Anthem is investigating the possibility with the OMPP of texting teenagers age 18 and younger.

Emergency Department (ED) Utilization

Is the QIP related to an OMPP P4O initiative?	Yes
QIP in place in the following Program(s)	HIP, HCC
Year in which the QIP began	2017
Will the QIP continue in the coming year?	Yes

Anthem utilizes the HEDIS measure for the Ambulatory ED Visit rate (AMB-ED) to assess the impact of this QIP.

Interventions

1. Referral of high ED utilizers to case management.
2. Referral of high ED utilizers to community health worker outreach.

Impact of the QIP

Measure Goal: Less than 80 ED visits per 1,000 member months

- HIP results: 88 per 1,000 in CY 2017 versus 92 per 1,000 in 2016
- HCC results: 106 per 1,000 in CY 2017 versus 109 per 1,000 in 2016

Lessons Learned / Next Steps

In the middle of CY 2017, Anthem began to receive daily feeds on hospital admissions, discharges and transfers from IHIE (the Indiana Health Information Exchange). Data is read in and synthesized to identify the members referred to case management for outreach and the members referred from case management to Community Health Workers. All members using the ED get a text message on ED diversion, however.

With this information, Anthem is segmenting for the case management staff which members are already in case management and which are the ED "frequent flyers".

In 2018, Anthem has initiated a program for members to text back "UCC" to get a list of urgent care centers in their area as a means to divert from the ED. They have also expanded the presence of community health workers in some large hospital EDs to connect with members in person.

Follow-up After Hospitalization for a Psychiatric Stay

Is the QIP related to an OMPP P4O initiative?	Yes
QIP in place in the following Program(s)	HHW, HIP, HCC
Year in which the QIP began	2015
Will the QIP continue in the coming year?	Yes

Anthem utilizes the HEDIS measure for 7-day follow-up visit after an inpatient psychiatric discharge (FUH) to assess the impact of this QIP.

Interventions

1. Reminder call to patients within 72 hours to discharge to make appointment. This is measured for effectiveness as number of successful calls made divided by total discharges identified.

Impact of the QIP

All of the rates went down due to the change in the HEDIS specification for the measures, but to varying degrees.

Measure Goal for 7-day: 64.2% (HEDIS 90th percentile)

- HHW results: 52.5% in CY 2017 versus 60.8% in 2016
- HIP results: 35.3% in CY 2017 versus 43.2% in 2016
- HCC results: 35.2% in CY 2017 versus 45.4% in 2016

Lessons Learned / Next Steps

Since March 2017, Anthem has been tracking on a monthly basis the number of members in need of a reminder call, the number of members who received a reminder call, the number of members with an appointment documented, and the number of members with both a reminder call and an appointment documented. They focus on the six counties with the highest prevalence of inpatient stays.

As a result of this analysis, six counties and the Community Mental Health Centers (CMHCs) in these counties have been targeted for enhanced outreach.

Additional interventions were also considered in CY 2017. Anthem started to send Community Health Workers to engage with members in the field, particularly those who could not be reached by their third day post-hospital discharge. Anthem is still collecting data on the effectiveness of this intervention. Anthem has also explored using telepsychiatry as a modality to meet the 7-day appointment, but the contract to initiate this had been stalled. Negotiations are underway to begin.

Members who were contacted through outreach calls who make an appointment and keep it are now given a $20 incentive payment as well.

New Member Health Needs Screening (HNS)

Is the QIP related to an OMPP P4O initiative?	Yes
QIP in place in the following Program(s)	HHW, HIP, HCC
Year in which the QIP began	2016
Will the QIP continue in the coming year?	Yes

Anthem utilizes the OMPP's measure specification for this QIP, that is, the percentage of new members (not with the MCE in the last 12 months) who have completed a HNS tool within 90 days of Anthem's notification of their new member.

Interventions

1. Use of Pursuant Health kiosks located in Walmart pharmacies throughout the state.
2. Text campaign to remind members to complete the HNS.
3. In-person outreach to members by deploying a specialized team in the field.

Impact of the QIP

Measure Goal: 70% completion rate (the OMPP P4O target)

- HHW results: 30.8% in CY 2017 versus 39.1% in 2016
- HIP results: 29.2% in CY 2017 versus 34.2% in 2016
- HCC results: 31.4% in CY 2017 versus 50.4% in 2016

Lessons Learned / Next Steps

Anthem learned in 2017 that although the kiosk modality yielded very positive results in 2016, this pace for HNS completion was not sustainable in 2017. As a result, other modalities are needed to reach members to complete the HNS. Anthem has initiated a text campaign as well as live-voice outbound calls in 2018.

Anthem also had internal and external challenges in identifying members for HNS completion in 2017. The State's migration to a new information system impacted Anthem's ability to correctly identify new members. Anthem also had an internal system migration which impacted its ability to swiftly identify new members. The third challenge was the movement of HCC members from MDwise. This large influx of new members impacted Anthem's ability to outreach to all members timely for the new member screening.

CareSource QIP Findings

New Member Health Needs Screening (HNS)

Is the QIP related to an OMPP P4O initiative?	Yes
QIP in place in the following Program(s)	HHW, HIP
Year in which the QIP began	2017
Will the QIP continue in the coming year?	Yes

CareSource utilizes the OMPP's measure specification for this QIP which is the same as Anthem (see above).

Interventions

1. Use of Pursuant Health kiosks located in Walmart pharmacies throughout the state (delayed).
2. Promote HNS completion through the member portal.
3. In-person outreach to members by deploying a specialized team in the field.

Impact of the QIP

Because CareSource came under contract in January 2017, this is the baseline year for measurement.

Measure Goal: 70% completion rate (the OMPP P4O target)

- HHW results: 11.0% in CY 2017
- HIP results: 22.0% in CY 2017

Lessons Learned / Next Steps

CareSource had intended to initiate the Pursuant kiosk modality in 2017 but ran into legal roadblocks. The target date to initiate this is now September 1, 2018.

Although it was not mentioned as an intervention in their QIP, CareSource had relied on an outside contractor to conduct outbound calls to do the intake of HNSs. After a review of the vendor's compliance and its rate of return, CareSource has terminated this agreement with the vendor and will bring this function in-house effective October 1, 2018. CareSource has outlined a work plan, training and monitoring system to more effectively track the return rate of completed HNSs when this begins.

Other actions cited by CareSource to improve the HNS completion rate is hiring a dedicated FTE to locate good contact information for members and to initiate reminder mailings to members.

Job Connect Program

Is the QIP related to an OMPP P4O initiative?	No
QIP in place in the following Program(s)	HHW, HIP
Year in which the QIP began	2017
Will the QIP continue in the coming year?	Yes

CareSource utilizes three measures to assess the effectiveness of its Job Connect program:

1. The rate of HNSs completed by members in the Job Connect program.
2. The rate of preventive visits (HEDIS AAP measure) for members in the Job Connect program.
3. The rate of ED utilization for members in the Job Connect program.

Interventions

CareSource has initiated a program in which resources are provided to HHW and HIP members to assist them in obtaining meaningful employment. Once a critical mass is reached, CareSource hopes to measure member behaviors using the measures cited above to compare individuals in the Job Connect program and those not in the program.

Impact of the QIP

This was the first year of the QIP and it started out slow, so CareSource was not able to effectively assess the impact of the Job Connect program in CY 2017. They did state that participants received an average of 3.4 referrals for job placement

Lessons Learned / Next Steps

It is CareSource's intention to measure pre- and post-intervention data on the individuals participating in the JobConnect program. In CY 2017, 147 members were engage in the program. CareSource has expanded the resources available to the program by adding four Life Coach positions that will allow for 320 additional members to receive program supports.

Managed Health Services QIP Findings

Alcohol and Other Drug Dependence (AOD) Treatment

Is the QIP related to an OMPP P4O initiative?	No
QIP in place in the following Program(s)	HHW, HIP, HCC
Year in which the QIP began	2015 (for HIP, HCC), 2017 (for HHW)
Will the QIP continue in the coming year?	Yes

MHS utilizes four measures to assess the impact of this QIP. Two measures are from the HEDIS measure for Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment (IET Initiation and IET Engagement). The other two measures are from the HEDIS Follow-up Visit After ER Visit for AOD (FUA 7-day and FUA (30-day).

Interventions

1. Clean Slate program (medication assisted treatment for opioids or alcohol)
2. Field-based case managers deployed to outreach to members.

Impact of the QIP

Measure Goal for IET Initiation: 45% (HEDIS 75th percentile)
- HHW results: 41.0% in CY 2017 versus 46.0% in CY 2016
- HIP results: 43.6% in CY 2017 versus 39.9% in CY 2016
- HCC results: 40.7% in CY 2017 versus 41.8% in CY 2016

Measure Goal for IET Engagement: 16% (HEDIS 75th percentile)
- HHW results: 10.6% in CY 2017 versus 14.2% in CY 2016
- HIP results: 17.3% in CY 2017 versus 13.8% in CY 2016
- HCC results: 10.7% in CY 2017 versus 8.0% in CY 2016

Measure Goal for FUA 7-day: 10% (set by MHS)
- HHW results: 5.8% in CY 2017 versus 4.3% in CY 2016
- HIP results: 8.8% in CY 2017 versus 8.2% in CY 2016
- HCC results: 6.8% in CY 2017 versus 9.6% in CY 2016

Measure Goal for FUA 30-day: 10% for HHW, 15% for HIP and HCC (set by MHS)
- HHW results: 9.7% in CY 2017 versus 5.5% in CY 2016
- HIP results: 12.7% in CY 2017 versus 12.0% in CY 2016
- HCC results: 9.3% in CY 2017 versus 14.6% in CY 2016

Lessons Learned / Next Steps

MHS had started to do the intake and review of next day information from the Michiana Health Information Network (MHIN) on admission/discharge/transfer (ADT) information as a way to identify individuals to outreach to. What was learned was that only primary diagnosis was present and often it was found that the AOD-related diagnoses did not appear as the primary diagnosis.

Emergency Department (ED) Utilization

Is the QIP related to an OMPP P4O initiative?	Yes
QIP in place in the following Program(s)	HHW, HIP, HCC
Year in which the QIP began	2014 (for HHW, HIP) and 2016 (for HCC)
Will the QIP continue in the coming year?	No

MHS utilizes a claims-based ED utilization per 1,000 member month metric that is discrete for each program to assess the impact of this QIP.

Interventions

1. Targeted outreach calls to members who presented with a non-emergent ED visit
2. Outreach emails/texts to the membership age 20-44 who presented with a non-emergent ED visit

Impact of the QIP

MHS set a different goal specific to each program:

Measure Goal for HHW: Less than 52 visits per 1,000 (below HEDIS 25th percentile)
- HHW results: 46 per 1,000 in CY 2017 versus 50 per 1,000 in 2016

Measure Goal for HIP: Less than 85 visits per 1,000 (defined by MHS)
- HIP results: 91 per 1,000 in CY 2017 versus 97 per 1,000 in 2016

Measure Goal for HCC: Less than 85 visits per 1,000 (defined by MHS)
- HCC results: 102 per 1,000 in CY 2017 versus 107 per 1,000 in 2016

Lessons Learned / Next Steps

Using information from the Michiana Health Information Network (MHIN) on admission/discharge/transfer (ADT) information, MHS now makes a phone call to all members with an ED visit that are identified through the ADT information. MHS sends out a list of urgent care centers in or near the member's zip code along with information about the services available at the urgent care clinics. This is being used as a way to divert members from the hospital ED.

Other modes were cited by MHS to prevent unnecessary ED visits such as education to parents for treating medical needs of children in their first year of life.

MHS stated that due to the improvement in the ED utilization rate, it has suspended this QIP at the end of CY 2017.

New Member Health Needs Screening (HNS)

Is the QIP related to an OMPP P4O initiative?	Yes
QIP in place in the following Program(s)	HHW, HIP, HCC
Year in which the QIP began	2017
Will the QIP continue in the coming year?	Yes

MHS utilizes the OMPP's measure specification for this QIP which is the same as the other MCEs.

Interventions

Some interventions were cited for CY 2017, but many others have been added in 2018 (see "Lessons Learned" below).

1. Use of Pursuant Health kiosks located in Walmart pharmacies throughout the state.
2. Allowing HIP Plus members to pay POWER Account contributions with member rewards funds.
3. Expanded data mining for obtaining alternative means to contact members.

Impact of the QIP

Measure Goal: 70% completion rate (the OMPP P4O target)

- HHW results: 27.0% in CY 2017 versus 36.9% in 2016
- HIP results: 26.2% in CY 2017 versus 22.6% in 2016
- HCC results: 29.2% in CY 2017 versus 39.3% in 2016

Lessons Learned / Next Steps

In order to boost the HNS completion rate, MHS determined in 2018 that it needed to turn this into a "campaign". Now, MHS sends out a weekly email until members complete the HNS and tie the completion to a reward. The reward amount goes down over time as it gets closer to the due date for completion. The email will change over time so it is not repetitive.

MHS is also sending ads on Facebook to its members. Text messages that are sent were changed to reflect more motivational language. Also, MHS has developed logic so that when its members access the internet and search under the Google or Bing engines, MHS personalized ads appear.

MHS has also initiated the following additional interventions:

- Automated welcome call which is a warm introduction to MHS. The HNS could also be accepted during this call.
- Adding a dedicated FTE to conduct research for alternative means to reach members (phone numbers, emails, etc).

MDwise QIP Findings

Follow-up After Hospitalization for a Psychiatric Stay

Is the QIP related to an OMPP P4O initiative?	Yes
QIP in place in the following Program(s)	HIP
Year in which the QIP began	2011
Will the QIP continue in the coming year?	Yes

MDwise utilizes the follow-up visit within seven days after inpatient discharge (FUH, as defined by HEDIS) to measure the effectiveness of this QIP.

Interventions

1. Targeted outreach (in-person meetings, education) to the five lowest-performing facilities.
2. Member incentives for completion of 7-day and 30-day follow-up appointments.
3. Outreach for high-risk members through case management.

Impact of the QIP

The rate went down due to the change in the HEDIS specification for the measure, but MDwise stated it went down less than what they expected.

Measure Goal for 7-day: 43.9% (HEDIS 50th percentile)

- For HIP, 36.2% in CY 2017 versus 41.8% in 2016

Lessons Learned / Next Steps

MDwise reported that it saw improvement in the FUH rate for all five of the lowest-performing facilities that it worked with in 2016 when it started this new intervention. As a result, five different facilities were selected for CY 2017.

With respect to the incentives intervention, MDwise followed the members and reported that no readmissions were found among the members that received an incentive payment for fulfilling their follow-up visit.

New interventions are underway in 2018 as well. MDwise is working to strengthen relationships between community mental health centers (CMHCs) and psychiatric hospitals. One relationship has been formed where a CMHC employee spends time at the hospital. Another method that MDwise has started to use to improve the FUH rate is to engage not only with the patient but also with his/her family members and primary medical provider. Lastly, MDwise has started to deploy individuals in the field to conduct in-person visits to patients in their homes. This is targeted to certain zip codes.

New Member Health Needs Screening

Is the QIP related to an OMPP P4O initiative?	Yes
QIP in place in the following Program(s)	HIP
Year in which the QIP began	2015 for HIP (2017 for HHW)
Will the QIP continue in the coming year?	Yes

MDwise utilizes the OMPP's measure specification for this QIP which is the same as the other MCEs.

Interventions

1. Email campaign to remind members to complete the HNS.
2. Phone campaign to remind members but adjust the auto-dialer to use a second phone number if available.
3. Introduction of the web portal to complete the HNS.

Impact of the QIP

MDwise set its target specific to each OMPP program.

Measure Goal for HHW: 72% completion rate

- HHW results: 72.3% in CY 2017 versus 70.3% in 2016

Measure Goal for HIP: 76% completion rate

- HIP results: 76.8% in CY 2017 versus 72.0% in 2016

Lessons Learned / Next Steps

MDwise introduced three new interventions at the start of CY 2017. The first is to send email blasts to all new members about completing the HNS. An email is sent out every other week to new members. MDwise tracks the number of members who opened the email to measure the effectiveness of this intervention. The second intervention is to initiate a second phone number in MDwise's auto-dialer. MDwise will assess the HNS completion rate for those with a second number available against those with no second number. The third intervention is the introduction of a web portal for members to complete the HNS online. MDwise reported low take up on this option in 2017.

Notification of Pregnancy (NOP)

Is the QIP related to an OMPP P4O initiative?	No
QIP in place in the following Program(s)	HHW (but tracking HIP as well)
Year in which the QIP began	2017
Will the QIP continue in the coming year?	Yes

MDwise uses the rate of completion of the NOP to measure the effectiveness of this QIP.

Interventions

1. Outreach to lowest-performing provider offices for 1:1 education and follow-up by MDwise case managers.

Impact of the QIP

Measure Goal for HHW: 23% completion rate (defined by MDwise)
- HHW results: 31% in CY 2017 versus 19% in 2016

Measure Goal for HIP: 23% completion rate (defined by MDwise)
- HHW results: 31% in CY 2017 versus 1% in 2016

Lessons Learned / Next Steps

This QIP was initiated in CY 2017 and piloted with one of MDwise's eight delivery systems. The State's transition to a new information system added some barriers that were eventually resolved but it took offices a lot of time and effort to get the correct access to complete the NOPs in the system online. Some offices that were initially engaged asked MDwise to stop follow-up with them. Other offices, however, worked hard to implement a process for this into the office routine.

MDwise also learned that there needs to be more education and training in offices regarding NOPs in general. Some offices had issues of being understaffed and some had high turnover rates. MDwise stated that this resulted in conducting more frequent training and education.

In working with the offices that did develop a process and completed NOPs, they were very willing and eager to complete them. They had extensive education and direct connection with MDwise's Care Management to assist with member needs. It allowed a positive collaboration to not only benefit the member but also the office.

Recommendations Related to the Validation of Quality Improvement Projects

Based on our review of the QIPs in this year's EQR, B&A has developed specific recommendations to the OMPP and to the MCEs on ways to improve on the reporting and analysis of QIPs.

Recommendations to the OMPP

1. The OMPP requested that each MCE initiate a QIP in an effort to improve the timely completion rate of HNSs. The MCEs have worked in coordination with the OMPP contractor, Optum, to provide information on HNS completions. Optum then calculates the percentage of each MCE's HCC or HIP members who have completed an HNS. The OMPP has a P4O incentive to the MCEs for meeting HNS completion targets. Right now, Optum is only computing each MCE's completion rate annually. The MCEs would prefer a quarterly measure on this statistic in order to synchronize with its own findings on the measure as it tracks within its QIP. B&A concurs with the MCE's request for this information and recommends that OMPP have Optum submit quarterly HNS completion results to each MCE along with a list of members identified with an HNS so that the MCEs can validate the totals against their internal records.

2. Because the HNS is deemed an important initiative to the OMPP, it is important the definitions of terms and programming logic are verified across the MCEs. In discussions with the MCEs, B&A learned that there are likely inconsistencies with what is being counted as a completed HNS, how the MCEs are treating presumptive eligibility, and how members who transition between OMPP programs (e.g., from HHW to HIP) are handled. B&A recommends that the OMPP release detailed specifications on these items and follow-up with verification that each MCE has implemented them according to the specifications.

3. Dental services were carved into the managed care contracts in CY 2017. Thus, for the HEDIS ADV measure, 2017 was a baseline year for the MCEs. Anthem chose to develop a QIP for ADV in CY 2017. It is anticipated that, with some known challenges to dental access, other MCEs may select ADV as a future QIP. B&A encourages the OMPP to run the ADV rates for CYs 2015 and 2016 in the fee-for-service system for all HHW members for use as a baseline to measure against future MCE QIPs.

4. In 2017, NCQA modified the specification for the FUH measure to exclude same day follow-up or "bridge" appointments. This significantly lowered the FUH rates for all MCEs. The OMPP has not yet adjusted its pay-for-performance benchmarks for this measure. B&A advises that the OMPP consider adjustments to its current performance benchmarks once the NCQA's Quality Compass report is released to calibrate for this change in the FUH specification.

Recommendations to the MCEs

1. There were several reporting items that could be improved for all the MCEs.
    a. Analyze data by cohort populations. These could be by program, by geographic region, by age, by ethnicity or other designation. This analysis could assist with targeting intervention resources where they will generate the most impact.
    b. Provide a comparison metric for each intervention metric. There needs to be a way to determine if an intervention improved the measure or if it was something else that resulted in the change. MCEs could compare the intervention group to a control group, a "reached" group versus an "unreached" group, a "before" intervention rate compared to an "after" rate for the same group of members, etc.

c. It is not necessary to repeat the same information if it is relevant to all OMPP programs. When the information is the same for all lines of business, in the quarterly summaries simply write "see above" where the text appears originally.
d. Compute measures and intervention rates more often that annually. Monthly or quarterly measurements allow for monitoring and acting upon program changes sooner than waiting an entire year.

2. B&A makes the following specific recommendations to Anthem:
    a. In its QIP narrative for FUH, Anthem mentioned that it is incentivizing providers for their attributed membership. B&A recommends that this be recorded as an intervention since this can easily be measured for effectiveness (the group that is targeted and the group that is not targeted for the incentive).
    b. B&A recommends to Anthem to change the numerators and denominators to assess the effectiveness of the intervention of referring high ED utilizers to case management by using a control group (members not referred versus those that were referred).

3. B&A makes the following specific recommendations to CareSource:
    a. CareSource attempted numerous interventions to affect the HNS rate. Because there were so many, it is hard to isolate the effectiveness of each one. B&A supports CareSource's plan to focus its resources on a more limited set of interventions for the HNS and develop detailed analytics related to its effectiveness that can be easily tracked and trended over time (e.g. modality used to complete the HNS, methods of communication used that may trigger action by the member to complete).

    b. The initiative that CareSource has launched related to its Job Connect program is commendable, but it appears that this program may be more of a control group for another QIP (such as ED utilization or adult primary care visits) or potentially an intervention rather than a QIP in and of itself. B&A encourages CareSource to think about how its Job Connect program could be better leveraged in the context of QIPs.

4. B&A makes the following specific recommendations to MDwise:
    a. MDwise is encouraged to think strategically when designing its interventions. For example, its intervention for NOP was to work with the lowest performing providers. There were incentives such as a provider reward that could encourage take-up in participation.
    b. For the HNS QIP, MDwise presented a number of helpful analytics based on member demographics. B&A recommends recasting some of the results found to compare each demographic to MDwise's overall average to assess the greatest opportunities for improvement within the sub-populations.
    c. The facility-specific report cards in the FUH QIP appear to be very helpful to each of the participating facilities. B&A suggests sharing blinded results of all facilities participating in the intervention to provide context to each individual facility and to stimulate competition to improve their own rate.

5. In last year's EQR, B&A recommended that MHS spend more time defining its interventions and how they will be evaluated and measured. This recommendation carries through in this year's review as well. For example,
    a. For the AOD Dependence QIP, MHS presented two interventions. They did not compare the results to a comparison control group or some other means to determine if the programs were effective.

b. Similarly, MHS did not compare its direct education intervention rate to members who did not get education for its ED QIP. The same was true for the evaluation of the text member intervention.
c. In the onsite interview, MHS cited additional interventions to achieve a higher HNS completion rate than what was submitted in the QIP Report. MHS should document its numerous efforts through new or additional interventions on this QIP report.
d. Also, MHS needs to ensure that numerators and denominators are always reported in the QIP reporting tool for those measures that utilize numerators and denominators.

SECTION V: MCE COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS AND OMPP CONTRACTS

Introduction

Section V of the report summarizes the scores that Burns & Associates, Inc. (B&A) assigned to the portion of the External Quality Review (EQR) related to the review of managed care entity (MCE) operations. B&A mapped the current contract requirements that the Office of Medicaid Policy and Planning (OMPP) has with the MCEs for each of its managed care programs—Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC)—to the CFR to ensure that all regulatory items were assessed. B&A utilized the CMS EQR Protocol 1: *Assessment of Compliance with Medicaid Managed Care Regulations* that was published in September 2012 to complete this review. The total score for each MCE is introduced followed by information related to each functional area that was reviewed. At the individual functional level, B&A reports on the specific scores assigned to each MCE. This section concludes with the noteworthy items identified by B&A found at each MCE followed by recommendations from B&A to each MCE for continuous quality improvement as well as recommendations to the OMPP with respect to oversight of MCE operations.

Summary of Scores

Exhibit V.1 summarizes by functional area the total points available to each MCE and the score that they were assigned.

Exhibit V.1
Summary of Scores Related to MCE Compliance with Managed Care Regulations and OMPP Contracts

Review Topic Area	Number of Scored Items	Maximum Score	Anthem Score	CareSource Score	MDwise Score	MHS Score
Administrative Oversight	24	80	80	80	80	77
Subdelegation Oversight	6	60	60	60	60	55
Member Services and Enrollee Rights	77	140	134	133	140	134
Grievances and Appeals	21	80	80	80	80	80
Provider Network Management, Contracting, and Relations	53	120	119	116	120	119
Utilization Management	35	140	137	137	140	140
Program Integrity	13	60	60	60	60	60
Disease, Care and Complex Case Management	34	120	118	116	120	120
Quality Management	15	100	96	92	90	96
Information Systems	26	120	112	118	102	119
POWER Account Tracking and Reporting	46	80	75	76	78	78
TOTAL	**350**	**1100**	**1071**	**1068**	**1070**	**1078**
			97.4%	**97.0%**	**97.2%**	**98.0%**

Methodology to Conduct the Review

In total, there were 350 review items scored. All of the review items were derived from language in the contracts between the OMPP and the MCEs for the HHW and HIP that became effective January 1, 2017 or the contract for HCC that became effective April 1, 2015. With the exception of the POWER Account Tracking and Reporting section, most items reviewed are directly or indirectly related to items that tie to a specific provision within the Medicaid managed care regulations identified in the Code of Federal Regulations (42 CFR).

Scoring for each item was set as follows:	Fully Met	2 points
	Partially Met	1 point
	Not Met	0 points

A *Fully Met* score means that the MCE met at least 90 percent of the criteria evaluated. If the MCE did not meet the criteria the full 100 percent but was given a Met score, B&A has provided a recommendation to the MCE to meet the criteria 100 percent in future years.

A *Partially Met* score means that the MCE met at least 50 percent of the provisions of the criteria evaluated. This could occur if the CFR requires a policy to be put in place which was completed but B&A did not find evidence that this policy was always put into practice. Another situation could be if the MCE is required to complete a variety of activities to meet the provisions of the criteria evaluated and most but not all items in the list were met.

A *Not Met* score means that the MCE did not meet at least 50 percent of the requirements of the criteria evaluated.

The impact of each review item on managed care operations varies. Therefore, B&A assigned a weight to each review item which sometimes included sub-items as well. The weight values assigned were in the range of 1 to 5 depending upon the level of impact on operations or service delivery.[11] For example, if a review item was given a weight of 5, then the possible scores for that review item were:

Fully Met	10 points (2 points * weight of 5)
Partially Met	5 points (1 point * weight of 5)
Not Met	0 points (0 points * weight of 5)

The MCEs were informed with the release of the EQR Guide that the review items would focus on the CFR or items in their contract Scope of Work. The MCEs were not given the language of each review item specifically or the points assigned to each review item. However, a crosswalk was provided for each of the 130 desk items requested to the section within the MCE contract Scope of Work. The desk review items requested appear in the appendix to the EQR Guide which is provided here in Appendix D.

The 11 review topic areas were consolidated into eight modules. Two members from the B&A Review Team were assigned to each module. Together, they were responsible for the review of all desk items and for facilitating the onsite interview with each MCE. A half-day was assigned to each of the eight modules in this review. Therefore, the B&A Review Team spent four full days conducting onsite interviews with each MCE individually related to its operations. Over 150 questions were asked of each MCE during the onsite interviews.

[11] There are some review items that contain sub-items that were assigned a weight of 0.25 or 0.50 each.

The information obtained from the desk and onsite reviews informed the scoring of each review item. The two B&A Review Team members independently scored each review item. If there was not a consensus on the score for a specific item, the team members convened until a unified score was established.

A summary of the scores for each review area appear in the sections below. The detailed scoring of individual review items is provided for each MCE in Appendix D.

Administrative Oversight

Key Areas Reviewed

B&A reviewed the following materials as part of the desk audit:

- Organizational chart identifying individuals in Executive Leadership and key managers
- Policies and procedures related to staff training
- Logs of staff training conducted in Calendar Year (CY) 2017
- Orientation materials provided during the onboarding of new staff
- Policy regarding periodic verification of MCE staff and providers against federal exclusion lists
- Current National Committee for Quality Assurance certification

Items covered in the interview with Executive Leadership included the following:

- MCE functions performed in and outside of Indiana
- Vetting process for hiring key positions
- Staff training activities and measuring the effectiveness of training
- Program integrity initiatives across the organization
- Areas of opportunity for improvement at the MCE and at the OMPP

Scoring

Exhibit V.2 shows that the MCEs scored Fully Met on all items in this functional area with the exception of one item from MHS which was scored Partially Met.

Exhibit V.2
Summary of Scores Related to Administrative Oversight

Potential Score = *80* *Total Items Scored =* *24*

			Number of Items Scored		
	MCE Score	**Pct of Potential**	**Fully Met**	**Partially Met**	**Not Met**
Anthem	80	100%	24	0	0
CareSource	80	100%	24	0	0
MDwise	80	100%	24	0	0
MHS	77	96%	23	1	0

Subdelegation Oversight

Key Areas Reviewed

B&A reviewed the following materials as part of the desk audit:

- Policies and procedures related to the oversight of delegated functions
- Subcontract agreements with each delegated entity
- Copies of any readiness reviews conducted with delegated entities
- Copies of the most recent audit used to monitor each delegated entity

Items covered in the interview with Delegation Oversight staff included the following:

- Confirmation of each subdelegated entity and their responsibilities
- Walk through of any readiness reviews conducted with each subdelegated entity
- Walk through of the most recent audits conducted with each subdelegated entity and the assessment made for each
- Discussion of any corrective action plans created in CY 2017 for subdelegated entities, the process followed, and the steps used to ensure that the corrective action was taken
- The types of data received from each subdelegated entity, how often it is received, and the process used by the MCE to verify the data received

Scoring

Exhibit V.3 shows that the MCEs scored Fully Met on all items in this functional area with the exception of one item from MHS which was scored Partially Met.

Exhibit V.3
Summary of Scores Related to Subdelegation Oversight

Potential Score = *60* *Total Items Scored =* *6*

	MCE Score	Pct of Potential	Number of Items Scored: Fully Met	Partially Met	Not Met
Anthem	60	100%	6	0	0
CareSource	60	100%	6	0	0
MDwise	60	100%	6	0	0
MHS	55	92%	5	1	0

Member Services and Enrollee Rights

Key Areas Reviewed

B&A reviewed the following materials as part of the desk audit:

- Policies and procedures related to member rights, including grievance and appeals processes, member confidentiality, the availability of materials to members and the formats they are offered, access to emergency services, and the ability to create an advance directive
- Welcome materials for new members, including the Member Handbook, for each of the three OMPP programs
- Materials provided to members on a periodic basis, such as member newsletters
- Access to the provider directory and how to look up providers in the director online
- The MCE's member website (both public views and the member portal)
- Training materials for Customer Service Representatives (CSRs) at the MCE
- Report of call volume statistics for a one week period in CY 2017 and quarterly summary reports
- Procedure for conducting initial health screenings and comprehensive health screenings
- Procedure on how the MCE ensures the accuracy and comprehension level of materials released to members and policies on interpretation and translation services
- Work plan or meeting agendas related to addressing cultural competency

Items covered in the interview with Member Services staff included the following:

- Confirmation of items enumerated in the MCE's written policies and procedures
- Decisions on what information to provide members, in what formats, and how often
- The methods used to train members on the concept of the POWER Account and utilizing services in the HIP
- Handling inquiries from non-English members or those with special needs
- The process and methods for conducting health risk assessments and identifying individuals with special health care needs
- Discussion of the process for training CSRs
- Monitoring and tracking CSR performance
- A presentation of the member portal
- A tour of the member services call center and a review of the software that tracks member calls in real-time during the day and generates reports for trending daily, weekly and monthly

Scoring

Exhibit V.4 shows that the MCEs scored Fully Met on must items in this section. Anthem and MHS each had one item scored Not Met while CareSource had two items scored Not Met.

Exhibit V.4
Summary of Scores Related to Member Services and Enrollee Rights

Potential Score = 140 *Total Items Scored = 77*

	MCE Score	Pct of Potential	Number of Items Scored		
			Fully Met	**Partially Met**	**Not Met**
Anthem	134	96%	76	0	1
CareSource	133	95%	75	0	2
MDwise	140	100%	77	0	0
MHS	134	96%	76	0	1

Grievances and Appeals

Key Areas Reviewed

B&A reviewed the following materials as part of the desk audit:

- Policies and procedures related to handling inquiries, grievances and appeals
- Notice of Action letters sent to members and providers on behalf of the member
- Notification to providers about their ability to make appeals on behalf of members
- Reports on the total grievances and appeals reported for CY 2017 for each OMPP program

Items covered in the interview with Grievances and Appeals staff included the following:

- Confirmation of items enumerated in the MCE's written policies and procedures
- Staffing levels for the intake process and "working" grievances and appeals
- Qualifications and credentials of staff making decisions on grievances and appeals
- The process for the review and decision-making step for grievances and appeals
- Walk through of the timelines for grievances, appeals (including expedited appeals), independent reviews, and the State Fair Hearing process
- The process for tracking and monitoring of grievances and appeals at the MCE

Scoring

Exhibit V.5 shows that all MCEs received Fully Met scores related to Grievances and Appeals.

Exhibit V.5
Summary of Scores Related to Grievances and Appeals

Potential Score = *80* *Total Items Scored =* *21*

	MCE Score	Pct of Potential	Number of Items Scored		
			Fully Met	Partially Met	Not Met
Anthem	80	100%	21	0	0
CareSource	80	100%	21	0	0
MDwise	80	100%	21	0	0
MHS	80	100%	21	0	0

Provider Network Management, Contracting and Relations

Key Areas Reviewed

B&A reviewed the following materials as part of the desk audit:

- GeoAccess reports for primary care physicians and specialists
- Policies and procedures related to assessing network adequacy
- Procedures for ensuring accessibility (e.g. 24 hour availability audit, standard office hours)
- Results from the most recent 24-hour availability audit
- Policies and procedures related to credentialing and recredentialing providers
- Examples of provider contracts with the MCE
- Procedure for notifying the OMPP and members about provider terminations
- Provider Manual
- Other training or educational materials for providers (e.g. practice guidelines)

Items covered in the interview with Provider Relations staff included the following:

- Confirmation of items enumerated in the MCE's written policies and procedures
- Tracking and monitoring compliance with OMPP access standards
- Current challenges to meet access standards
- Identifying providers to meet the needs of members with special health care needs
- Identifying and contracting with physician extenders and school-based health centers
- Provider audits (e.g., medical records review, availability)
- A presentation of the provider website (including internal portal)
- Composition and responsibilities of the provider network outreach team
- Any value-based contracting arrangements with providers

Scoring

Exhibit V.6 shows that the MCEs scored Fully Met on must items in this section. Anthem and MHS each had one item scored Partially Met while CareSource had three items scored Partially Met.

Exhibit V.6
Summary of Scores Related to Provider Network Management, Contracting and Relations

Potential Score = 120 *Total Items Scored = 53*

			Number of Items Scored		
	MCE Score	**Pct of Potential**	**Fully Met**	**Partially Met**	**Not Met**
Anthem	119	99%	52	1	0
CareSource	116	97%	50	3	0
MDwise	120	100%	53	0	0
MHS	119	99%	52	1	0

Utilization Management

Key Areas Reviewed

B&A reviewed the following materials as part of the desk audit:

- Policies and procedures related to authorization requests (pre-service, concurrent and retrospective)
- Roster and credentials of the staff reviewing authorization requests as of 12/31/17
- Policies and procedures related to staff completing authorization reviews and testing for inter-rater reliability
- Example of notices given to all parties when authorization requests are denied
- Example of notices given to all parties when authorization request is approved for an amount, duration or scope that is less than what was requested
- Policies covering utilization management (UM) in general
- Methods used to track inappropriate emergency department utilization
- Information on training for UM staff (e.g., content, periodicity)
- Policy on the MCE's UM committee

Items covered in the interview with Utilization Management staff included the following:

- Confirmation of items enumerated in the MCE's written policies and procedures
- Staffing for UM and, specifically, authorizations review
- Tools/guidelines to make authorization decisions and how they are used
- Step-by-step process for intake and decisions of authorization requests
- Methods to monitor over- and under-utilization, access to preventive care
- More information on the MCE's UM committee (e.g., membership, meeting schedule, responsibilities)

Scoring

Exhibit V.7 shows that the MCEs scored Fully Met on all items with the exception of Anthem and CareSource each scoring Partially Met on one item.

Exhibit V.7
Summary of Scores Related to Utilization Management

Potential Score = 140 *Total Items Scored = 35*

	MCE Score	Pct of Potential	Number of Items Scored: Fully Met	Partially Met	Not Met
Anthem	137	98%	34	1	0
CareSource	137	98%	34	1	0
MDwise	140	100%	35	0	0
MHS	140	100%	35	0	0

Program Integrity

Key Areas Reviewed

B&A reviewed the following materials as part of the desk audit:

- The MCE's Program Integrity Plan
- Policies and procedures for internal controls in place that are designed to prevent, detect and report known or suspected fraud, waste and abuse activities
- Procedure to fraud and abuse data mining, provider profiling and member service utilization
- Policy and procedure for overpayment recovery

Items covered in the interview with Program Integrity staff included the following:

- Description of the credentials, experience and roles of individuals in the Program Integrity Unit
- Training (initial and ongoing) of individuals in the Program Integrity Unit
- Examples of recent findings from research conducted where fraud or abuse was found
- Process for corrective or disciplinary action against a provider (including levels of escalation)
- Goals or areas of focus of the Program Integrity Unit in the current year

Scoring

Exhibit V.8 shows that all MCEs received Fully Met scores related to Program Integrity.

Exhibit V.8
Summary of Scores Related to Program Integrity

Potential Score = *60* *Total Items Scored =* *13*

			Number of Items Scored		
	MCE Score	**Pct of Potential**	**Fully Met**	**Partially Met**	**Not Met**
Anthem	60	100%	13	0	0
CareSource	60	100%	13	0	0
MDwise	60	100%	13	0	0
MHS	60	100%	13	0	0

Disease, Care and Complex Case Management

Key Areas Reviewed

B&A reviewed the following materials as part of the desk audit:

- Information on the MCE's 24/7 Nurse Line
- Policies and procedures related to disease, care and complex case management
- List of case managers and their credentials/experience
- Policies and procedures related to identifying members by each condition of interest

- Procedure for how individuals are assigned to care or case management (e.g. predictive model, referrals, etc.)
- CY 2017 reports that quantify enrollment in the MCE's disease, care and complex case management programs
- Policies and procedures related to integrating physical health and behavioral health care
- Policies and procedures related to communication plans between PMPs and behavioral health providers

Items covered in the interview with Disease, Care and Case Management staff included the following:

- Confirmation of items enumerated in the MCE's written policies and procedures
- Walk through of the screens in the MCE's care management software, the data elements integrated into the software (e.g., claims data), what the care/case manager enters
- How the care/case manager navigates the software (e.g., building a care plan, creating work queues)
- Tracking members by condition of interest
- Tracking outreach calls and materials sent to members enrolled in care or case management
- Internal tracking and assignment of caseloads, ongoing management of caseloads
- Coordination, discuss or peer review of individual cases, particular with physical and behavioral co-morbidities
- Information flows to providers about members in their panel who are in case management
- Education to providers about making referrals to care or case management
- Information flow from the 24/7 Nurse Line, types of calls, how the data is used

Scoring

Exhibit V.9 shows all of the MCEs scored Fully Met on most items related to Disease, Care and Complex Case Management. Anthem scored Partially Met on one item and CareSource scored Partially Met on two items.

Exhibit V.9
Summary of Scores Related to Disease, Care and Complex Case Management

Potential Score = 120 *Total Items Scored = 34*

	MCE Score	Pct of Potential	Number of Items Scored: Fully Met	Partially Met	Not Met
Anthem	118	98%	33	1	0
CareSource	116	97%	32	2	0
MDwise	120	100%	34	0	0
MHS	120	100%	34	0	0

Quality Management

Key Areas Reviewed

B&A reviewed the following materials as part of the desk audit:

- The MCE's 2017 Quality Improvement Work Plan
- The Annual Evaluation of the MCE's Quality Improvement Work Plan
- Minutes from Quality Management committee meetings held in 2017
- MCE Practice Guidelines

Items covered in the interview with Quality Management staff included the following:

- The construct of all Quality Management and Improvement Committee and any sub-committees
- Areas of focus for the Committee(s) in 2017
- Specifics about an MCE Culturally and Linguistically Appropriate Services (CLAS) committee, sub-committee or CLAS-related agenda items in 2017
- Source and uses of data that are incorporated into quality management
- Information collected from subcontractors that is incorporated into quality management
- Review of the MCE's member and provider incentive plans

Scoring

Exhibit V.10 shows that each of the MCEs had at least one item that was Not Met. CareSource had two items scored Not Met in Quality Management and the other three MCEs each had one item scored Not Met.

Exhibit V.10
Summary of Scores Related to Quality Management

Potential Score = 100 *Total Items Scored = 15*

	MCE Score	Pct of Potential	Number of Items Scored: Fully Met	Partially Met	Not Met
Anthem	96	96%	14	0	1
CareSource	92	92%	13	0	2
MDwise	90	90%	14	0	1
MHS	96	96%	14	0	1

Information Systems

Key Areas Reviewed

B&A reviewed the following materials as part of the desk audit:

- Process flows of the information systems at the MCE
- Policies and procedures on the encounter submission and adjudication process
- Policy or procedure on information system contingency planning
- A copy of the MCE's Business Continuity and Disaster Recovery Plan
- Policies and procedures regarding privacy and security
- Policies and procedures to address coordination of benefits and cost avoidance
- Policies and procedures for maintaining records on third party liability (TPL) and reporting this to the OMPP

Items covered in the interview with Information Systems staff included the following:

- Walk through of all data sources and uses within the information system and if/how they integrate
- Initiatives, if any, of further integration of data sources
- Users of each data source and their access to data sources
- Information received and integrated from subcontractors
- Methods to ensure claims adjudication timeliness
- Methods to ensure claims adjudication accuracy
- Encounters work plan and validation items (discussed in more detail in a separate onsite meeting on encounter validation, see Section VI of this report)

Scoring

Exhibit V.11 shows that some items were Partially Met or Not Met for each MCE within the Information Systems section. It should be noted, however, that the 26 items that were scored are not equal in weight. In fact, there are eight out of 26 items that may be deemed a lower priority related to documentation requirements that the OMPP has imposed on the MCE's Business Continuity/Disaster Recovery Plans. Most of the items scored Not Met in this functional area are related to this topic.

Exhibit V.11
Summary of Scores Related to Information Systems

Potential Score = 120 *Total Items Scored = 26*

	MCE Score	Pct of Potential	Number of Items Scored		
			Fully Met	**Partially Met**	**Not Met**
Anthem	112	93%	19	1	6
CareSource	118	98%	21	0	5
MDwise	102	85%	20	4	2
MHS	119	99%	23	0	3

POWER Account Tracking and Reporting

Key Areas Reviewed

B&A reviewed the following materials as part of the desk audit:

- Procedure to identify and track members across HIP products
- Procedure to track HIP members defined as medically frail
- Policy and procedure related to initial notifications to presumptively eligible members
- Policies and procedures related to the administration of POWER Accounts
- Information given to members about POWER Accounts (initially and ongoing)
- Policies and procedures for tracking third party POWER Account contributions
- Sample invoices sent to members to bill for POWER Account contributions
- Sample POWER Account statement in PDF format and online
- Sample notifications/reminders to members about potential loss of coverage due to non-payment, actual loss of coverage due to non-payment, and reinstatement
- Flowchart of the process related to generating the POWER Account Reconciliation File

Items covered in the interview with POWER Account staff included the following:

- Confirmation of items enumerated in the MCE's written policies and procedures
- Review of areas of responsibility completed by the MCE and those completed by a contractor
- Training to the MCE staff that support POWER Account administration
- Flowcharts of the different scenarios related to receiving and disbursing funds from members, employers and the State related to POWER Accounts
- Presentation of the member portal to show POWER account deposits and disbursements
- Tracking preventive services received by members
- Discussion of the flowchart to generate the POWER Account Reconciliation File

Scoring

Exhibit V.12 shows that the MCEs mostly scored Fully Met on all items related to POWER Account tracking and reporting. Two of the MCEs had one item scored Not Met while the other two had two items scored Not Met. Anthem had one other item scored Partially Met as well.

Exhibit V.12
Summary of Scores Related to POWER Account Tracking and Reporting

Potential Score = *80* *Total Items Scored =* *46*

	MCE Score	Pct of Potential	Number of Items Scored: Fully Met	Partially Met	Not Met
Anthem	75	94%	43	1	2
CareSource	76	95%	44	0	2
MDwise	78	98%	45	0	1
MHS	78	98%	45	0	1

Noteworthy Items Identified at Each MCE

Through the desk review of materials completed and the onsite interviews with the subject matter experts within each functional area at each MCE, the MCEs showed to the EQR Review Team either innovative approaches or best practices pertaining to managing the delivery of services to its members in the HHW, HIP and HCC programs. Examples of these noteworthy items are listed by functional area below.

Subdelegation Oversight

- Anthem and CareSource both demonstrated a robust delegation oversight process and efficient management reporting tools that summarize the oversight that is conducted.

Member Services

- All four MCEs redesigned their Member Handbook for the new contract period beginning in 2017. The handbooks provide comprehensive information necessary to communicate to members yet in an easy-to-understand format and layout.

- Anthem has developed relationships with community-based organizations such as Easter Seals and Bosma Enterprises (services to blind and visually impaired individuals) to assist their members with wrap-around services.

- CareSource has hired an individual that serves as the criminal justice liaison who meets members in person at the local court or where the members may be to serve as a resource for obtaining health care.

- MHS has developed a number of innovative ways to reach members including member-specific information that pops up in Google or Bing searches when members are on the internet. MHS has rethought many of their member communication strategies as "media campaigns" so that, for example, repetitive messages during the year change with each new release.

Provider Network Management

- All of the MCEs have embraced contracting with physician extenders as a way to expand access to primary care services throughout the state.

- Anthem has been proactive in creating value-based payment contracts with providers that represent service delivery to a majority of their membership. Anthem offers an array of value-based payment options based on provider readiness that key off of CMS's four categories of scaled risk value-based payment arrangements.

- MHS performs the annual provider availability audit on 100 percent of its primary medical providers. Additionally, it surveys approximately 375 providers each month within its network for OMPP programs to verify if providers are accepting new patients.

Utilization Management

- Anthem performs a monthly analysis on over 60 utilization measures in which results are measured year-over-year. With this analysis, measure results are further broken down by region and zip code. Gaps in care reports are also created from this utilization review.

- CareSource and MDwise also run gaps in care reports on a monthly basis on numerous utilization measures.

- Anthem, MDwise and MHS all review admission, discharge and transfer (ADT) reports that they receive on a daily basis and take proactive action to reach out to members to educate them about inappropriate ED use.

- CareSource illustrated the detailed analytics that they are conducting on ED utilization with data reported by census tract, by facility, by age, by gender and by reason for the ED visit. A recent focus has also been on targeted populations such as homeless or recently incarcerated individuals.

- In addition to "working" the ADT reports, MHS also crosswalks member ED visits to PMP visit utilization and to pharmacy utilization.

- All four MCEs showed a comprehensive process for how they have operationalized the OMPP contract requirements related to the Right Choices Program (member lock-in).

Disease, Care and Complex Case Management

- All of the MCEs reported caseloads for care and complex case management within accepted industry standards (generally within the 1:40 to 1:60 range).

- Anthem and MHS conduct weekly rounds to review more involved cases in complex case management with participation from physical health and behavioral health case managers as well as the Medical Director.

- In some situations, MHS case managers are accompanying MHS members that are enrolled in case management due to behavioral health conditions to pertinent medical appointments, particularly those members that had recently been discharged from an inpatient psychiatric stay.

- Anthem conducts a robust return on investment analysis of its care and case management program.

- With respect to integrating physical and behavioral health care, Anthem has contracted with recuperative care facilities for patients who are homeless or with behavioral health needs that needs extensive acute care assistance post-hospitalization. MHS now offers telehealth in three schools related to behavioral health where a school-based health center is not located. CareSource is starting a similar telehealth program in January 2019.

Information Systems

- Anthem migrated to a new information system which allows for more seamless integration of all of its data across multiple functional areas.

- CareSource has integrated its data systems so that there are triggers for customer service representatives to see, for example, if a HHW member still needs a health needs screening or if a HIP member still needs a preventive care service. Additional triggers are built into its care management system.

- MDwise has integrated pharmacy claims data into its care management software to make it easier for care managers. Like CareSource, MDwise also has care gaps identified in this software.

- MHS has the trigger for the health needs screening in its call center software as well as care gaps. MHS also has care gaps identified in its care management software.

- All MCEs perform claims adjudication accuracy testing on a monthly basis, but MHS performs this audit with every check run.

Recommendations to the MCEs

The recommendations from B&A offered to each MCE are in response to the scores given in this portion of the EQR. Specifically, B&A provides recommendations to each MCE in areas where the MCE was given a score of "Partially Met" or "Not Met". We have also provided some recommendations where the MCEs may have scored a "Met", but the recommendation offered is to foster the continuous quality improvement process.

Recommendations to All MCEs

1. Although B&A saw evidence of documentation and testing of its IT Business Continuity Plan (ITBCP), each should ensure that the elements that the OMPP requires in the MCE's ITBCP are fully documented. Within the Information Systems section of the review, this recommendation pertains to all of the Not Met items that Anthem, CareSource and MHS received and to one of the two Not Met scores that MDwise was given.

2. B&A did not see evidence in any MCE's policies regarding the MCE's preparedness to translate POWER account statements into Spanish, as requested. Each MCE's policy on POWER account statements should reflect this.

Recommendations to Anthem

1. B&A learned of challenges that Anthem had with the implementation of its new information system in 2017, but it should develop a plan to ensure to meet the OMPP contractual requirement of submitting 100 percent of its adjudicated claims within 30 days of adjudication to the OMPP.

2. Anthem should add language to its HIP Member Handbook to publicize to members that employers and other third parties may contribute to a member's POWER account.

3. Anthem should add language on its monthly POWER account statement regarding reminders to seek preventive services.

4. Anthem states that they conduct the prudent layperson test for ED services, but their policies do not state the staffing level that performs this function. B&A recommends that this language be added to a policy on utilization management.

5. The sample provider contract that Anthem submitted for the EQR desk review stated that providers would be given 30 days notification of material changes. The OMPP contract with the MCEs states that 45 days' notice is required. Anthem should change this in future contracts.

6. The OMPP contract stipulates that the MCEs must track website hits for its disease management program but Anthem does not do so. Anthem should develop a method to track website hits.

7. To conform to the OMPP contract, Anthem should include a provider relations project in its annual Quality Management and Improvement work plan.

Recommendations to CareSource

1. CareSource should add language to its HIP Member Handbook to publicize to members that employers and other third parties may contribute to a member's POWER account.

2. CareSource should include clinicians external to those employed by CareSource to consult on the development and ongoing review of practice guidelines.

3. CareSource should add language related to coverage of post-stabilization care in its Member Handbooks as required by 42 CFR 422.113(c) and the OMPP contract.

4. B&A recognizes that CareSource was continuing to build its provider network in its first contract year. But CareSource should ensure to OMPP that it is continuing to work towards meeting the OMPP network adequacy standard for dentists as well as building relationships with school-based health centers.

5. The sample provider contract that CareSource submitted for the EQR desk review stated that providers would be given 30 days notification of material changes. The OMPP contract with the MCEs states that 45 days' notice is required. CareSource should change this in future contracts.

6. The OMPP contract stipulates that the MCEs must track website hits for its disease management program but CareSource does not do so. CareSource should develop a method to track website hits.

7. To conform to the OMPP contract, Anthem should include a provider relations project in its annual Quality Management and Improvement work plan.

8. The OMPP contract stipulates that MCEs should compile utilization statistics on hospitalizations, ED, primary care and specialty care for individuals enrolled in complex case management. While onsite, B&A learned from CareSource of a new dashboard report scheduled for release in August 2018. CareSource should be prepared to present this dashboard report to the OMPP to meet this contractual requirement.

9. To conform to the OMPP contract, CareSource should include a provider relations project in its annual Quality Management and Improvement work plan.

10. To conform to the OMPP contract, CareSource should develop a physician incentive program as part of its annual Quality Management and Improvement work plan.

Recommendations to MDwise

1. Based on a review of CY 2017 quarterly report submissions, B&A recommends that MDwise should take corrective action to ensure that it is meeting the claims adjudication timeliness standards imposed by the OMPP.

2. As required in the OMPP contract, MDwise should provide real-time access to POWER account balances in a secure format.

3. Although MDwise is submitting encounters to the OMPP like the other MCEs, B&A did not see written policies and procedures to address encounter submissions. B&A recommends that MDwise develop policies and procedures and submit them to the OMPP.

4. B&A learned of challenges that MDwise had with one claims adjudication vendor in 2017, but it should develop a plan to ensure to meet the OMPP contractual requirement of submitting 100 percent of its adjudicated claims within 30 days of adjudication to the OMPP.

5. MDwise should develop a more robust process for monitoring and reporting the completeness of claims and encounter data received from providers.

6. In the review of the minutes from 17 Quality Management and Improvement Committee meetings held in CY 2017, there appeared to be little participation from the Medical Director and Pharmacy Director in these meetings. MDwise should develop a process to ensure the participation of these key staff members.

Recommendations to MHS

1. As stipulated in the OMPP contract, MHS should develop quarterly training of some type for its utilization management staff (either in-person, web-based, or IRR testing). Currently, MHS has annual training on clinical guidelines and semi-annual IRR testing.

2. MHS indicated that for vendors that it uses that are part of the Centene corporate family of companies, pre-delegation oversight was not conducted. However, MHS has separate contracts with these entities as if they were non-Centene vendors. In the future, MHS should conduct a pre-delegation oversight on any entity with which it subcontracts to deliver services to members.

3. The sample provider contract that MHS submitted for the EQR desk review does not give a notice for material changes. The OMPP contract with the MCEs states that 45 days' notice is required. MHS should add language to the contract pertaining to this notice.

4. To conform to the OMPP contract, MHS should include a provider relations project in its annual Quality Management and Improvement work plan.

Recommendations to the OMPP

The recommendations presented here to the OMPP are offered as they pertain to the State's and the MCEs' adherence to Medicaid managed care requirements as well as to the MCEs' contractual requirements. The recommendations are based upon B&A's desk review of MCE policies and procedures, our onsite interviews with MCE staff, and feedback received from both the OMPP and the MCEs during this year's EQR.

Information Systems

1. The OMPP is encouraged to develop a process for documenting member's changes between MCEs or between OMPP programs, e.g., between fee-for-service and managed care. One way to report these changes may be on the enrollment file that is sent to MCEs. This would help with continuity of care, prior authorizations, care planning and the Right Choices Program.

2. Similarly, the information from the enrollment broker to the MCEs could be more accurate (addresses, phone numbers) and more complete (race, ethnicity) to assist the MCEs in improving member outreach, most particularly with the requirement to complete the health needs screener within 90 days of enrollment with the MCE.

3. The MCEs reported conflicting information between what is delivered to them on 834 files compared to what providers see online in the State's provider portal pertaining to member eligibility. The OMPP is encouraged to focus on the root cause of these discrepancies.

4. The files prepared by the OMPP contractor to the MCEs on provider enrollment are numerous and cumbersome and often do not match the information that the MCEs have on the same provider. At minimum, the OMPP should require its contractor to streamline the provider information sent to the MCEs so the MCEs can validate against its own data.

5. The MCEs reported that the error rate between capitation payments and MCE enrollment file has been substantially reduced in recent years, but there is no formal process to report that errors that do exist. B&A endorses the MCE's request for the OMPP to develop a more formal feedback process when these situations occur.

Claims Adjudication

6. In recent years, the volume of paper claims submitted by providers has diminished significantly. The OMPP continues to have adjudication timeliness thresholds for both paper and electronic claims. B&A recommends that the OMPP consider a single threshold for all claims combined.

7. Since the MCEs often key off of the OMPP fee-for-service rate schedules to determine what it pays providers, B&A recommends that the OMPP set a minimum timetable for notice of rate changes to give the MCEs sufficient time to program and test changes in their systems.

Utilization Management

8. B&A strongly supports the OMPP's requirement that MCE staff performing authorization determinations keep updated on changes to guidelines regularly. The OMPP may want to consider changing its requirement to annual refresher training from the current requirement of

quarterly training, particularly if it requires evidence of periodic (either quarterly or semi-annually) IRR testing of the utilization management staff on the guidelines.

9. There is variation in how the MCEs track and report situations where a hospital requests authorization for inpatient level of care but it is denied by the MCE but observation status is offered instead. Some MCEs void the original request, some track it as denied, while others track it as modified. The OMPP should provide guidance on how this should be reported since it will impact the authorization denial rates reported by the MCEs.

10. The OMPP should consider adding to one of its reports that the MCEs submit on ED utilization a breakout between ED and urgent care clinic utilization.

Member Services

11. In lieu of requiring the MCEs to individually conduct health needs screenings then report results to the State and its contractor, the OMPP should consider requiring individuals applying for Medicaid to complete a health needs screening upon application. In this way, the State will have this information upfront and can pass it on, as needed, to each MCE if the individual enrolls with the MCE. The MCE would still be responsible for administering the comprehensive health assessment tool when necessary.

12. Also as part of the application process, the OMPP should consider having applicants attest to their agreement to receive communications from the MCEs by phone (voice or text), by email or by mail. Individuals should still be given the opportunity to opt out as well. If the individual has not opted out, the MCEs have the authority to contact their member in any of these modalities.

Grievance and Appeals

13. Whereas in past years, the number of State Fair Hearings was minimal, in 2017 the volume increased dramatically due to terminations from HIP because of missed POWER account payments. Significant effort was completed by the MCEs in support of these hearings but not all of the information for the case was delivered to the MCEs to help support the State. The OMPP should facilitate a work group to ensure that timely information is delivered to the MCEs to help them support State Fair Hearings for their members.

Provider Relations and Contracting

14. With respect to the reporting of network adequacy:
    a. Given the growth in the industry, the OMPP should consider adding urgent care clinics as one of the provider types that MCEs report on for network adequacy.
    b. The OMPP may want to consider having the MCEs break out physician extenders from physicians to assess primary care capacity.
    c. Similarly, break out mid-level behavioral health providers from other behavioral health providers.
    d. Lastly, identify school-based health clinics as their own provider type or as part of the FQHC/RHC provider type.

15. In lieu of or in addition to the current provider network reports that track any contracted provider, the OMPP should consider requiring the MCEs report on the providers which members sought

care from. For example, instead of tabulating the average distance from member's home to any contracted provider, the computation would be to the provider that the member saw. This would be most important for primary care and dental services.

16. Given the volume of provider access reports to track, the OMPP may consider having each MCE report a unified set of access reports across all of their Indiana Medicaid lines of business.

Care and Complex Case Management

17. Although it is a contractual requirement that behavioral health providers must submit notification of member visits within five days of the visit to the MCEs, the MCEs report mixed compliance with this requirement which they impose on their providers. Given that the MCE case and care managers are communicating regularly with these providers telephonically, the OMPP may want to consider eliminating this requirement. Some MCEs indicated that this level of burden was limiting interest from providers to enroll with the Medicaid program.

SECTION VI: FOCUS STUDY ON ENCOUNTER VALIDATION

Introduction

In the External Quality Review (EQR) conducted in Calendar Year (CY) 2017, Burns & Associates, Inc. (B&A) performed a validation of claims adjudication reports that are submitted by each managed care entity (MCE) for all three of the Office of Medicaid Policy and Planning's (OMPP's) managed care programs—Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC). There were discrepancies found in the volume reported by each MCE for institutional and professional claim types compared to what was captured in the OMPP's data warehouse either as an accepted or rejected encounter.

In this year's EQR, B&A conducted a focus study of the validation of the encounters submitted by the MCEs to the OMPP. The objectives of the study are as follows:

1. To track the pace at which encounters are being submitted timely to the OMPP by the MCEs for the HHW, HIP and HCC programs.
2. To track the accuracy of key variables on the encounters that are being submitted to the OMPP and to determine if certain key variables are what are causing an encounter to be rejected.
3. To track the rate of completeness of the encounters that are being submitted that are deemed accepted and those deemed rejected.
4. To assist the OMPP in defining what is a "successful" encounter submission encompassing factors pertaining to timeliness, accuracy and completeness.
5. To identify process improvements that can be completed by all parties that are involved in the encounter collection and validation process.
6. To identify specific areas of opportunity within each MCE to assist them with successful encounter submissions.
7. To provide recommendations to the OMPP to strengthen the oversight and the accountability of the MCEs related to successful encounter submissions.

Overview of the Encounter Submission Requirements and Process Today

The OMPP requires that the MCEs submit both paid and denied claims as encounters to the State's Enterprise Data Warehouse (EDW). Information on institutional, professional, pharmacy and dental claim types are required to be submitted for the HHW, HIP and HCC programs. The level of detail required to be submitted is equivalent to what would be submitted on a fee-for-service claim. The OMPP's fiscal agent for fee-for-service claims, DXC Technology (DXC), publishes documentation called Companion Guides which detail the requirements for the content, format and syntax for encounter submissions.

The OMPP uses encounters for capitation rate setting, calculation of incentive payments and quality reporting. As such, the OMPP has established the following requirements in its contracts with the MCEs:

- The OMPP requires the MCE to develop an encounter claims work plan annually. These were not collected in CY2017 due to continual ongoing work with the OMPP and its partners throughout the year (see below).

- With respect to submission requirements, each MCE must submit at least one batch of paid and denied institutional, professional and pharmacy claims by Wednesday at 5pm each week.

- With respect to completeness,
  - The MCEs must submit all adjudicated claims within 15 months of the earliest date of service on the claim.
  - The MCEs must submit void or replacement claims within 24 months of the earliest date of service on the claim.
  - The MCEs must have a system for monitoring and reporting the completeness of claims and encounter data received from providers, i.e., claim details should be identical to that for fee-for-service claims.

- With respect to timeliness,
  - The MCEs must submit 100 percent of adjudicated claims within 30 calendar days of adjudication.

- With respect to accuracy,
  - The MCEs must adhere to compliance with pre-cycle (HIPAA) edits.
  - The MCEs must submit encounter claim details that accurately represent the services provided and that the claims are accurately adjudicated according to the MCE's internal standards and all state and federal requirements.

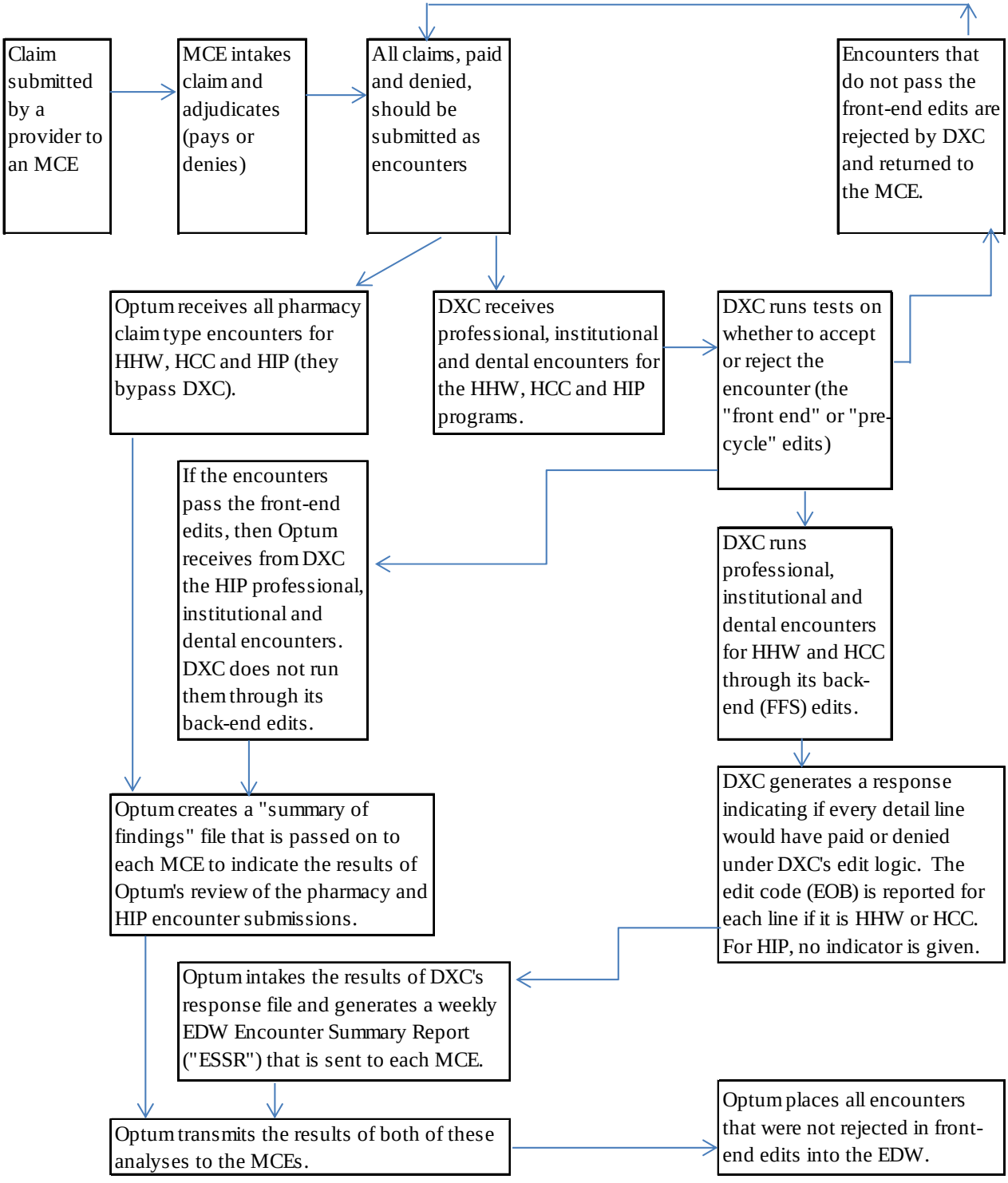
There are multiple parties involved in the encounter validation process and the type of validation varies between the parties. DXC, the OMPP fiscal agent, intakes encounters submitted by the MCEs and runs a series of edits on the encounters that are the same as or similar to the edits run on the fee-for-service claims submitted by providers to DXC. Optum is the entity that manages the FSSA's EDW. Optum runs validations on encounters submitted for pharmacy claims from all three programs (HHW, HIP and HCC) as well as encounters for medical claims for HIP. The validation that Optum completes does not mimic the editing logic applied in the fee-for-service program.

After the validations occur, response files are sent to the MCE from each validating entity that conveys the results of the validations completed by each entity. The encounters are ultimately populated into the EDW.

Exhibit VI.1 that appears on the next page details the data flow of the encounter submission process.

In CY 2017 and continuing into CY 2018, significant effort has occurred between all parties to improve the submission and processing of encounters. Starting in late 2017, weekly meetings have occurred between the MCEs, DXC, Optum and the OMPP to determine ways to improve processes. Much of this work is a result of changes that occurred when OMPP contracted with DXC to change its claims processing platform. The new platform, *Core*MMIS, was launched in February 2017. The procedures followed and the response files given to the MCEs changed with the introduction of *Core*MMIS. Additionally, the types of back-end edits that are now applied to encounters have been strengthened since *Core*MMIS was launched. As a result, more attention has been directed to the timeliness, accuracy and completeness of encounter submissions.

Exhibit VI.1
Submission, Validation and Processing Flow for Indiana's Managed Care Program Encounters



Approach to Conduct This Study

With this information in mind and the knowledge that some improvements in encounter submissions were occurring in real time during our study, B&A developed the following approach to conduct the study:

- *Operational procedures study*: B&A conducted onsite interviews with each MCE to learn more about its encounter validation and submission procedures.

- *Completeness study*: B&A requested a three-month period of claims adjudicated by each MCE and compared this to the encounters found in the OMPP's EDW to assess completeness.

- *Timeliness study*: For the encounters that were submitted by the MCEs, B&A analyzed the average time period from the MCE adjudication date to the encounter submission date. Two datasets examined—first, claims with MCE adjudication dates that occurred in the Third Quarter of 2017; second, all encounters reported on ESSR files from the First and Second Quarters of 2018 regardless of MCE adjudication date.

- *Accuracy study*: B&A analyzed a selected set of variables reported on medical encounters to assess if a value was reported when there should be one and that the value reported was a valid value for that variable.

- *Accuracy study*: B&A examined the EOBs reported on the weekly EDW Encounter Summary Reports (ESSRs) for the HHW and HCC encounters that were validated by DXC using FFS-equivalent claims adjudication edits. The two datasets used in the timeliness study were also used for this accuracy study.

It should be noted that sampling was not conducted for this study per se. That is, all encounters submitted for the time periods defined above were analyzed. Also, there were no medical record abstractions conducted for the validation of values reported on encounters. The source for all data used in the study was the encounter submissions themselves.

<u>Methodology to Assess Encounter Completeness</u>

B&A requested each MCE to deliver four files in Excel that showed claim information at the header level. One file was for each of the four claim types UB-04/837I, CMS-1500/837P, Pharmacy and Dental. The file layout was the same for all four files. The MCEs were instructed to provide information for all programs that they are under contract with the OMPP (HHW, HIP and HCC) in the same file.

The MCEs were instructed to submit information on any claim that they adjudicated during the time period of July 1, 2017 through September 30, 2017. The key variables requested, among others, included:

- MCE ID to identify the OMPP program
- MCE claim ID
- Medicaid member ID
- From and to service dates
- Date claim was received from the provider
- Date claim was adjudicated by the MCE
- Date claim was submitted by the MCE as an encounter

B&A read in the files submitted by each MCE and validated the data received. In some cases, B&A worked with the MCE to ensure the validity of the data submitted.

Separately, B&A requested information from the OMPP EDW for this year's EQR. This included member-level information, provider information, and encounter information at both the header and detail level. B&A requested all encounters with dates of service from January 1, 2016 through December 31, 2017 as received in the EDW by March 31, 2018. In addition to this request, B&A requested all weekly ESSRs for the time period July 1, 2017 through June 30, 2018.

To assess the rate of completeness of encounters submitted, B&A compared the unique claims adjudicated by each MCE from the extracts that they submitted to B&A against the unique encounters that B&A had received from the EDW for each MCE/program.

Methodology to Assess Encounter Timeliness

B&A also used the MCE file submissions, ESSRs and EDW encounters to assess encounter timeliness. From the information self-reported by the MCEs on their file submissions, B&A computed the following statistics:

- The average number of days between the claim service date and the date received by the MCE
- The average number of days between the date received by the MCE and the adjudication date
- The average number of days between the adjudication date and the date submitted as an encounter

The first two measures are intended to assess if the MCEs are meeting the OMPP requirement that all encounters must be submitted within 15 months of the earliest date of service on the claim. The last measure is intended to assess if the MCEs are submitting 100 percent of their adjudicated claims within 30 days of adjudication.

Through interviews with the OMPP and the MCEs, it was known that there had been considerable work in the second half of CY 2017 to submit encounters that would be accepted in the new *Core*MMIS particularly for dates of service through CY 2016. Recognizing that results in the July 1 through September 30, 2017 time period may not be indicative of more recent experience by the MCEs, to assess the encounter timeliness rate B&A ran the calculations under two time periods:

- First, for the claims adjudicated by the MCEs from July 1 through September 30, 2017
- Second, for all of the encounters submitted by the MCEs as reported on ESSRs from January 1 through June 30, 2018 regardless of MCE adjudication date

Methodology to Assess Encounter Accuracy

B&A conducted two separate analyses as a means to assess encounter accuracy. The first analysis examined specific variables submitted on encounters by the MCEs to assess if the values provided for each variable were complete and valid. B&A examined all encounters in the FSSA's EDW that were submitted on either the institutional or professional claim type for the HHW, HIP and HCC programs. The specific encounters reviewed were for services with a starting date of service between January 1 and December 31, 2017. The specific variables that were validated on these encounters included:

- Medicaid member ID (as assigned by the OMPP)

- Billing National Provider Identifier (NPI)
- Rendering NPI
- From date of service
- To date of service
- Principal ICD-10 diagnosis
- At least one CPT/HCPCS code (for all except inpatient hospital encounters)
- DRG assignment (only for inpatient hospital encounters)

The second analysis was a review of the adjudication codes (called Explanation of Benefit codes, or EOBs) that DXC reported on for institutional, professional and dental encounters for the HHW and HCC programs. The source for this information is the ESSRs that were produced on a weekly basis from July 1, 2017 through June 30, 2018. The results were examined for two discrete time periods—first, for the ESSRs from July 1 through December 31, 2017; second, for the ESSRs from January 1 through June 30, 2018. The reason for this distinction was to discern if there were any changes in trends found during CY 2018 as a result of the focused attention on encounter validation that occurred in the latter half of CY 2017.

DXC's adjudication determination on encounters indicate the disposition that DXC would have made on the encounter (to pay or to deny) if the encounter was submitted as a fee-for-service claim. This determination is made at the individual claim line level. Therefore, unlike the completeness and timeliness studies mentioned above which tracked and trended information at the claim header level, the analysis of EOBs conducted by B&A is at the claim detail level.

B&A used a crosswalk table delivered by DXC to the MCEs that mapped each EOB into either a "post and pay" or "deny" category. B&A's primary focus was to review encounters which hit EOBs in the deny category. Before doing this, B&A identified and isolated some detail lines reported on ESSRs which were not considered in the study because DXC does not process them through the back-end edits:

- Encounters attributed to the HIP program
- Encounters attributed to the dental claim type (During the CY 2017 study period, DXC was not processing these encounters through the back-end edits. Dental encounters have started to be included in the editing process in CY 2018.)
- Encounters in which the MCE indicated that it denied payment for the original claim submitted

For the encounters that were not excluded from the study, B&A analyzed the percentage of details submitted that had post-and-pay EOBs versus those that had denial EOBs. This was examined overall and for each MCE separately. The distribution was examined based on number of claim lines and by the MCE paid amounts that were attributed to these details.

For the denial EOBs, B&A ran frequencies for each EOB to understand the prevalence by type of EOB. This was also examined overall and for each MCE separately.

As stated previously, because B&A knew that there had been ongoing work in late 2017 to improve the completeness, timeliness and accuracy of encounter submissions, B&A ran reports on EOB frequencies for two discrete time periods—first, for the ESSRs from July 1 through December 31, 2017; second, for the ESSRs from January 1 through June 30, 2018.

For the top 10 denial EOBs based on volume in the July through December 2017 ESSR period, B&A conducted a root cause analysis by examining the prevalence of this EOB across six variables.

Findings from the Review of MCE Encounter Submission Procedures

The B&A EQR team conducted introductory meetings separately with DXC, Optum and Milliman (the OMPP actuary) in February 2018 to learn each vendor's role in encounter validation and their perspective on pertinent issues still open or recently resolved in the encounter validation process.

After conducting some initial analysis of ESSRs from July – December 2017, B&A then met in one-on-one meetings with each MCE at their home office on May 17-18, 2018 to discuss the encounter submission and validation process from their perspective. The information that B&A gained from these meetings was used to inform the next rounds of analysis that B&A conducted in its independent encounter validation process. A summary of the feedback from the MCE meetings appears below.

Terminology

There have been and continue to be a variety of files that the MCEs have received from OMPP's vendors related to encounter validation.

- The 837 file is the format in which the MCEs submit encounters to DXC or Optum (for pharmacy).

- The 835 file is the response file that is returned to the MCEs by DXC, but unlike the ESSR, it only represents the encounters that DXC has processed through back-end edits.

- The TA1 file is the response file returned if the entire encounter batch is rejected due to bad syntax.

- The 999 file is the response file returned if individual encounter records are rejected due to bad syntax.

- The 277U file is the response file whereby the encounters that are not submitted due to TA1 or 999 but the records that are denied by DXC due to invalid combinations of Billing NPI, Billing Taxonomy and zip code+4 or missing MCE ID.

- The 835 Supplemental file (also referred to as the SSR) file was the response file that DXC provided to each MCE that indicated the disposition of the encounters submitted by the MCEs to DXC. The SSR file excluded pharmacy encounters. The SSR file was eliminated with the introduction of *Core*MMIS in February 2017.

- If the encounters pass and do not appear on a TA1, 999 or 277U file, they should now appear on an ESSR file. The ESSR file is the replacement to the SSR. The responsibility for generating the ESSR is now with Optum. It contains the encounters submitted for HHW, HCC and HIP; however, it only shows the results of adjudication of those encounters reviewed by DXC (HHW and HCC medical and dental). Pharmacy encounters are not on the ESSR just like they were not on the SSR.

MCE Activities to Prepare Encounter Files

Each of the MCEs cited similar processes with respect to preparing encounter files to be submitted to the OMPP. Each MCE reviews its most recently adjudicated claims to prepare for submission on an 837 file. The claims that are ready to be submitted as encounters are stored in an encounter repository at the MCE. When encounters from other subdelegated entities are sent to the MCE, these also go to the MCE's encounter repository.

Every MCE stated that they do not mix the encounters from their own claims adjudication system with those that are prepared by their subdelegated entities. Also, even though the MCE submits an 837 for its own encounters at least once per week as mandated in the OMPP contract, it is often the case that the subdelegated entity's encounters are submitted less often. Although pharmacy encounters are usually submitted weekly by each MCE, this is not true for dental, vision and transportation encounters. Although the timing is not the same for these specialized services, every MCE confirmed that they are submitting encounters for these services to the OMPP.

It appears that the level of validation that the MCEs conduct varies on the encounter files prior to submission to DXC or Optum. All of the MCEs run their encounter files through the "front-end" HIPAA compliance edits. If it is found that specific records would not pass the front-end edits, these records are removed from the batch and worked until resolution.

Anthem runs its encounter files through a test run to ensure that all front-end edits are cleared. CareSource also runs its encounter files through a software package developed by Edifecs that is intended to replicate Indiana-specific edits. MHS runs its encounter files through a software package created by Trizetto that also contains some state-specific edits. MDwise does no additional tests beyond the front-end edits.

Because of this front-end validation, all of the MCEs reported that they receive few errors from DXC with respect to rejected encounters. In other words, TA1 and 999 response files are infrequent.

All of the MCEs reported a material change in the encounter validation process performed by DXC with the transition to *Core*MMIS. Prior to *Core*MMIS implementation, the edits for NPI and taxonomy were performed by DXC on the front end but was not a "strong" edit. With the new *Core*MMIS system, this edit was "strengthened" and now appears on the back end for encounters. It appeared as a front-end edit in the fee-for-service environment.

DXC informed the MCEs of this change and delivered to the MCEs an NPI-taxonomy crosswalk table. This is the table that DXC uses to test the edit in fee-for-service. The MCEs learned that the DXC crosswalk table did not match the information that they often had on file from providers. There was considerable effort to validate the data on both files. Anthem took the step to deny claims from its providers at the beginning of *Core*MMIS if the data they received from providers did not match the DXC crosswalk table (in other words, mimic the fee-for-service edit). There was significant provider abrasion felt due to the high rate of denials for this reason. As a result, Anthem turned off this edit in its own claims adjudication system. DXC also turned off this edit in fee-for-service.

Other MCEs also expressed concern about what they observed as mismatches with the DXC crosswalk (although the other MCEs were not denying provider claims because of it). As a result of this, DXC turned off its edit related to this reason as well when the MCEs submitted encounters (this is EOB code 1010). After significant cleanup of the crosswalk table, DXC has "turned on" the EOB 1010 edit once again effective October 29, 2017.

Tracking and Assessing Encounter Completeness and Timeliness

Although all of the MCE's verified that they reviewed the TA1 and 999 response files to resolve to resubmit these encounters as "clean", none of the MCEs indicated that significant effort was put forth to ensure the completeness of the percent of claims adjudicated submitted as encounters or the timeliness of encounter submissions. As of May 2018, Anthem and MHS both reported that they have built dashboard report to assess and trend completeness and timeliness rates. CareSource is in the process of building their dashboard reports.

Tracking and Assessing Adjudication Error Codes (EOBs) from DXC

Because of the other known issues since the implementation of *Core*MMIS, the MCEs admitted that there has been little focus on the EOBs reported by DXC on the ESSRs. Anthem and MHS did mention that recently there has been work to prioritize the denial EOBs observed on its ESSRs based on highest dollars paid by the MCE since the MCE paid the claim.

B&A was also notified that it was not until March 2018 that DXC had given the MCEs a comprehensive list of all EOBs that may appear on ESSRs. The list provided flagged each EOB as either a "post-and-pay" notification or a "denial" EOB (that is, DXC would have denied payment if the service was billed in fee-for-service). So the MCEs can now prioritize based on the more limited list of denial EOBs. B&A used this same mapping for its independent analysis.

Other Feedback from the MCEs

Although the MCEs acknowledged that there has been significant work from all parties (OMPP, DXC, Optum and the MCEs themselves), there are still a number of unresolved issues that are preventing the MCEs, in their words, from further resolving some of the encounter issues. Some of this feedback includes:

1. The records on a given ESSR file do not exactly match the records on 837 submissions from the MCE. Even though the ESSR file is produced weekly and, in effect, should represent the encounters submitted in the prior week, it can often take multiple weeks before encounters on an MCE's 837 are reported on an ESSR file.

2. Some encounter records never appear on an ESSR file. This implies that they do not make it into the FSSA's EDW and are not included in capitation rate setting.

3. The requirement of a zip+4 in the NPI-taxonomy-zip+4 mapping is still problematic because the "+4" is often incorrect or missing.

4. The ESSR files are not as useful as the previous SSR files.

5. The 835 files are not useful without the EOBs reported on them.

6. DXC documentation is lacking with respect to the reasons for denial EOBs. The MCEs cannot predict why an encounter hit a denial EOB.

7. DXC employs hierarchical logic. This means if a denial EOB is hit, that is what is reported on the ESSR even though there may be other reasons. So an MCE may fix the first denial reason then the encounter will be denied with the resubmission for another reason.

8. It is unclear to the MCEs if some denial EOBs are more important than others. In other words, where should the MCEs focus their priorities?

Findings from the Examination of Encounter Completeness

When comparing the claims that the MCEs adjudicated in the third quarter of CY 2017 against what was submitted as encounters, it was found that, in the aggregate across all MCEs and programs, 97.3 percent of institutional claims and 97.2 percent of professional claims had been submitted by the MCEs.

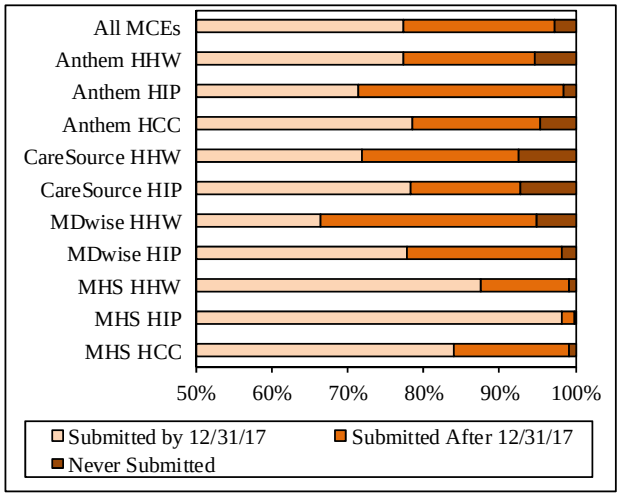
Exhibit VI.2 shows the completion rates by MCE and program as well as by claim type. For institutional claims, the encounter completion rate range was from a low of 92.5 percent for CareSource HHW to a high of 99.9 percent for MHS HIP. For professional claims, the encounter completion range was from a low of 91.5 percent for CareSource HHW to a high of 100.0 percent for MHS HIP.

Although the encounter completion rates are high for the claims adjudicated in this quarter, the timeliness of submission was not always high. B&A computed the completion rate of encounters submitted by December 31, 2017 against encounters submitted after December 31, 2017. In the aggregate, 20.0 percent of all institutional claims were submitted as encounters after December 31, 2017 (90 to 120 days after adjudication, depending upon the adjudication date within the 3rd Quarter of 2017). For professional claims, 27.2 percent were submitted after December 31, 2017. The range among the MCEs was 15 to 34 percent with the exception of MHS HHW which was in the 11 percent range and MHS HIP which only had two percent of institutional and six percent of professional encounters come in after December 31, 2017.

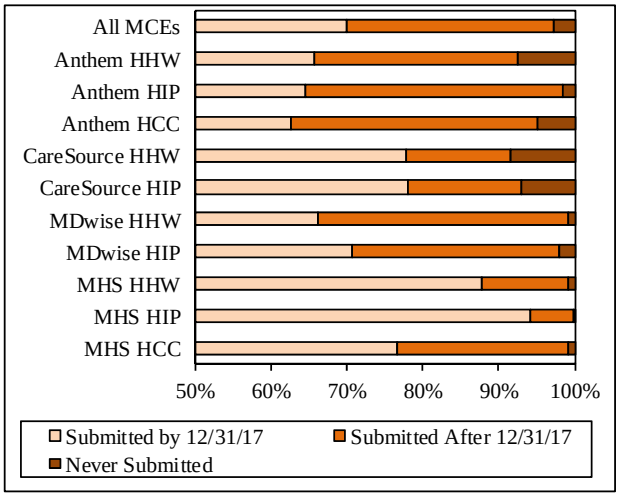
Although a small proportion of the total, it should be noted that B&A also observed that 0.8 percent of all of the claims processed by the MCEs had been submitted as encounters, were reported on an ESSR, but were not present in the EDW.

Exhibit VI.2
MCE Claims Adjudicated in Third Quarter 2017 and Encounter Completion Rate
For the HHW, HIP and HCC Programs by MCE and by Claim Type

UB-04 or 837I Claims



CMS-1500 or 837P Claims



	Number of Claims Adjudicated by MCE		
	Submitted by 12/31/17	Submitted After 12/31/17	Never Submitted
All MCEs	781,249	202,210	27,652
Anthem HHW	87,086	19,625	5,885
Anthem HIP	209,940	79,110	4,432
Anthem HCC	100,387	21,559	6,023
CareSource HHW	11,429	3,287	1,198
CareSource HIP	14,320	2,660	1,325
MDwise HHW	68,461	29,452	5,161
MDwise HIP	116,305	30,327	2,634
MHS HHW	53,438	7,081	449
MHS HIP	76,710	1,310	68
MHS HCC	43,173	7,799	477

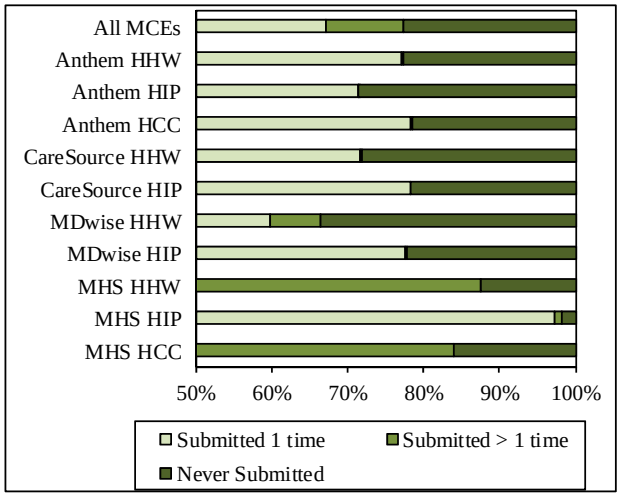
	Number of Claims Adjudicated by MCE		
	Submitted by 12/31/17	Submitted After 12/31/17	Never Submitted
All MCEs	2,755,477	1,070,882	110,153
Anthem HHW	384,905	156,371	44,155
Anthem HIP	652,045	344,329	15,199
Anthem HCC	330,899	171,508	25,145
CareSource HHW	44,768	7,922	4,905
CareSource HIP	41,950	7,993	3,793
MDwise HHW	300,247	150,240	3,354
MDwise HIP	369,252	143,166	9,983
MHS HHW	242,142	31,752	2,053
MHS HIP	245,380	15,389	69
MHS HCC	143,889	42,212	1,497

Note: MDwise terminated its contract with the OMPP for HCC on March 31, 2017. Some residual claims and encounters were still being processed by MDwise later in 2017 for this program. These encounters have been excluded from this report.

B&A also reviewed if encounters are being submitted multiple times, particularly if in the first submission the MCE was notified on a subsequent ESSR that a claim hit one or more denial EOBs. Exhibit VI.2 shows that, for the claims adjudicated by the MCEs in the 3rd quarter of 2017, it was infrequent that the same claim was submitted as an encounter more than once. For institutional claims overall, among those encounters that were submitted by December 31, 2017, 86.8 percent were submitted once. This finding, however, is solely due to the fact that MHS resubmitted almost all of their HHW and HCC encounters during this time period whereas the other MCEs hardly ever did. For professional claims overall, among those encounters that were submitted by December 31, 2017, 98.7 percent were submitted once. This finding was similar for all MCEs and all programs.

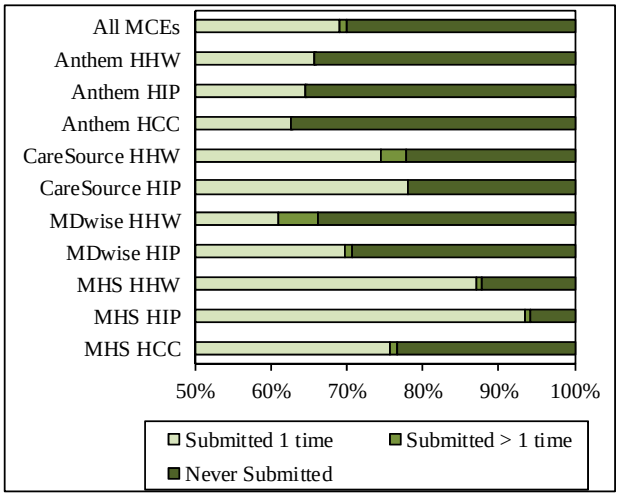
Exhibit VI.3
MCE Claims Adjudicated in Third Quarter 2017 and Number of Encounter Submissions by December 31, 2017
For the HHW, HIP and HCC Programs by MCE and by Claim Type

UB-04 or 837I Claims



	Number of Claims Adjudicated by MCE		
	Submitted 1 time	Submitted > 1 time	Never Submitted
All MCEs	677,936	103,313	229,862
Anthem HHW	86,884	202	25,510
Anthem HIP	209,843	97	83,542
Anthem HCC	100,165	222	27,582
CareSource HHW	11,424	5	4,485
CareSource HIP	14,320	0	3,985
MDwise HHW	61,616	6,845	34,613
MDwise HIP	115,692	613	32,961
MHS HHW	1,077	52,361	7,530
MHS HIP	75,898	812	1,378
MHS HCC	1,017	42,156	8,276

CMS-1500 or 837P Claims



	Number of Claims Adjudicated by MCE		
	Submitted 1 time	Submitted > 1 time	Never Submitted
All MCEs	2,719,917	35,560	1,181,035
Anthem HHW	384,410	495	200,526
Anthem HIP	651,948	97	359,528
Anthem HCC	330,684	215	196,653
CareSource HHW	42,852	1,916	12,827
CareSource HIP	41,950	0	11,786
MDwise HHW	277,104	23,143	153,594
MDwise HIP	364,995	4,257	153,149
MHS HHW	240,065	2,077	33,805
MHS HIP	243,879	1,501	15,458
MHS HCC	142,030	1,859	43,709

Note: MDwise terminated its contract with the OMPP for HCC on March 31, 2017. Some residual claims and encounters were still being processed by MDwise later in 2017 for this program. These encounters have been excluded from this report.

Findings from the Examination of Encounter Timeliness

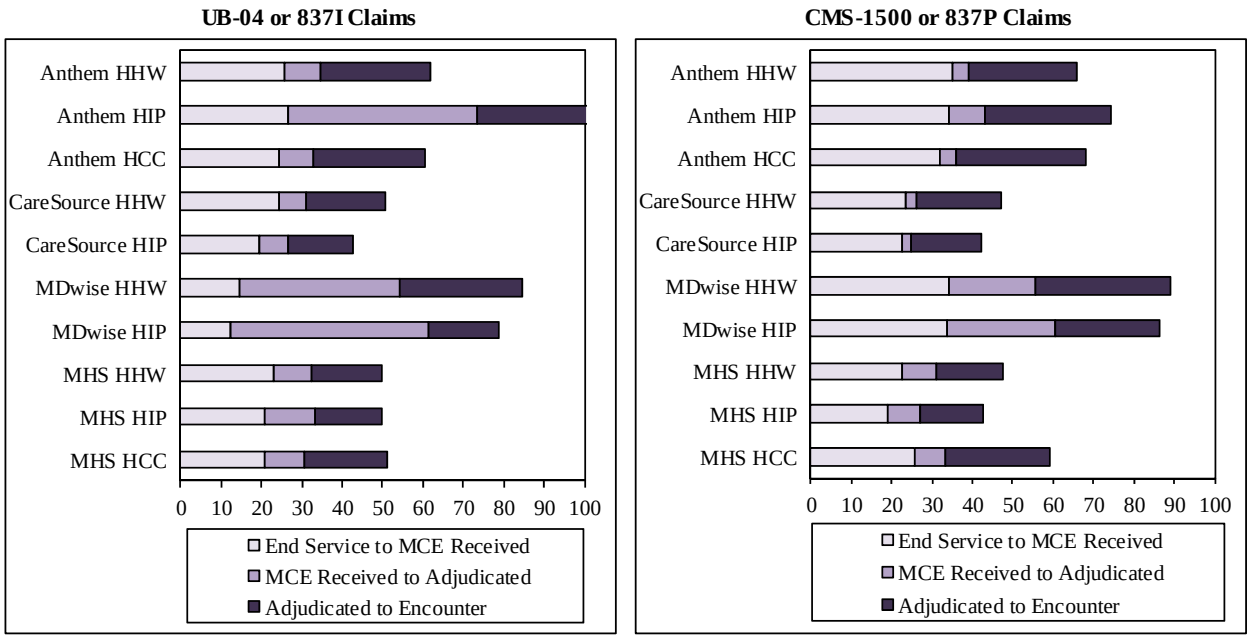
Although it was observed in Exhibit VI.2 that encounters may not have been submitted as timely as the OMPP was expecting, it does appear that the MCEs are meeting the requirement that all adjudicated claims be submitted as encounters within 15 months of the earliest date of service on the claim. B&A used the claim files submitted by the MCEs for claims adjudicated in the 3rd Quarter of 2017 to track the time from service date to encounter submission.

Exhibit VI.4 tracks by MCE and OMPP program the average days from service date to receipt by the MCE, from receipt by the MCE to adjudication, and then from adjudication to submission as an encounter. With the exception of Anthem's HIP claims, for all other MCEs the total duration of these three events was, on average, less than 90 days. For Anthem HIP, the institutional claim average was

closer to 120 days. Still, all MCEs are meeting the OMPP requirement of 15 months (or approximately 450 days).

When reviewing each event in isolation, the greatest commonality across the MCEs was seen in the average time from end date of service to submission to the MCE by the provider. With some exceptions that were lower, the average days value was typically between 20 and 35 days. The average days from receipt to adjudication was also low (less than 10 days) with the exception of MDwise and Anthem HIP institutional claims. There was variance seen in the average days from MCE adjudication to encounter submission.

Exhibit VI.4
Tracking Claims Adjudicated by the Amount of Time to Submission to OMPP as Encounters
For the HHW, HIP and HCC Programs by MCE and by Claim Type
For Claims Adjudicated by the MCEs between July 1 and September 30, 2017



	Average Number of Days		
	End Service to MCE Received	MCE Received to Adjudicated	Adjudicated to Encounter
Anthem HHW	25.5	9.0	27.2
Anthem HIP	26.6	46.9	44.4
Anthem HCC	24.6	8.2	27.5
CareSource HHW	24.3	6.9	19.7
CareSource HIP	19.5	6.9	16.3
MDwise HHW	14.6	39.6	30.5
MDwise HIP	12.4	48.8	17.4
MHS HHW	23.2	9.3	17.4
MHS HIP	20.6	12.6	16.5
MHS HCC	20.8	9.8	20.6

	Average Number of Days		
	End Service to MCE Received	MCE Received to Adjudicated	Adjudicated to Encounter
Anthem HHW	34.9	4.4	26.5
Anthem HIP	34.0	9.1	31.1
Anthem HCC	31.9	3.9	32.2
CareSource HHW	23.5	2.7	20.9
CareSource HIP	22.5	2.4	17.3
MDwise HHW	34.4	21.1	33.4
MDwise HIP	33.7	26.8	26.0
MHS HHW	22.7	8.4	16.7
MHS HIP	19.1	7.9	15.8
MHS HCC	25.8	7.6	25.6

Note: MDwise terminated its contract with the OMPP for HCC on March 31, 2017. Some residual claims and encounters were still being processed by MDwise later in 2017 for this program. These encounters have been excluded from this report.

Because of the ongoing work on encounter submissions at the end of CY 2017, B&A compared the average days from MCE adjudication to encounter submission for two time periods—first, for the initial study period of MCE adjudicated claims in the 3rd Quarter of 2017; second, for encounters submitted in the first six months of CY 2018. In both study periods, the average days computation was limited to the institutional and professional claim types. For the first study period, the MCE adjudication date was reported by the MCEs to B&A directly. For the second study period, B&A used the MCE adjudication date as reported by the MCEs to the OMPP and stored in the EDW. There were some instances where the MCE adjudication date was invalid (e.g., 1/1/1900) or unrealistic (e.g., from CY 2012). B&A removed all encounters that had an invalid or potentially invalid adjudication date from the study (any date prior to 1/1/2017).

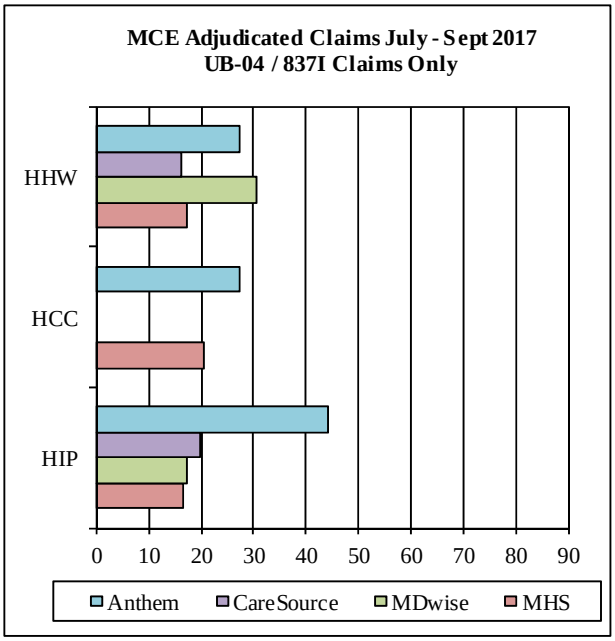
The total claims examined in the first study period were just over 4.8 million; in the second study period, it was just over 13.2 million.

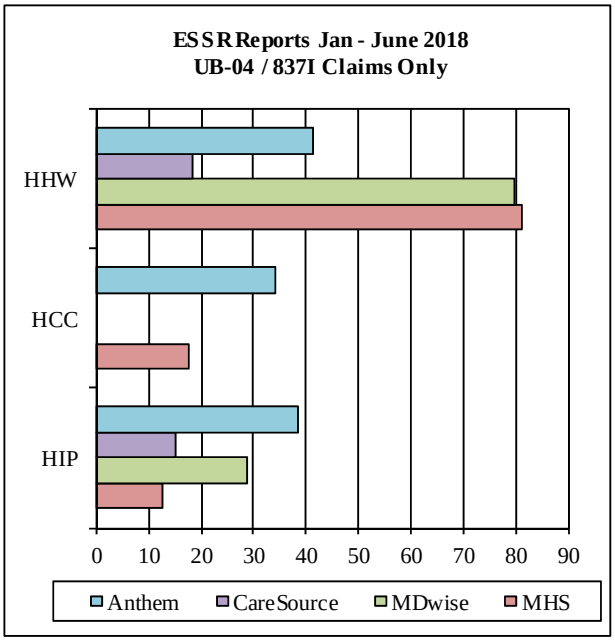
In Exhibit VI.5, four boxes are shown. The two top boxes represent encounters from UB-04 claims. The two bottom boxes represent encounters from CMS-1500 claims. The left side shows the average days to submit encounters from the claims adjudicated by MCEs in the 3rd Quarter of 2017. The right side shows the average days to submit encounters for any encounter submitted from January to June 2018 regardless of MCE adjudication date (but excluding the invalid dates).

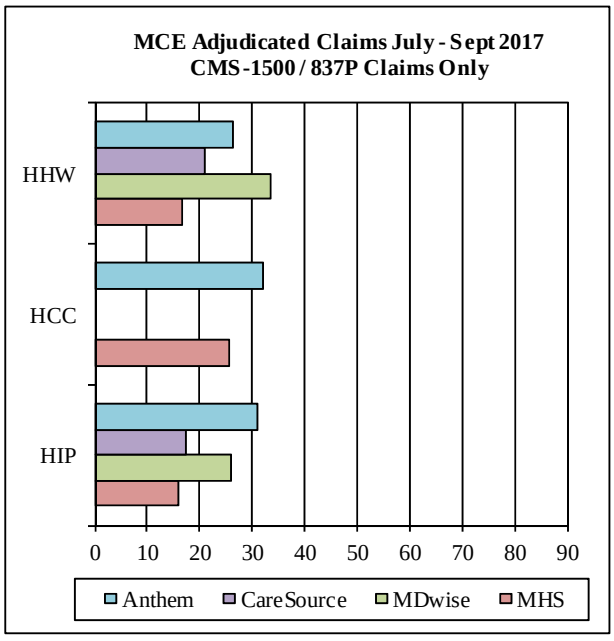
In the exhibit, when comparing the 2017 and 2018 time period results, the average days to submit encounters increased for Anthem institutional claims in HHW and HCC but not in HIP. For CareSource, the results were relatively similar in both time periods. For MDwise, the average days increased substantially for HHW institutional claims in 2018. This was also true for MHS HHW. However, the average days improved for MHS's institutional claims for HIP and HCC in 2018.

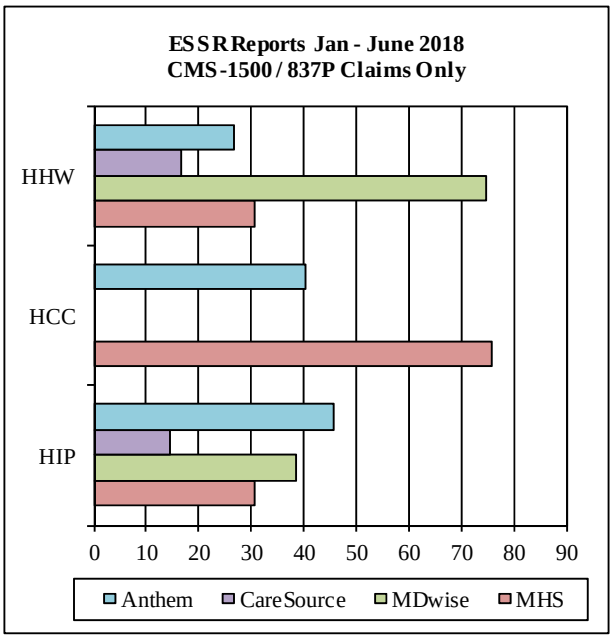
For the professional claims, Anthem also had an increase in its average days from 2017 to 2018 for HIP and HCC but for HHW the average was the same. CareSource had some improvement in 2018 for the average days to submit encounters. For MDwise, the average days increased substantially for HHW professional claims in 2018. This also occurred for the MHS HCC claims. MHS also saw in increase in its average days in 2018 for HHW and HIP, but not as great as what was found for HCC.

Exhibit VI.5
Average Number of Days between MCO Adjudication and Encounter Submission









UB04 2017	Anthem	CareSource	MDwise	MHS
HIP	44.4	19.7	17.4	16.5
HCC	27.5			20.6
HHW	27.2	16.3	30.5	17.4

UB04 2018	Anthem	CareSource	MDwise	MHS
HIP	38.6	15.0	28.7	12.8
HCC	34.1			17.8
HHW	41.3	18.5	79.7	81.3

CMS 2017	Anthem	CareSource	MDwise	MHS
HIP	31.1	17.3	26.0	15.8
HCC	32.2			25.6
HHW	26.5	20.9	33.4	16.7

CMS 2018	Anthem	CareSource	MDwise	MHS
HIP	45.8	14.4	38.5	30.7
HCC	40.4			75.8
HHW	26.6	16.7	74.9	30.7

The results in Exhibit VI.5 show the average days to submit encounters as a weighted average—that is, the total days across all claims adjudicated divided by the number of days. The OMPP has set a target that 100 percent of all claims adjudicated by the MCEs will be submitted as encounters within 30 days of the adjudication date. B&A examined what proportion of each MCE's claims met this target.

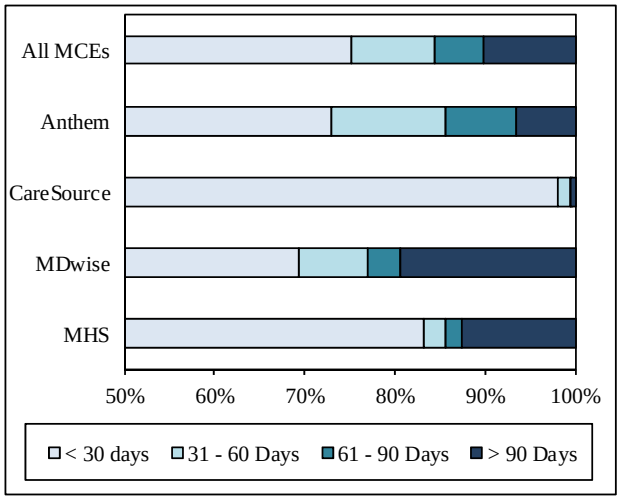
In Exhibit VI.6, all of the encounters that appeared on ESSRs from January 1 through June 30, 2018 that had not previously been excluded were examined. Dental encounters were included in the analysis since these encounters were added on ESSRs in CY 2018. Over 13.7 million encounters were analyzed.

The exhibit spreads the proportion of encounters submitted based upon the number of days since their MCE adjudication date. The portion of each bar at the far left (light blue) represents the percentage of encounters that meet the OMPP standard of submission within 30 days. As seen in the exhibit, across all MCEs, 75 percent of encounters were submitted within 30 days. A total of 90 percent of encounters were submitted within 90 days. But there was wide variation across the MCEs. For the statistic of percent of encounters submitted within 30 days, the range was from a low of 69 percent for MDwise to a high of 98 percent for CareSource.

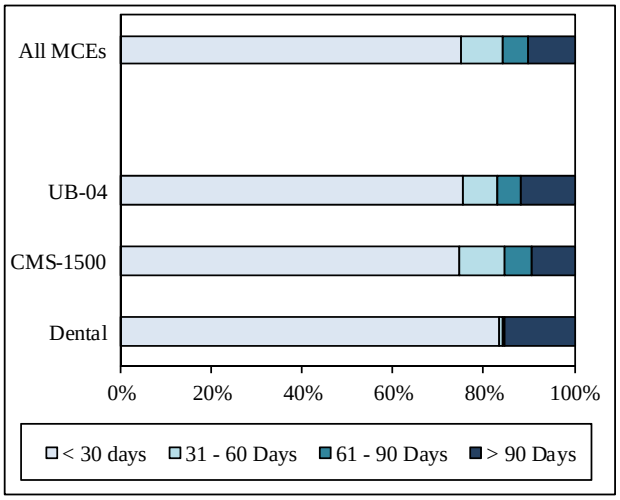
When reviewed by claim type, the percent of both institutional and professional encounters submitted within 30 days was at 75 percent. Dental encounters were higher at 83 percent, but dental encounters represent only 3.7 percent of all encounters that were submitted.

Exhibit VI.6
Distribution of Timeliness of Encounter Sumbissions
For the HHW, HIP and HCC Programs by MCE and by Claim Type
Using Encounters Reported on ESSRs Between January 1 and June 30, 2018

By MCE (All Programs Combined)



By Claim Type (All Programs Combined)



	Number of Claims Adjudicated by the MCE			
	< 30 days	**31 - 60 Days**	**61 - 90 Days**	**> 90 Days**
All MCEs	10,338,694	1,266,374	747,223	1,399,731
Anthem	5,500,540	963,365	589,798	494,560
CareSource	653,408	9,694	348	3,321
MDwise	2,103,061	232,032	111,113	587,546
MHS	2,081,685	61,283	45,964	314,304

	Number of Claims Adjudicated by the MCE			
	< 30 days	**31 - 60 Days**	**61 - 90 Days**	**> 90 Days**
All MCEs	10,338,694	1,266,374	747,223	1,399,731
UB-04	1,948,367	198,146	131,153	303,351
CMS-1500	7,962,263	1,064,106	613,011	1,017,615
Dental	428,064	4,122	3,059	78,765

Findings from the Examination of Encounter Accuracy

B&A reviewed just over 18.3 million encounters that were submitted by the MCEs for paid services that were rendered between January 1 and December 31, 2017 and billed on institutional or professional claims. The reviewed included all three of the OMPP's managed care programs (HHW, HIP and HCC).

B&A reviewed if values were populated for eight key variables on each encounter and, if so, if the value shown was a valid value. The results of this validation appear in Exhibit VI.7 appearing on the next page and are summarized below. The cells in the exhibit highlighted in yellow represent those instances where a valid value was found on less than 90 percent of all encounters submitted for the claim type/MCE/program combination.

- Indiana Medicaid Member ID: In all but a few instances, a valid value was found.

- Billing Provider NPI: A valid value was found in most all cases on institutional claims, but there were issues found on professional claims for the HCC program among all MCEs participating in this program and for MDwise in the HHW program. B&A used the master provider reference file in the FSSA's EDW as the reference to determine valid Billing NPI. In the situations where it was not always present, it could be either that the NPI provided was not found in the EDW provider reference file or the field was blank on the encounter.

- Rendering Provider NPI: This variable had the most gaps among all of the variables that B&A reviewed. In most instances, when B&A determined that the Rendering NPI was invalid it was because the field was blank on the encounter. On inpatient hospital encounters, the presence of the Rendering NPI was more predominant on HIP encounters than the other two programs. The Rendering NPI was found infrequently on outpatient hospital encounters. On professional encounters, the Rendering NPI was valid most of the time on HHW encounters but less frequently on HIP and HCC encounters.

- From and To Service Dates: B&A found that these values were valid 100 percent of the time.

- CPT or HCPCS Code: B&A reviewed outpatient hospital and professional encounters (this field is not applicable to inpatient hospital encounters). At least one valid CPT or HCPCS was found 97 percent or more of the time for every claim type/MCE/program except for MDwise HHW outpatient (93.3%).

- DRG Value: This variable is applicable to inpatient hospital encounters only. The DRG value should be an APR-DRG value on HHW and HCC encounters and an MS-DRG value on HIP encounters. The presence of a valid DRG was more common on HIP encounters than on HHW and HCC encounters. B&A reviewed the instances where the DRG value was not valid to determine if it was because the hospital was not paid by DRG and, thus, a DRG assignment is not needed. It was observed that when the DRG value was not valid, it was on encounters from hospitals that are paid by DRG and where valid DRG values were also found for the hospital.

- Primary Diagnosis Code: A valid ICD-10 primary diagnosis code was usually found on HIP encounters but not always on HHW and HCC encounters. When the field did not have a valid value, B&A researched the root cause. Most of the time, it was because the field was blank (second to last column) as opposed to a value present but the value was invalid (last column).

Exhibit VI.7
Selected Variables Validation Report
For Claims with Dates of Service Between Jan 1-Dec 31, 2017 Reported in the EDW as of Aug 2018

			Source: EDW	Percent of Total Header Claims where									
Claim Type	**MCE**	**Program**	**Header Claims in EDW as of Aug 2018**	**Valid Medicaid ID (RID) Present**	**Valid Billing NPI Present**	**Valid Rendering NPI Present**	**Valid From Date of Service Present**	**Valid To Date of Service Present**	**At Least 1 Valid CPT/HCPCS Present**	**Valid DRG Present**	**Valid Primary Diag Code Present**	**Primary Diag Code Field Blank**	**Primary Diag Code Present but NOT Valid**
UB-04/837-I Inpatient Only	Anthem	HHW	42,780	100.0%	99.9%	0.0%	100.0%	100.0%		76.2%	26.8%	73.2%	0.0%
		HCC	27,573	100.0%	99.9%	0.0%	100.0%	100.0%		70.2%	23.6%	76.4%	0.0%
		HIP 2.0	52,827	100.0%	99.7%	59.2%	100.0%	100.0%		86.6%	90.6%	0.8%	8.6%
	CareSource	HHW	6,214	100.0%	99.8%	0.0%	100.0%	100.0%		85.9%	48.1%	51.9%	0.0%
		HIP 2.0	2,170	100.0%	100.0%	57.3%	100.0%	100.0%		18.6%	90.4%	0.3%	9.3%
	MDwise	HHW	12,915	100.0%	100.0%	0.0%	100.0%	100.0%		78.4%	77.6%	22.4%	0.0%
		HCC	776	100.0%	96.1%	0.6%	100.0%	100.0%		95.7%	93.8%	6.1%	0.1%
		HIP 2.0	18,315	100.0%	100.0%	64.1%	100.0%	100.0%		99.8%	90.2%	0.0%	9.8%
	MHS	HHW	32,456	100.0%	100.0%	0.0%	100.0%	100.0%		63.3%	58.8%	41.1%	0.0%
		HCC	5,873	100.0%	99.8%	0.0%	100.0%	100.0%		25.4%	24.2%	75.8%	0.0%
		HIP 2.0	20,002	96.9%	100.0%	0.0%	100.0%	100.0%		96.2%	86.7%	4.0%	9.3%
UB-04/837-I Outpatient Only	Anthem	HHW	347,164	100.0%	99.9%	0.2%	100.0%	100.0%	98.6%		76.2%	23.8%	0.0%
		HCC	328,699	100.0%	99.9%	0.1%	100.0%	100.0%	99.4%		81.7%	18.3%	0.0%
		HIP 2.0	730,290	100.0%	99.9%	16.4%	100.0%	100.0%	99.5%		92.6%	0.1%	7.3%
	CareSource	HHW	48,773	100.0%	99.0%	0.2%	100.0%	100.0%	99.7%		95.2%	4.8%	0.0%
		HIP 2.0	53,842	100.0%	100.0%	13.8%	100.0%	100.0%	99.6%		91.3%	0.1%	8.7%
	MDwise	HHW	418,255	100.0%	94.5%	0.0%	100.0%	100.0%	93.3%		75.1%	24.9%	0.0%
		HCC	57,522	100.0%	93.3%	0.0%	100.0%	100.0%	97.8%		73.2%	26.8%	0.0%
		HIP 2.0	461,554	100.0%	100.0%	16.6%	100.0%	100.0%	97.9%		92.7%	0.0%	7.3%
	MHS	HHW	526,817	100.0%	100.0%	0.0%	100.0%	100.0%	97.5%		58.3%	41.7%	0.0%
		HCC	133,981	100.0%	99.9%	0.0%	100.0%	100.0%	98.2%		24.4%	75.6%	0.0%
		HIP 2.0	357,505	98.7%	100.0%	0.0%	100.0%	100.0%	98.5%		91.9%	1.4%	6.7%
CMS-1500/837P	Anthem	HHW	1,840,700	100.0%	96.8%	98.1%	100.0%	100.0%	100.0%		76.4%	23.6%	0.0%
		HCC	1,640,352	100.0%	85.6%	86.3%	100.0%	100.0%	99.8%		69.1%	30.9%	0.0%
		HIP 2.0	3,172,029	100.0%	96.7%	79.7%	100.0%	100.0%	99.6%		99.9%	0.1%	0.0%
	CareSource	HHW	232,173	100.0%	92.9%	98.8%	100.0%	100.0%	100.0%		84.8%	15.2%	0.0%
		HIP 2.0	186,012	100.0%	96.4%	86.4%	100.0%	100.0%	99.7%		100.0%	0.0%	0.0%
	MDwise	HHW	2,016,464	100.0%	81.1%	98.4%	100.0%	100.0%	100.0%		70.4%	29.6%	0.0%
		HCC	334,999	100.0%	68.4%	87.2%	100.0%	100.0%	99.8%		56.5%	43.4%	0.0%
		HIP 2.0	1,598,162	100.0%	97.9%	97.4%	100.0%	100.0%	99.7%		100.0%	0.0%	0.0%
	MHS	HHW	1,634,521	100.0%	98.5%	98.7%	100.0%	100.0%	99.9%		81.9%	18.1%	0.0%
		HCC	724,993	100.0%	86.6%	86.9%	100.0%	100.0%	99.8%		70.0%	30.0%	0.0%
		HIP 2.0	1,293,869	99.2%	93.0%	80.2%	100.0%	100.0%	99.8%		99.1%	0.9%	0.0%

Analysis of Adjudication Codes Assigned by DXC

As previously stated, DXC reads in encounters from MCEs for institutional, professional and dental claim types for the HHW and HCC programs and assigns adjudication codes to each detail line on these encounters. B&A's focus was to analyze the detail lines and associated adjudication codes in instances where the MCE assigned a paid status to the detail line but DXC assigned a denied status if this same detail was submitted as a fee-for-service claim. B&A then reviewed the specific EOB codes when this situation occurred to determine if the distribution by reason is similar across MCEs and if it has been consistent over time.

The two time periods examined were the details on ESSRs from July 1 to December 31, 2017 against the details on ESSRs from January 1 to June 30, 2018. The total details reviewed in these two time periods were 52.5 million and 61.5 million, respectively.

Exhibit VI.8 on the next page distributes the detail lines for the two reporting periods on both the number of detail lines and the payments associated with these detail lines. There are four tables that are formatted in the same manner. The first row in the table is the sum of the three below it. The second row shows the occurrences when the DXC adjudication status using fee-for-service edit logic matches the MCE's edit logic to pay the detail. Also included on this row are details where a test was not run by DXC (HIP encounters). The third row in the table shows details also not reviewed by DXC because the MCE indicated that it had denied payment for the service. The last row of the table is of most interest since it shows when the MCE paid the detail line but DXC would have denied it.

In the first study period, there was 8.1 percent of all detail lines reported on ESSRs where DXC would have denied when the MCE paid for the service. These detail lines represent 11.6 percent of all payments made by the MCEs. The variance across the MCEs when measuring the percentage of detail lines is small (from a low of 7.2% for MHS to a high of 9.4% for Anthem). But when measuring based on payments, there is greater variance across the MCEs (from a low of 7.6% for CareSource to a high of 12.3% for Anthem).

Overall, the results did not change much when analyzing the results for the second study period. The percentage of details that DXC would have denied that the MCEs paid was 8.7 percent (8.1% in the earlier period). When measuring based on payments, the overall percentage increased to 16.3 percent from 11.6 percent in the first study period. For both measures, the variance was greater across the MCEs in the second study period than it was in the first study period. When examining the percent of details that DXC would have denied that the MCEs paid, the range was from a low of 7.0 percent for CareSource to a high of 9.8 percent for MHS. When examining payments, the range was from a low of 6.8 percent for MDwise to a high of 23.2 percent for Anthem.

The percentage of details denied outright by each MCE was 16.6 percent in the first study period and increased to 25.1 percent in the second study period. In both periods, there was high variation observed across the MCEs. In the first study period, MDwise had the lowest denial rate at 11.9 percent while Anthem had the highest denial rate at 22.4 percent of total details submitted. In the second study period, MDwise once again had the lowest denial rate at 14.5 percent and Anthem once again had the highest denial rate but it was 33.9 percent.

Exhibit VI.8
Distribution of Detail Lines on ESSR Reports Based on MCE and DXC Assigned Status
For Two Time Periods Studied

Results for ESSR Reports Released from July 1 through December 31, 2017

	Total	Pct of Total	Anthem	Pct of Total	CareSource	Pct of Total	MDwise	Pct of Total	MHS	Pct of Total
Total on All ESSRs in 6-Month Time Period	**52,562,736**	**100.0%**	**17,645,992**	**100.0%**	**1,630,619**	**100.0%**	**16,756,744**	**100.0%**	**16,529,381**	**100.0%**
MCE and DXC Status = Paid or Not Reviewed (HIP	39,572,175	75.3%	12,028,270	68.2%	1,289,739	79.1%	13,488,471	80.5%	12,765,695	77.2%
MCE Denied so DXC Did Not Review	8,733,900	16.6%	3,960,019	22.4%	207,135	12.7%	1,991,443	11.9%	2,575,303	15.6%
MCE Paid but DXC Status = Denied	4,256,661	8.1%	1,657,703	9.4%	133,745	8.2%	1,276,830	7.6%	1,188,383	7.2%

	Total	Pct of Total	Anthem	Pct of Total	CareSource	Pct of Total	MDwise	Pct of Total	MHS	Pct of Total
Total on All ESSRs in 6-Month Time Period	**$2,484,136,718**	**100.0%**	**$1,060,307,354**	**100.0%**	**$96,160,077**	**100.0%**	**$760,465,493**	**100.0%**	**$567,203,794**	**100.0%**
MCE and DXC Status = Paid or Not Reviewed (HIP	$2,195,708,670	88.4%	$929,395,482	87.7%	$88,854,560	92.4%	$670,322,288	88.1%	$507,136,340	89.4%
MCE Denied so DXC Did Not Review	$0	0.0%	$0	0.0%	$0	0.0%	$0	0.0%	$0	0.0%
MCE Paid but DXC Status = Denied	$288,428,048	11.6%	$130,911,872	12.3%	$7,305,517	7.6%	$90,143,205	11.9%	$60,067,454	10.6%

Results for ESSR Reports Released from January 1 through June 30, 2018

	Total	Pct of Total	Anthem	Pct of Total	CareSource	Pct of Total	MDwise	Pct of Total	MHS	Pct of Total
Total on All ESSRs in 6-Month Time Period	**61,583,530**	**100.0%**	**30,015,943**	**100.0%**	**2,798,334**	**100.0%**	**12,401,283**	**100.0%**	**16,367,970**	**100.0%**
MCE and DXC Status = Paid or Not Reviewed (HIP	40,797,618	66.2%	17,281,195	57.6%	2,005,711	71.7%	9,585,081	77.3%	11,925,631	72.9%
MCE Denied so DXC Did Not Review	15,430,315	25.1%	10,184,020	33.9%	596,352	21.3%	1,804,126	14.5%	2,845,817	17.4%
MCE Paid but DXC Status = Denied	5,355,597	8.7%	2,550,728	8.5%	196,271	7.0%	1,012,076	8.2%	1,596,522	9.8%

	Total	Pct of Total	Anthem	Pct of Total	CareSource	Pct of Total	MDwise	Pct of Total	MHS	Pct of Total
Total on All ESSRs in 6-Month Time Period	**$3,486,296,490**	**100.0%**	**$1,954,520,482**	**100.0%**	**$144,446,139**	**100.0%**	**$568,692,121**	**100.0%**	**$818,637,748**	**100.0%**
MCE and DXC Status = Paid or Not Reviewed (HIP	$3,081,553,383	88.4%	$1,708,233,168	87.4%	$134,522,284	93.1%	$516,894,673	90.9%	$721,903,258	88.2%
MCE Denied so DXC Did Not Review	$0	0.0%	$0	0.0%	$0	0.0%	$0	0.0%	$0	0.0%
MCE Paid but DXC Status = Denied	$404,743,107	11.6%	$246,287,314	12.6%	$9,923,855	6.9%	$51,797,448	9.1%	$96,734,490	11.8%

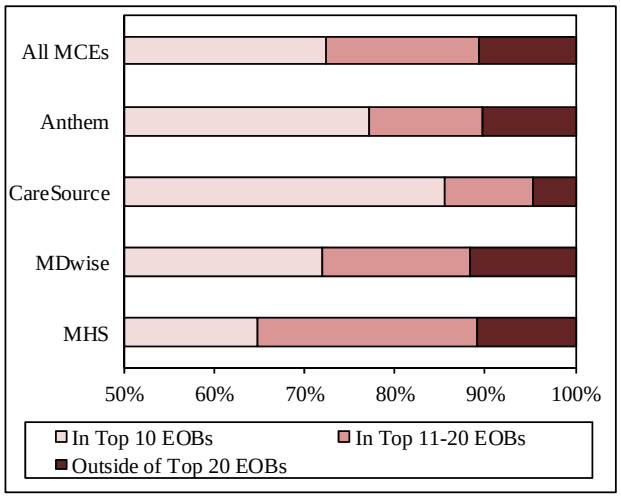
B&A then conducted a review of the EOBs that were present when DXC assigned a denial status but the MCE assigned a paid status to the detail line. It was found that in both study periods reviewed, the top 10 EOBs statewide in these situations comprise the majority of all occurrences. In the July to December 2017 ESSR period, the top 10 EOBs statewide represent 72.4 percent of all DXC denial EOBs. In the January to June 2018 ESSR period, this percentage is 75.0 percent.

B&A then looked to see if the MCEs had a similar pattern to the statewide results. In the July to December 2017 ESSR period, the top 10 EOBs statewide also represented between 64.8 percent (MHS) and 85.5 percent (CareSource) at the individual MCE level of all DXC denial EOBs. In the January to June 2018 ESSR period, the top 10 EOBs statewide also represented 66.4 percent (MHS) to 83.7 percent (CareSource).

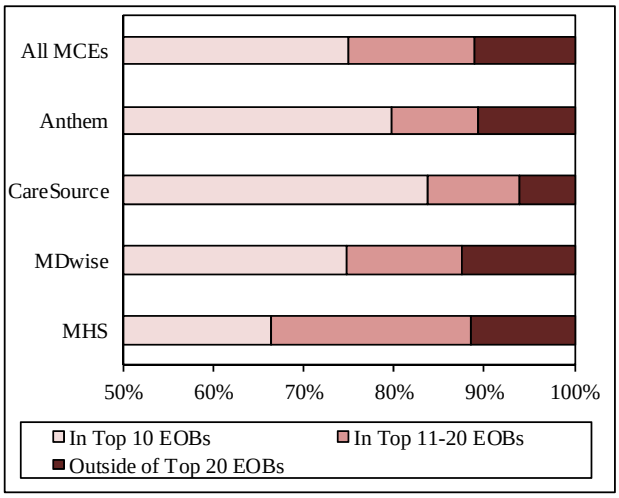
When the top EOBs were broadened to the top 20 by volume, the top 20 represented at least 88 percent of all denial EOBs for every MCE in both time periods examined.

Exhibit VI.9
Measuring Volume of Top EOBs When DXC Denied the Detail that the MCE Paid
For the HHW and HCC Programs - Institutional, Professional and Dental Encounters Only

ESSRs from July 1 - Dec 31, 2017



ESSRs from Jan 1 - June 30, 2018



	Number of DXC Denied Detail Lines		
	In Top 10 EOBs	In Top 11-20 EOBs	Outside of Top 20 EOBs
All MCEs	3,080,842	721,848	453,971
Anthem	1,278,340	207,525	171,838
CareSource	114,406	13,151	6,188
MDwise	918,016	211,103	147,711
MHS	770,080	290,069	128,234

	Number of DXC Denied Detail Lines		
	In Top 10 EOBs	In Top 11-20 EOBs	Outside of Top 20 EOBs
All MCEs	4,014,807	750,478	590,312
Anthem	2,033,825	245,776	271,127
CareSource	164,360	19,850	12,061
MDwise	756,525	130,207	125,344
MHS	1,060,097	354,645	181,780

Once it was known that the EOBs found when DXC denied an encounter that the MCEs paid were concentrated in just a few EOB categories, B&A then examined individual EOB codes to determine the relative volume that each EOB individually contributes to the total as well as to determine if there has been a change in the highest-volume EOBs over time.

To conduct this analysis, B&A synthesized the results that DXC produces monthly of the top 10 denial EOBs by claim type (institutional and professional) and by program (HHW and HCC). These reports are summarized for all MCEs combined as well as by each MCE individually.

The DXC Top 10 reports were re-introduced in August 2017 after the transition to the *Core*MMIS system. B&A reviewed monthly trends in the Top 10 reports for the period October 2017 through June 2018. On the reports, the total number of details that hit each EOB is shown. B&A converted this to a percentage of all details in the month by claim type/program/MCE. The EOBs were then ranked from highest to lowest proportion within the top 10.

Exhibit VI.10 on the next page summarizes the results found across all MCEs for UB-04 encounters in the HHW and HCC programs. Exhibit VI.11 on the page that follows summarizes the results found across all MCEs for CMS-1500 encounters.

In both exhibits, if a cell is highlighted in yellow, this means that the specific EOB represented more than 20 percent of all EOB denials for the claim type/program in the given month. If the cell is highlighted green, it means that the EOB represented more than 10 percent but less than 20 percent of all details.

Exhibit VI.10 shows that the top denial EOBs are similar between the HHW and HCC programs for the UB-04 encounters. Further, as evidenced by the yellow and green cells, in most months just a few EOB codes represent more than half of all of the denial detail lines. On a month-to-month basis, there is just a small fluctuation in the ranking of the top five EOBs. For institutional encounters, the only notable change over the nine-month period is that EOB 0304: *Valid code invalid* is no longer prominent since October 2017 and EOB 5001: *Duplicate of another claim* has become more prominent since March 2018.

There is even more consistency in the top denial EOBs across the nine-month time period for the CMS-1500 encounters. Exhibit VI.11 shows that two denial reasons are usually ranked first and second in each month for both the HHW and HCC programs. EOB 4013: *Procedure code not covered for the date of service* represented at least 20 percent of all denied details each month in the HHW program and in all but one month in the HCC program. The other prominent EOB is 1010: *Rendering provider is not an eligible member of billing group or provider number*. This EOB reason also represented at least 20 percent of all denied details in most months in the HHW program but less so in the HCC program. Another prominent EOB within the CMS-1500 encounters is EOB 1120: *Rendering provider LPI or Medicaid ID is submitted on the claim, but is invalid or does not crosswalk/not reported to the IHCP*.

Similar trends were found in the rankings of the top 10 denial EOBs on DXC's reports for each MCE when compared to the statewide totals.

B&A independently computed the top denial EOBs using the two time periods of ESSRs (July – Dec 2017 and Jan – June 2018). The independent tabulation also yielded high rankings for EOBs 1010, 1120, 5001 and 4013. B&A also observed high volume in both study periods for the following EOBs:

- EOB 1003: *Billing provider not enrolled at the service location submitted on the claim*
- EOB 3001: *Dates of service not on the PA master file*
- EOB 4005: *The submitted charge is more than five times the allowed rate*
- EOB 4020: *Units billed exceed allowable units for this service*
- EOB 4121: *T1015 must be billed with a valid CPT/HCPCS code*

Exhibit VI.10

Ranking of Top 10 Denial EOBs for UB-04 Encounters Submitted in the Month

		Results for all MCEs Combined in the HHW Program								
EOB	**Description**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**
Total Details Reviewed		**8,545**	**16,318**	**50,307**	**63,507**	**27,995**	**28,892**	**24,920**	**30,928**	**56,814**
0304	Value code invalid	1	1	8	10	10	8	9	6	
0522	The claim contains conflicting discharge information, verify patient status code	9	6			8			7	6
0545	Your claim was filed past the filing time limit without acceptable documentation								9	
1109	The billing NPI is report to multiple service locations	8	9							
2008	Member not eligible for this level of care for dates of service									
2029	Member not eligible for ihcp benefits for dates of service			10	9					
3317	The procedure billed on this detail is included in the composite rate revenue									
4013	This procedure code is not covered for this date of service	5	5	2	2	3	2	3	4	4
4014	Claim being reviewed for pricing	6	7	5	5	4	5	5	5	5
4021	Procedure code is not covered for the dates of service for the program billed			9	8	9	9	8		
4095	A non-surgical service is not reimbursed individually if performed in conjunction	2	2	3	4	2	3	4	1	2
4107	Revenue code or type of claim is not appropriate/not covered for the type of servic	3	3	1	1	1	1	1	2	3
4218	Service billed is not allowed on this claim type	7	8	6	6	6	6	6	8	7
4975	The service billed is not applicable for the member's benefit plan	10		7	7	7	7	7		8
5001	This is a duplicate of another claim	4	4	4	3	5	4	2	3	1

		Results for all MCEs Combined in the HCC Program								
EOB	**Description**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**
Total Details Reviewed		**25,349**	**42,416**	**49,177**	**177,229**	**73,513**	**17,076**	**105,360**	**74,278**	**195,384**
0304	Value code invalid	1		7						
0522	The claim contains conflicting discharge information, verify patient status code		9	4						
0545	Your claim was filed past the filing time limit without acceptable documentation									
1109	The billing NPI is report to multiple service locations	6								
2008	Member not eligible for this level of care for dates of service			8		9				
2029	Member not eligible for ihcp benefits for dates of service	9	8	9	8	10	8	8	9	7
3317	The procedure billed on this detail is included in the composite rate revenue								8	
4013	This procedure code is not covered for this date of service	3	2	2	2	3	2	2	2	2
4014	Claim being reviewed for pricing	7	5		4	4	5	7	5	9
4021	Procedure code is not covered for the dates of service for the program billed				9	8	9	9		8
4095	A non-surgical service is not reimbursed individually if performed in conjunction	4	3		3	2	3	4	3	6
4107	Revenue code or type of claim is not appropriate/not covered for the type of servic	2	1	1	1	1	1	3	1	3
4218	Service billed is not allowed on this claim type	5	4	5	5	5	6	5	6	4
4975	The service billed is not applicable for the member's benefit plan	8	6	3	6	7	7	6	7	5
5001	This is a duplicate of another claim	10	7	6	7	6	4	1	4	1

Source: DXC Top 10 Denial EOB Reports provided monthly to the OMPP

Exhibit VI.11

Ranking of Top 10 Denial EOBs for CMS-1500 Encounters Submitted in the Month

		Results for all MCEs Combined in the HHW Program								
EOB	**Description**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**
Total Details Reviewed		**47,431**	**73,614**	**96,115**	**359,323**	**183,340**	**184,891**	**181,364**	**115,206**	**163,242**
0201	Billing LPI/LPI is missing									
0231	Rendering LPI is missing	9	9	6	5	4	5	5	6	5
0235	The procedure code is not in a valid format				8					
0512	Your claim was filed past the filing time limit without acceptable documentation	10	10	3	6			7	3	8
1003	Billing provider not enrolled at the service location submitted on the claim	3	3	10						
1010	Rendering provider is not an eligible member of billing group or the group prov				2	2	1	1	1	1
1012	Service and or modifier billed not payable for your provider type/specialty					9			10	
1109	The billing LPI is report to multiple service locations	2	5	7	9	8	3	8	9	6
1120	The rendering provider LPI or medicaid ID is submitted on the claim, but is inv	5	7	4	4	3	4	4	5	4
4013	This procedure code is not covered for this date of service	1	1	1	1	1	2	2	2	2
4021	Procedure code is not covered for the dates of service for the program billed									
4033	The modifier used is not compatible with the procedure code billed	7	6	8	10	7	9	9		9
4218	Service billed is not allowed on this claim type	6	4	5	7	6	7	6	7	7
4865	Service billed not allowed for this claim region, claim must be special batched	8	8			10	8	10		10
5001	This is a duplicate of another claim	4	2	2	3	5	6	3	8	3
5008	Original ICN not present on 837 or not found in history			9						

		Results for all MCEs Combined in the HCC Program								
EOB	**Description**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**
Total Details Reviewed		**129,092**	**77,998**	**105,698**	**438,734**	**446,762**	**200,865**	**135,913**	**140,170**	**323,478**
0201	Billing LPI/LPI is missing	3	6		9			8		
0231	Rendering LPI is missing	10	5	6	8		4	4	4	8
0235	The procedure code is not in a valid format		4	2	4					
0512	Your claim was filed past the filing time limit without acceptable documentation		7	3	6				5	
1003	Billing provider not enrolled at the service location submitted on the claim	6	3							
1010	Rendering provider is not an eligible member of billing group or the group prov				2	6	2	2	2	4
1012	Service and or modifier billed not payable for your provider type/specialty					3				9
1109	The billing LPI is report to multiple service locations	4					6			
1120	The rendering provider LPI or medicaid ID is submitted on the claim, but is inv	2	2	4	3	10	3	3	3	6
4013	This procedure code is not covered for this date of service	1	1	1	1	2	1	1	1	1
4021	Procedure code is not covered for the dates of service for the program billed			10	10	8		9	10	5
4033	The modifier used is not compatible with the procedure code billed	9				4		10	8	7
4218	Service billed is not allowed on this claim type	5	8	5	7	1	8	7	6	3
4865	Service billed not allowed for this claim region, claim must be special batched	7	10				7	5	7	
5001	This is a duplicate of another claim	8	9	8	5	5	5	6	9	2
5008	Original ICN not present on 837 or not found in history			7			10			

Source: DXC Top 10 Denial EOB Reports provided monthly to the OMPP

Drilldown Reports of the Highest-Volume Denial EOB Codes

Once it was determined that a small number of EOB codes were driving the volume of DXC denials when the MCEs paid the detail lines, B&A analyzed more specific information about each of the top 10 denial EOB codes that were found in the analysis.

B&A looked for trends in the prevalence of the EOB across six variables:

- Provider Type
- Provider Specialty
- Provider Billing ID
- CPT/HCPCS
- Revenue Code
- Place of Service

The analysis was conducted in a similar manner for all of the high-volume denial EOB codes. The results of this analysis were shared with the OMPP and with each MCE.

Since the format of the findings was presented in the same manner for all of the top 10 denial EOBs, Exhibit VI.12 is shown as an example of the summary of findings from the research conducted. For EOB 4013, it was determined that this EOB is common to all MCEs and to the same provider types and specialties across all of the MCEs. In fact, the EOB is appearing on some providers who are under contract with all MCEs. Further, the EOB is appearing on a specific set of CPT/HCPCS related either to drugs to treat hemophilia or services related to obstetrics.

Where applicable, for all of the top 10 denial EOBs, B&A offers recommendations for further research for the MCEs to fix their encounter coding or to educate providers on billing such that the prevalence of the denial EOB occurrences can be reduced in the future.

Exhibit VI.12

Example of Root Cause Analysis for Reasons for Occurrence of EOB 4013: *This procedure is not covered for this date of service*

		ALL	Anthem	Caresource	MDwise	MHS	Potential Next Steps
By Provider Type	Top 10 in this group is x% of Total Payments	98.2%	97.7%	99.8%	99.3%	97.5%	MDwise has a much higher percentage in 31 Physician than the other MCEs and it appears to be driven by St. Vincent (see below).
	Highest in category based on payments	31 Physician 47.3%	25 DME 19.8%	31 Physician 55.8%	31 Physician 80.3%	31 Physician 28.8%	
	Number in All MCE Top 10 in MCE-specific Top 10		9	7	9	10	
By Provider Specialty	Top 10 in this group is x% of Total Payments	84.2%	80.7%	89.9%	93.6%	85.6%	Anthem has hardly any dollars in 316 Family Practitioner. Research their 250 DME details.
	Highest in category based on payments	316 Family Practitioner 29.2%	250 DME 19.9%	311 Anesthesiologist 35.9%	316 Family Practitioner 67.3%	250 DME 20.9%	
	Number in All MCE Top 10 in MCE-specific Top 10		8	8	7	9	
By Provider ID	Top 10 in this group is x% of Total Payments	39.5%	31.1%	44.5%	78.3%	22.9%	St. Vincent is highest overall and this is caused solely by MDwise. Almost all of CareSource's high dollar providers are anesthesiologists.
	Highest in category based on payments	100268960A St Vincent Hospital Health Care Physicians 27.0%	100375510A Community Hospital East 5.9%	200086540B Northside Anesthesia Services 11.1%	100268960A St Vincent Hospital Health Care Physicians 66.4%	100385800A St Vincent Kokomo Ambulance Service 6.2%	
	Number in All MCE Top 10 in MCE-specific Top 10		4	2	6	3	
By CPT or HCPCS	Top 10 in this group is x% of Total Payments	51.3%	32.5%	74.1%	78.3%	54.6%	27% of all payments attributed to this EOB are in J7189. MDwise is the only one that has this code.
	Highest in category based on payments	J7189 factor viia 26.6%	J7205 Injection, factor viii fc fusion protein	01967 Anesth/analg vag delivery 21.6%	J7189 factor viia 65.4%	59409 obstetrical care 14.4%	
	Number in All MCE Top 10 in MCE-specific Top 10		5	4	5	6	
By Revenue Code	Top 10 is x% of Total Pmts	Not applicable					
	Highest in category based on payments	Not applicable					
	Number in All MCE Top 10 in MCE-specific Top 10	Not applicable					
By Place of Service	Top 10 in this group is x% of Total Payments	98.8%	98.7%	99.9%	98.8%	99.5%	The findngs by place of service appear to be directly related to the top providers impacting this result, so no futher research needed.
	Highest in category based on payments	21 Inpatient Hospital 41.0%	22 Outpatient Hospital 43.1%	21 Inpatient Hospital 51.1%	21 Inpatient Hospital 73.7%	12 Home 41.1%	
	Number in All MCE Top 10 in MCE-specific Top 10		9	8	9	7	

Recommendations to the OMPP

Although the MCEs and the OMPP contractors have made a number of strides to improve the completeness, timeliness and accuracy of encounter submissions, more work can be done. B&A has observed the commitment from all parties to make this happen, including the dedicated resources being put forth by the OMPP to make this a priority. Even over the course of this study, B&A observed progress that was made. For example, the completeness of encounter submissions for CY 2017 dates of service is near 100 percent.

Recognizing that activity is moving quickly to resolve issues, B&A puts forth both short-term and long-term recommendations in an effort to simplify and streamline the encounter submission and validation process for all parties.

1. From an operational standpoint, it is not clear why multiple vendors (DXC and Optum) are participating in the encounter intake process. Since multiple parties "touch" the encounters, the opportunity for records to be lost increases. It also makes the resolution process harder for the MCEs since they receive multiple—and different—information from each party. B&A suggests that the OMPP make a clear distinction in the responsibilities for its vendors with respect to encounter intake and validation.

2. Regardless of where the responsibility ultimately falls, the ESSR file format is not as useful to the MCEs as they would like it to be. The ESSR adds another layer to check against in addition to the 835 file. B&A recommends the following:
    a. Eliminate the ESSR file format.
    b. Resume the 835 supplemental file and add the DXC EOB codes to it.
    c. Add fields for multiple EOBs, if possible, to the 835 supplemental file.
    d. Work with the MCEs to determine if there are other variables that would be meaningful to them to assist in "working" encounters in addition to the EOB and add these to the 835 file format as well.

    With a single return file that records "back-end" edits, the MCEs will be assured that:
    - The records on a given 837 submission will all be returned on the same response file.
    - There will be no need to reconcile against multiple response files or wait weeks for an encounter to hit a response file.

3. The OMPP should prioritize the current set of denial EOBs and then hold the MCEs accountable to this priority set of EOBs. For example,
    a. Assign each denial EOB a score of "no importance", "low importance" or "high importance" across defined factors such as financial impact to capitation rate setting, priority for quality and outcomes reporting, and/or priority for federal reporting.
    b. Weight each factor to develop a score for each denial EOB.
    c. Create a cutoff of only EOBs above the threshold score.
    d. Utilize the OMPP contractor (currently DXC) to replace the current Top 10 Denial EOB report with a report of Volume of All Priority EOBs (regardless of volume each month).
    e. Communicate the priority EOBs to the MCE.
    f. Build an accuracy benchmark for the MCEs to meet on these EOBs specific to each claim type. (For example, "The total number of encounter lines submitted by the MCEs in a reporting quarter that contain priority EOBs cannot be above [x]%.")

4. The OMPP is encouraged to engage a dedicated OMPP resource or hire one of its contractors to create a more nuanced dashboard to trend the priority EOBs over time to assess if improvement is being made. The trend reports should not only focus on the absolute number that occur but based on the percentage of all encounter details reported. B&A observed trends where the absolute number of details that hit an EOB dropped on the current top 10 reports but still represented a higher percentage of the total than the prior month because the encounter submissions for the entire month went down from the prior month.

5. With respect to other MCE contract requirements, the OMPP should consider strengthening its current requirement that the MCE should submit an encounter file each week. For example, more specificity can be provided on the claim types, service type and/or minimum volume of records.

6. The OMPP should provide more clarity with respect to what defines a "clean encounter". For example,
    a. Determine if the +4 in the zip+4 field is necessary.
    b. Determine if non-priority denial EOBs are factored into the definition.
    c. Determine the importance of the unit field (which may depend upon the claim type).

7. The OMPP should add encounter submission statistics either to its current quarterly claims adjudication report or as a separate report in that section of the MCE Reporting Manual. At minimum, any statistics on encounter reporting should be:
    a. Reported separately by claim type;
    b. Reported separately for claims paid and denied by the MCE;
    c. Tie back to claims adjudicated by the MCE to assess the completeness rate; and
    d. Report based on timeliness in a similar manner to what is reported for claims adjudication.

8. The OMPP should resume the requirement for the MCEs to maintain and encounter work plan in CY 2019 with detailed tasks and milestones and ongoing reporting to track progress.

Recommendations to the MCEs

Many of the recommendations that B&A might put forth to the MCEs are dependent upon the decisions from the OMPP on actions that may be taken on the recommendations to the State, but regardless of these decisions, B&A has some recommendations for the MCEs that can take effect immediately.

1. Each MCE should build an internal dashboard to track encounter completeness rates, timeliness rates and accuracy rates. It is suggested that measures be tracked at the claim type level as well as the category of service level. Accuracy measures can include both rejection rates (e.g., records on TA1 and 999 response files), acceptance rates (e.g., post-and-pay EOBs) and denial rates (e.g. all denial EOBs or OMPP-defined priority denial EOBs).

2. With respect to conducting root cause analyses of the denial EOBs, B&A concurs with some MCE's current focus on the denial EOBs based on dollars paid out by the MCE. B&A suggests that analyses be conducted similar to what was presented in Exhibit VI.12 to further determine the root cause for the denial.

3. If not done already, each MCE should maintain an issues log database to track open and resolved items worked on individually or collectively in the encounter working group sessions.

SECTION VII: FOCUS STUDY ON PHARMACY MANAGEMENT

Introduction

The responsibility of the managed care entities (MCEs) to cover pharmacy services has evolved in the Office of Medicaid Policy and Planning's (OMPP's) contracts for its three managed care programs:

- In Healthy Indiana Plan (HIP), pharmacy was carved in effective February 1, 2015.
- In Hoosier Care Connect (HCC), pharmacy was carved in with the inception of the program effective April 1, 2015.
- In Hoosier Healthwise (HHW), pharmacy was carved in with a new contract effective January 1, 2017.

At present, for all three programs, the MCEs are responsible for the full spectrum of pharmacy benefit management which includes, but is not limited to:

- Developing and maintaining a preferred drug list (PDL);
- Maintaining and monitoring adherence to state and federal laws on prescribing limits (e.g., mental health drugs);
- Making determinations on authorization requests;
- Supporting e-prescribing services;
- Adjudicating claims; and
- Submitting encounters to the OMPP to ensure that the State can achieve the appropriate Medicaid drug rebates

The MCEs have discretion on how to approach other aspects of pharmacy benefit management which are not mandated in the OMPP contract such as medication adherence programs, medication synchronization programs, and mail order programs.

Approach to Conduct this Study

To evaluate each MCE's compliance and effectiveness with the requirements set forth in the OMPP contract, Burns & Associates, Inc. (B&A) conducted both a desk review of materials requested from each MCE as well as a facilitated onsite interview with key staff responsible for pharmacy management at each MCE. The desk review was conducted by two members of the B&A External Quality Review (EQR) team in advance of the onsite interviews. From this review, the team members created a standardized interview questionnaire. The onsite interviews were facilitated by the same team members who conducted the desk review and covered all topics in the questionnaire as well as ad hoc discussions. The onsite interviews conducted at each MCE were approximately three hours in duration. The findings of these reviews are discussed in the sections below.

Related to this review, B&A performed data analytics at the request of the OMPP on pharmacy claims with service dates in Calendar Year (CY 2017) to analyze two specific aspects of pharmacy management.

The first study was to assess the rate at which the MCEs are including national drug codes (NDCs) on professional and institutional claims for physician-administered drugs (PADs). The OMPP requires the MCEs to record an NDC on specific Healthcare Common Procedure Coding System (HCPCS) codes that are listed on guidance released and maintained by the OMPP. The OMPP is requiring the NDC in these situations because a HCPCS code alone is not at the level of granularity that is appropriate for reporting

rebate information directly to manufacturers. Therefore, any omissions of a proper NDC accompanying a HCPCS code on an MCE encounter would understate the amount of rebates due to the state.

The second study conducted was an analysis of the range of dispensing fees paid to pharmacies. There was interest from the OMPP in this study to ensure sufficient access to pharmacies throughout the state, particularly in areas where the pharmacy chain stores are not present.

For both of these analyses, B&A utilized a data extract from the State's Enterprise Data Warehouse (EDW) that included all paid and denied pharmacy encounters submitted by the MCEs for scripts filled in CY 2017 as received in the EDW by March 31, 2018. For the study of NDC reporting on PAD encounters, B&A used the guidance from the State titled "Procedure Codes That Require National Drug Codes (NDCs)" published April 17, 2018.

Responsibilities for Pharmacy Management at Each MCE

To assist them in the administration of the pharmacy benefit, each MCE under contract with the OMPP uses a Pharmacy Benefits Managers (PBM). The PBM under contract with the MCE covers all programs for which the MCE is under contract with the OMPP. Both CareSource and MHS use CVS as their PBM. Anthem uses Express Scripts (ESI) as its PBM and MDwise uses MedImpact (Walgreens).

MCEs were asked to identify the division of responsibilities for pharmacy management between themselves and their contracted PBM. A summary of the responsibilities is presented in Exhibit VII.1 on the next page. Cells highlighted in blue represent when the responsibility is primarily with the MCE. Cells in orange represent when the responsibility is primarily with the PBM. Cells in green represent when the responsibility is shared between the MCE and its PBM.

As the exhibit shows, the MCEs and their PBM partners generally employ similar approaches to the management of each functional area. More information about how each of these tasks is completed is discussed in the sections that follow.

Exhibit VII.1

Responsibilities for Pharmacy Benefit Management at Each MCE

Item	Area of Responsibility	**Anthem** Express Scripts	**CareSource** CVS	**MDwise** MedImpact	**MHS** CVS
		Responsible Party			
1	Contract with pharmacies, ensuring network adequacy	PBM	PBM	PBM	PBM
2	Monitor and report network adequacy	MCE	MCE	MCE	MCE
3	Provider education and outreach (e.g. on the formulary, authorization requirements, changes to guidelines)	SHARED	MCE	SHARED	MCE
4	Intake and review of non-preferred drug list (PDL) authorizations	SHARED	MCE	MCE	MCE
5	Maintain a provider call center related to pharmacy	PBM	PBM	PBM	PBM
6	Intake and adjudicate pharmacy claims	PBM	PBM	PBM	PBM
7	Conduct research and maintain guidelines released for authorization requests for specific classes of drugs	MCE	MCE	SHARED	SHARED
8	Conduct research and maintaining the formulary/ Preferred Drug List	MCE	MCE	SHARED	SHARED
9	Conduct audits of pharmacy providers	PBM	PBM	PBM	PBM
10	Build reports required by the OMPP on a periodic basis	SHARED	MCE	MCE	SHARED
11	Build reports required by the Drug Utilization Review (DUR) Board	MCE	MCE	SHARED	SHARED
12	Participate in the MCE Pharmacy and Therapeutics Committee	MCE	MCE	MCE	MCE
13	Administer the e-prescribing program	PBM	PBM	PBM	PBM

Initial Readiness Assessment and Ongoing Monitoring of PBMs

Upon initial contracting with its PBM, each MCE provided evidence of the initial assessments that were conducted for the PBM's readiness to complete the work required under the OMPP contract scope of work for the HHW, HIP and HCC programs. This included, but was not limited to, the following:

- Development and maintenance of an implementation work plan/grid to track the readiness of specific functional requirements;
- Assessment of the network of pharmacies to ensure sufficient access across the state;
- Walk through and programming of the formulary and benefit design features specific to the OMPP programs;
- Significant testing of authorization and claim adjudication scenarios specific to the design of Indiana's programs;
- Verification and testing of 834 (enrollment) file transmissions and encounter submissions to the MCE; and
- Development of reports to manage PBM operations (e.g., turnaround time for authorization requests, call center statistics) and pharmacy utilization.

On an ongoing basis, each MCE has a robust oversight process of its PBM.

At Anthem, the MCE conducts a weekly meeting on encounter submissions with ESI that is specific to the Indiana contracts. Anthem also attends a weekly meeting with ESI that covers multiple markets that ESI works in to stay abreast of topics applicable to the entire enterprise. Anthem also meets regularly with ESI on items specific to regulatory changes or formulary changes. On a day-to-day basis, Anthem maintains an electronic database that tracks all open ticket items with ESI related to pharmacy management until resolution.

At CareSource, CVS employs nine full time staff to support CareSource contracts (multiple state Medicaid contracts). The MCE conducts a weekly meeting with the assigned account executive at CVS and a separate weekly operations meeting where open ticket items for the Indiana contracts are reviewed and tracked. There are also weekly calls scheduled to discuss items related to the formulary and a separate bi-weekly call to address specialty formulary items. On a quarterly basis, CareSource conducts an onsite meeting with CVS to review the ongoing business relationship.

At MDwise, the MCE conducts a weekly meeting with the MedImpact team to address open ticket items that are maintained in an automated issues log through resolution. A separate weekly call is conducted to focus on clinical items such as formulary changes. On a quarterly basis, MDwise conducts a meeting with the executives of both the MCE and the PBM to review the ongoing business relationship. Due to its delivery system design, MDwise also conducts other meetings with its delivery system partners regarding information on pharmacy management that flows from the PBM. The delivery systems receive weekly, monthly and quarterly reports on pharmacy utilization. On a bi-monthly basis, MDwise conducts a meeting with its delivery systems that is specific to pharmacy.

At MHS, the MCE conducts a weekly call with CVS on operational issues such as the call center, authorizations and eligibility. Like the other MCEs, MHS maintains an electronic open ticket item log that tracks issues through resolution. Although there is correspondence on a daily basis related to coverage and formulary-related items, MHS also conducts meetings that are more clinical in nature on an as-needed basis with CVS. MHS also conducts a quarterly meeting with the senior leadership from both the MCE and the PBM to review the ongoing business relationship.

The OMPP requires notification when specific elements of the MCE's service level agreements (SLAs) with the PBMs are not being met. The specific items that are required to be reported include:

- Turnaround time for authorization requests not being met within 24 hours
- Less than 90 percent of pharmacy calls not being answered within 30 seconds
- Less than 95 percent of pharmacy calls not being resolved within the first call

Anthem reported some issues with the turnaround time metric in early CY 2017, but this has since been resolved. MHS also reported issues with the turnaround time metric in early CY 2017 which was resolved, but then there was another issue later in the year due to a software implementation change at CVS. The PBM took corrective action and the issue was resolved. None of the MCEs reported issues with the call center timeliness metrics.

All of the MCEs did cite an ongoing struggle with meeting the 24-hour turnaround time requirement. One specific example cited was related to the review of authorization requests for Makena, a drug used to prevent pre-term birth in pregnant women. The MCEs cited that requests for this script are usually approved but more than 24 hours is required to make the medical necessity determination to approve.

Education and Communication Related to Pharmacy Benefits Management

Training, Education and Communication with Prescribers and Pharmacies

With respect to their interactions with prescribers and providers, the MCEs reported a similar set of activities, although there was some variation in modality or intensity of activities and the extent of shared responsibility perceived between the MCE and PBMs. The MCEs hold their PBMs responsible for maintaining the relationship with network pharmacies through their call-in centers and network pharmacy information dissemination activities. With respect to the dissemination of training, education and communication with prescribers on coverage and benefit changes, the MCEs that contract with CVS (CareSource and MHS) retain this responsibility. Both Anthem and MDwise cited that this responsibility is shared between itself and its PBM.

Whether through the provider portal, fax blasts, or other modalities, the MCEs ensure communication with its network of pharmacies on a regular basis with respect to new claim adjudication edits, changes to the PDL, or more focused topics. For example, CareSource cited recent communication with its pharmacies on opioid edits and multiple MCEs cited recent communications with its pharmacies on the decision by the OMPP to carve out Hepatitis C drugs from the MCE contract.

The MCEs cited similar information that is communicated to prescribers such as changes to the PDL, changes to policy (such as the Hepatitis C carve-out), or information on MCE-specific programs such as enhanced prior authorization, medication treatment management (MTM), or medication adherence programs. All of the MCEs stated that they release information relevant to specific prescribers based on the provider's prescribing patterns.

The MCEs cited that the most common questions that come to their call centers about the pharmacy benefit are related to member eligibility, coverage, or the authorization process.

MCE Programs for Members and Prescribers that Support Pharmacy Management

In the CY 2017 EQR covering review year CY 2016, B&A conducted a specific focus study on each MCE's medication adherence program. The results of this study are discussed in last year's report.[12] B&A inquired about any new features to these programs that are occurring in CY 2017 or 2018. Each MCE cited expansion of medication adherence efforts to both providers and members.

- Anthem stated that they have recently added calls to members related to medication adherence to treat asthma. They have also expanded their MTM program by moving more members into the program.

- CareSource just entered into its contract with the OMPP in CY 2017, so it mentioned its initial efforts related to pharmacy programs in the Indiana market. Their initial focus will be on medication adherence for antipsychotics, adherence rates by provider panel, and the expansion of its MTM program.

- MDwise stated that it has initiated meetings starting in late 2017 with individual community mental health centers (CMHCs). At these meetings, information is reviewed on individual

[12] External Quality Review of Indiana's Care Programs: Hoosier Healthwise, Hoosier Care Connect and Healthy Indiana Plan 2.0 for Review Year Calendar 2016, February 26, 2018.

MDwise members who seek services at the CMHC. Additionally, MDwise has added more notifications to all prescribers on the lack of medication adherence in a broader context with member-specific profiles.

- MHS has initiated automated calls and texting to encourage better medication adherence rates, specifically for respiratory-related conditions and for antidepressants. In the fall of 2018, MHS is planning to introduce provider profile reports on their member panel's adherence to medications that are more user-friendly than the Excel reports that are distributed to providers currently.

Development and Maintenance of Preferred Drug Lists

The MCEs must maintain a PDL that has been submitted to the Drug Utilization and Review (DUR) Board for their review and recommendation prior to being approved by the OMPP in accordance with state statute (IC 12-15-35-46). The MCEs are required to maintain a Pharmacy and Therapeutics (P&T) Committee which meets regularly to make recommendations for changes to the PDL. The MCE must submit proposed changes to its PDL to the OMPP at least 45 days before any removal or new restriction on a drug. (Positive changes to the PDL can be submitted within 30 days of the effective date on a retrospective basis.) The OMPP then forwards these requested changes to the DUR for their review and recommendation prior to making an approval, disapproval or requested modification. The MCEs then have 60 days to comply with those decisions. The MCEs must be responsive to DUR requests and provide a range of data and reports as necessary. An additional requirement of the MCEs is that, prior to implementing a restriction on any mental health drug, the State's Mental Health Medicaid Quality Advisory Committee must be consulted.

B&A reviewed MCE policies and procedures related to maintaining the PDL list in detail during the desk and onsite review. Each MCE reported a very comprehensive and similar process for complying with these requirements. Each MCE's processes and procedures are above the minimum requirements stipulated in the contract.

All MCEs reported that their P&T Committees meet at minimum on a quarterly basis. The MCE Pharmacy Director and Medical Director participate in these meetings. Membership on the committee includes both internal MCE clinical staff and external providers. The MCE's pharmacy research team prepares the information that will be used for discussion in the meetings that pertain to formulary changes. This includes research on MCE-specific utilization and expenditures as well as a review of the literature on studies pertaining to the medication being reviewed. In addition to the cost to the MCE of the specific drug, the total cost of a member's care is often considered to determine the overall impact of formulary changes. The MCEs cited that it is often the case that, based on discussions at the P&T Committee, a final decision is held for a future meeting so that additional research can be conducted at the request of Committee members. If a drug is considered neutral by the P&T Committee in terms of its clinical effectiveness, some MCEs report using an economic valuation to determine the status of a given drug.

A significant number of items are reviewed by each MCE's P&T Committee annually. For all of the changes below, each MCE cited 100 percent approval by the DUR Board:

- Anthem: 327 changes (this could include items as specific as dosage changes)
- CareSource: 280 changes (this included 99 criteria edits as opposed to drugs coming on/off)
- MDwise: average of 15 to 20 changes per month
- MHS: average of 20 to 30 changes per quarter

The OMPP contract allowed the MCEs to build a PDL that was unique to each program (HHW, HCC and HIP) and even within a program (HIP Basic and HIP Plus). The MCE PDL lists could differ from the OMPP PDL for its fee-for-service program.

In preparation for the carve-in of pharmacy in January 2017, the MCEs collectively built a comparison table of the PDLs across all programs in late 2016 that was shared with the OMPP and the DUR Board. Ultimately, the MCEs individually decided to maintain two PDLs—one for the HIP Plus program and one for all other programs.

Due to provider confusion, the OMPP is working with the MCEs to further streamline the PDL between the MCEs and fee-for-service. All of MCEs conveyed that the primary difference between the OMPP's fee-for-service PDL and their own was the placement of products into the preferred product category. Specifically, the MCEs reported that they have more generic products on their PDL.
In addition to establishing whether a drug is preferred or non-preferred, the MCEs must also transparently report all utilization management for coverage drugs like quantity limits, step-therapy or indications. MCEs report that their P&T Committees make these recommendations and that they are included in the DUR Board reviews.

While there are no specific requirements imposed by the OMPP related to PDL changes, all of the MCEs reported proactive identification and notification of PDL changes to impacted prescribers and members. The MCEs give a minimum of 30 day notice for these changes through mailings, emails or phone calls. Individual members who are affected by PDL changes are inventoried through a claims sweep and prescribing providers are notified.

The MCEs also described the thorough process in which they test changes to the PDL with their PBM. Test cases are developed to ensure compliance with all possible scenarios. A sign-off process is in place to ensure acceptance of testing prior to go live. The MCEs also stated that they conduct post-implementation testing of changes as well.

Utilization Management

All of the MCEs provided documentation to B&A supporting a robust utilization management program related to the pharmacy benefit. A summary of these activities can be divided into functions related to prior authorization and ongoing utilization trend reports.

Prior Authorization

The OMPP does not require the MCEs to report on prior authorization statistics related to pharmacy on a separate report; rather, the information is reported by the MCEs on a quarterly authorization report that includes all other medical authorization information as well.

Despite this, each MCE reported that they track pharmacy authorization requests closely. This includes the approval and denial rates as well as the turnaround time for authorization decisions. Three of the four MCEs (Anthem being the exception) reported reviewing authorization statistics daily. All of the MCEs review the statistics quarterly as well to meet the reporting requirements for the OMPP.

The most common reason cited for denial of an authorization request is lack of complete information. This may be an artifact of the turnaround time requirement of 24 hours for Medicaid outpatient drug authorization decisions. In order to meet this turnaround time requirement, if the data is not complete to make the authorization determination, the MCEs stated that the authorization request will be denied.

Among the denied authorizations, all of the MCEs cited that a disproportionate number of denials are related to opioids, asthma and diabetes. Some MCEs also cited drugs that are part of a step therapy protocol are also denied more often because the prescriber is not following the protocol guideline.

For authorization requests for drugs not on the MCE's PDL, the MCEs cited that the documentation required will vary by therapeutic class. Each MCE has online tools related to verification of the documentation required, but the number of forms specific to therapeutic classes varies greatly by MCE (one MCE cited only three while another cited approximately 145).

Each MCE adheres to the OMPP requirement and federal law that a member is eligible for approval for a 72-hour emergency supply of a covered prescription drug in an emergency. The MCEs have internal controls in place that a specific code is entered by the pharmacist when an emergency script is filled. The MCEs then conduct retrospective reviews to check for any patterns of overuse of this benefit by prescribers or members. All MCEs reported that they have seen no significant issues with this benefit.

Each MCE also has policies related to prescription refills, that is, the percent of days' supply that must elapse before a script can be refilled. The policy varies by MCE (but the policy is consistent across OMPP programs within each MCE):

- Anthem: 90% days elapse on retail scripts, 75% on mail order or specialty
- CareSource: 85% days elapse on non-controlled scripts, 90% on controlled scripts
- MDwise: 75% days elapse on retail scripts, 66% on mail order
- MHS: 80% days elapse on non-controlled scripts, 88% on controlled scripts, 75% on mail order

Utilization Trending

Each of the MCEs conducts ongoing pharmacy utilization tracking and trending, but the type of tracking and level of detail does vary by MCE. Anthem stated that they review reports on a regular basis both from the prescriber perspective and the member perspective such as highest cost individuals or number of scripts as one way to detect potential fraud and abuse. MDwise is focusing on groups of prescribers such as CMHCs, and performing detailed analytics on the prescribing patterns of CMHCs looking at member-level detail. MHS looks at reports on overall pharmacy expenditure trends, generic substitution rates, top controlled substances prescribed and top opioids prescribed. They are in the midst of launching more user-friendly reports to individual prescribers about their member panels. CareSource is starting to build more detailed analytics on pharmacy now that they have a full year of claims experience in the Indiana market. Their focus will be on behavioral health utilization overall and prescribers with high dollars in behavioral health prescriptions.

Each MCE also tracks step therapy medication utilization. All of the MCEs have built in edits prospectively with their PBMs at the point of sale. Anthem also conducts retrospective utilization reviews regularly. MHS conduct this utilization review annually. MDwise reviews authorization denial rates on a monthly retrospective basis.

The OMPP requires that the MCEs submit a quarterly report on audits that have been conducted by the MCE in the most recent quarter. The MCEs have discretion on the format of how to submit the report, but they must include the number of audits completed, the number of claims reviewed for each entity audited, and the type of audit conducted (telephone, desktop or onsite). The number of audits to be completed and the findings from each audit are not required to be reported.

The MCEs cited varying numbers of audits performed and the modality used to audit. Anthem conducts approximately 70-80 per quarter, MDwise conducts approximately 105-120 per quarter, MHS conducts approximately 50 per quarter and CareSource conducts three to six per quarter (their enrollment is much lower than the other MCEs). The audits are performed by each MCE's PBM. The MCE is given the name of the providers to be audited in advance to ensure that the PBM audit does not conflict with an ongoing state investigation. It should be noted that MHS stated that CVS contracts with an outside vendor to audit actual CVS stores.

Three of the MCEs receive summary information on the audit findings to take corrective action if needed, such as recoupment of payments. Anthem does not receive the results of audit findings from ESI.

Claims Adjudication and Encounter Submissions

Pharmacy Claims Adjudication

All of the MCEs worked with their PBMs on the design of the claims adjudication edits for pharmacy. Many edits can be defined as standard National Council for Prescription Drug Program (NCPDP) edits (e.g., refill too soon) while others are specific to the OMPP programs (e.g. member eligibility).

As a percentage of all pharmacy claims, the denied claim rate reported by each MCE varied significantly. But this is an artifact of what is "countable" as a claim. For example, at the point of sale, a technician may try to enter a pharmacy claim ten times and it is rejected the first nine times. Each of these nine claims is counted as a rejection even though they appeared in rapid succession.

The most common reasons cited by most all MCEs for pharmacy claim denials included member not found to be eligible (or not on file), refill too soon, quantity limit on script, no authorization on file when required and DU rejection code (i.e., step therapy duplication).

None of the MCEs reported tracking or trending claim denial rates at the individual provider or prescriber level on a routine basis. There are instances when this is done if the provider is subject to an audit.

Encounter Submissions

Each MCE receives encounter files from their PBM in the format that is requested by the OMPP for encounter submissions. The encounter files are submitted to the OMPP on a weekly basis. Each MCE conducts verification of encounter completion by matching against invoices from the PBM. Each MCE submits both paid and denied pharmacy encounters to the OMPP for all managed care programs. The NCPCP adjudication code is included with each encounter submission. Every MCE reported a minimum 99.5 percent acceptance rate on their pharmacy encounter submissions to the OMPP in CY 2017. Unlike the many issues addressed by the OMPP and the MCEs on encounters for medical claims in 2017, the MCEs cited few instances of issues with pharmacy encounter submissions in CY 2017. Of the few issues identified, they have all been resolved.

B&A Analysis of NDCs on PADs

For retail pharmacy scripts, there is no issue related to tracking on the claim the specific NDC which was filled. As stated previously, the OMPP has an edit in its fee-for-service program that requires an NDC on professional or outpatient hospital claims that are billed with certain HCPCS. In the OMPP's fee-for-service program, payment will be denied if an NDC is not recorded on the pre-determined list of HCPCS that require an NDC. In the managed care programs, the OMPP is requiring the MCEs to mimic this edit

and to ensure that the NDC is recorded, when required, on professional and outpatient hospital encounters that include PADs.

B&A verified compliance with this requirement by analyzing encounters with PADs billed with service dates in CY 2017. Data was summarized by MCE and by program. B&A used the OMPP guidance memo released in April 2018 that identifies the specific HCPCS that require an NDC. The final dataset, therefore, was limited to encounters in CY 2017 where HCPCS codes were reported by MCEs that require an NDC. B&A counted the number of times an NDC was present and when one was not present. When an NDC was not present, B&A summed the total payments made by the MCEs for these drugs. This value represents the total payments from which the OMPP may be able to seek rebates from manufacturers (but not the value of the rebates themselves).

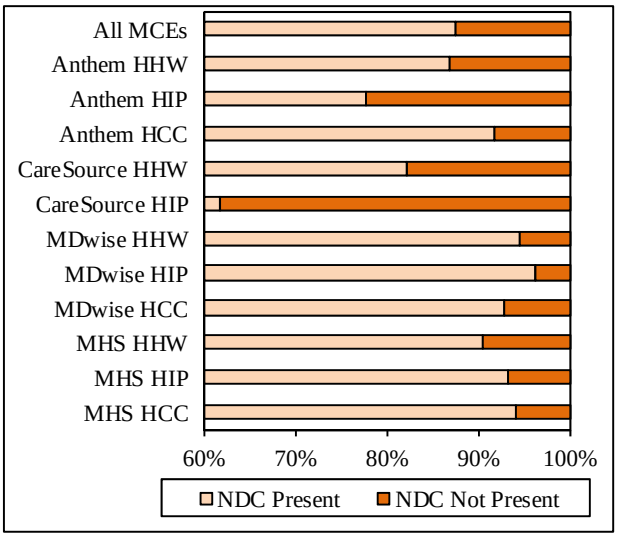
B&A identified just over 1.34 million PAD detail lines and just over $236 million in payments on these PAD detail lines from professional and outpatient hospital encounters submitted by the MCEs to the FSSA's EDW for CY 2017 services.

Exhibit VII.2 on the next page shows the frequency of missing NDCs on PAD detail lines by MCE and by program. In the aggregate, the NDCs were missing on 12.5 percent of all detail lines in CY 2017. This average is heavily weighted, however, by the Anthem HIP (22.3% of details) and Anthem HHW (13.0% of details) programs which represent almost half of all of the PAD details missing NDCs. CareSource also had a high percentage of detail lines missing NDCs, but their volume was very low in CY 2017.

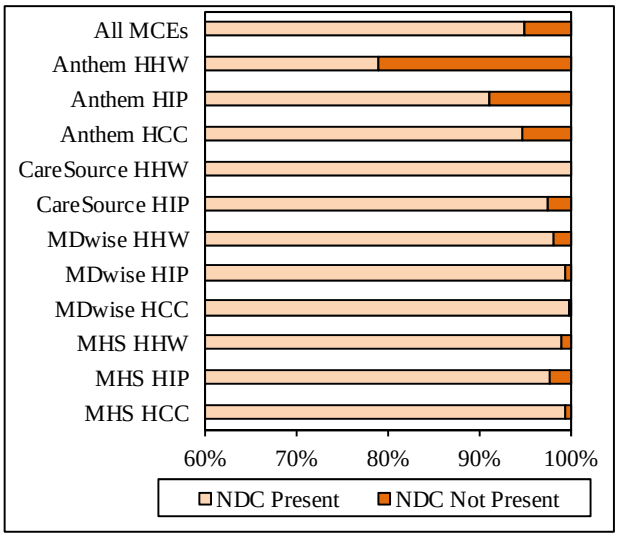
Although there were 12.5 percent of PAD detail lines missing an NDC, this represented only 5.1 percent of all PAD payments made by the MCEs. Once again, this weighted average percentage statewide is heavily weighted by the payments for Anthem's programs which collectively represented $10.9 million of the $12.0 million shown on PAD detail lines with a missing NDC. The payments for the other three MCEs when a missing NDC was found were nominal. B&A did find situations where there was a PAD detail line was missing an NDC, the line had a status of paid, but the MCE paid amount was $0. This could be one of the reasons why the 5.1 percent of paid PAD details with missing NDCs is so much lower than the percentage of detail lines missing an NDC.

Exhibit VII.2
Distribution of Physician-Administered Drug Details with or without an NDC Present on the Encounter
For the HHW, HIP and HCC Programs by MCE

Distribution by Number of Paid Details



Distribution by Paid Amount on Details



	Number of Details Paid by the MCE	
	NDC Present	NDC Not Present
All MCEs	1,176,684	168,173
Anthem HHW	59,433	8,891
Anthem HIP	334,679	96,264
Anthem HCC	163,824	14,794
CareSource HHW	6,005	1,301
CareSource HIP	13,429	8,270
MDwise HHW	45,202	2,562
MDwise HIP	211,793	8,069
MDwise HCC	25,590	1,941
MHS HHW	110,289	11,621
MHS HIP	181,880	12,918
MHS HCC	24,560	1,542

	Paid Amount on PAD Details	
	NDC Present	NDC Not Present
All MCEs	$224,475,864	$11,978,576
Anthem HHW	$9,633,429	$2,549,683
Anthem HIP	$55,643,851	$5,449,047
Anthem HCC	$51,789,638	$2,887,955
CareSource HHW	$365,689	$0
CareSource HIP	$1,017,347	$26,302
MDwise HHW	$6,225,698	$110,147
MDwise HIP	$31,461,429	$155,275
MDwise HCC	$15,665,525	$29,517
MHS HHW	$18,114,948	$177,388
MHS HIP	$24,137,151	$530,846
MHS HCC	$10,421,159	$62,416

B&A performed an analysis to see if the missing NDCs were more prevalent in certain categories of PAD detail lines than others. Similar to Exhibit VII.2, this was reviewed by the percentage of details and by the percentage of all PAD payments made by the MCEs. The results depending upon which measure is used. Exhibit VII.3 on the next page shows the top 10 therapeutic classes (as defined by the OMPP in its EDW) where there were missing NDCs on PAD detail lines. The top 10 represent 73.6 percent of all situations in CY 2017 where the NDC was missing. In the right side of the exhibit, however, the top 10 therapeutic classes based on MCE payments where there was a missing NDC for a PAD are shown. The top 10 using this measure represent 94.4 percent of all payments made when an NDC was missing where there should have been one present.

Three therapeutic classes in particular represent 75 percent of all payments where an NDC was missing on a PAD detail line: Hematological Agents – Misc. (35.6%), Antineoplastics & Adjunctive Therapies (24.9%) and "Unknown" (14.6%).

Exhibit VII.3
PAD Detail Lines with Missing NDCs by Therapeutic Class

MCE/Program	Total Detail Lines	Pct of All Detail Lines	Rank	Total Payments	Pct of All Payments	Rank
All PAD Detail Lines with Missing NDCs	**168,173**	**100.0%**		**$11,978,576**	**100.0%**	
Top 10	**123,783**	**73.6%**		**$11,311,010**	**94.4%**	
Analgesics- Antiimflammatory	15,470	9.2%	3	$217,264	1.8%	9
Analgesics- Opioid	22,391	13.3%	1	$4,579	0.0%	
Anitcoagulants	11,148	6.6%	5	$1,451	0.0%	
Anitemetics	16,575	9.9%	2	$132,409	1.1%	10
Anithistamines	10,879	6.5%	6	$759	0.0%	
Antineoplastics & Adjunctive Therapies	5,538	3.3%	10	$2,976,691	24.9%	2
Cephalosporins	8,611	5.1%	8	$3,939	0.0%	
Corticosteroids	15,255	9.1%	4	$20,841	0.2%	
Endocrine & Metabolic Agents - Misc.	1,018	0.6%		$337,016	2.8%	6
Gastrointestinal Agents - Misc.	2,324	1.4%		$500,731	4.2%	5
Hematologicial Agents - Misc.	2,579	1.5%		$4,264,423	35.6%	1
Hematoppoietic Agents	4,000	2.4%		$699,789	5.8%	4
Minerals & Electrolytes	7,522	4.5%	9	$4,307	0.0%	
Misc Therapeutic Classes	1,282	0.8%		$160,333	1.3%	9
Passive Immunizing & Treatment Agents	715	0.4%		$272,761	2.3%	7
Unknown	10,394	6.2%	7	$1,749,594	14.6%	3

Pharmacy Pricing

Overview of Pricing

With regard to pricing, all MCEs indicated that their PBMs all use a similar approach to establishing payments for drugs on their unified drug lists. A price is typically set by applying the lesser of one of three methods: (1) the average wholesale price (AWP) minus a percentage, (2) the Maximum Allowable Cost (MAC) (often for generics), or (3) the usual and customary (U&C) charge (not used often). Pricing updates under each of these scenarios occur at different rates. Anthem indicated that updates to pricing are usually done annually whereas MHS indicated it is usually done semi-annually. Prices may be paid as a flat fee or as a percentage of source pricing. If paid by percentage, this percentage can vary by therapeutic class.

With respect to dispensing fees, every MCE pays a flat amount as the dispensing fee, but this fee is negotiated by the PBM with each pharmacy in the network.

B&A Analysis of Dispensing Fees Paid

B&A received all retail pharmacy encounters submitted by the MCEs for scripts filled in CY 2017 from the FSSA's EDW to analyze the variation in dispensing fees paid.

Although the average dispensing fee paid in CY 2017 across all MCEs and programs was $0.97, there was variation seen by MCE. There was consistency found within each MCE, however. Exhibit VII.4 shows the average dispensing fee paid by MCE within each program. Anthem's average was between $1.43 and $1.45 for all three programs that it under contract with the OMPP. CareSource and MDwise were between $0.62 and $0.66 for its programs, while MHS was between $0.48 and $0.50 for its programs.

Exhibit VII.4
Average Dispensing Fee Paid in OMPP's Managed Care Programs

MCE/Program	Average Dispensing Fee	Total Encounters	Pct of All Encounters
All MCEs/Programs	**$0.97**	**14,653,178**	**100.0%**
Anthem HHW	$1.43	936,271	6.4%
Anthem HIP	$1.43	3,752,164	25.6%
Anthem HCC	$1.45	1,992,749	13.6%
CareSource HHW	$0.65	101,396	0.7%
CareSource HIP	$0.62	230,151	1.6%
MDwise HHW	$0.65	1,057,619	7.2%
MDwise HIP	$0.64	2,527,581	17.2%
MDwise HCC*	$0.66	362,492	2.5%
MHS HHW	$0.48	791,004	5.4%
MHS HIP	$0.48	1,781,168	12.2%
MHS HCC	$0.50	1,120,583	7.6%

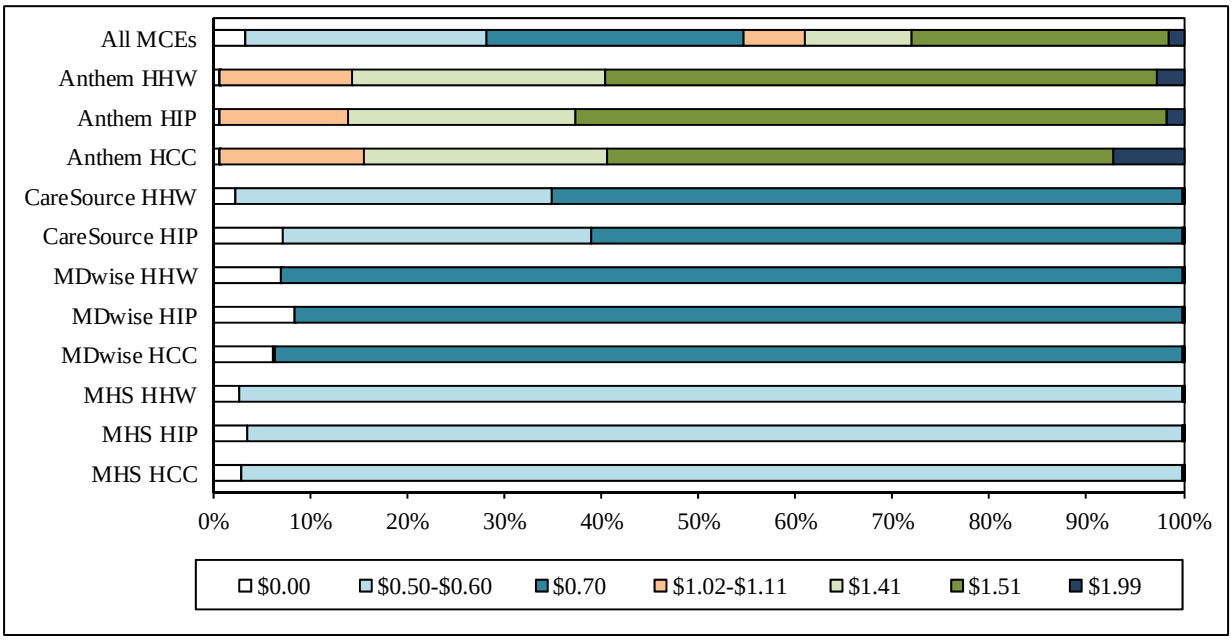
* MDwise exited the HCC program on 3/31/.17.

There was a limited spread in the actual dispense fee values found. Among the 14.6 million scripts analyzed, the encounter data analyzed showed that 97.7 percent of the scripts were paid one of the following eight dispensing fees: $0.00 (3.3% of the total), $0.50 (23.2%), $0.70 (26.2%), $1.02 (1.9%), $1.11 (4.4%), $1.41 (11.0%), $1.51 (26.2%) or $1.99 (1.6%).

Exhibit VII.5 which appears on the next page shows the distribution of dispensing fees paid for the pharmacy encounters within each MCE and program. The fees paid are consistent for all of the programs within an MCE but the fees vary across MCEs. Anthem almost always pays a fee between $1.02 and $1.51, but more than half of the time the fee is $1.51. CareSource pays $0.70 more than 60 percent of the

time; for the remainder of most of the scripts, the amount is between $0.50 and $0.60. MDwise pays $0.70 nearly all the time, but in some instances the dispensing fee amount on the encounter was reported as $0.00. MHS pays between $0.50 and $0.60 nearly all the time, but like MDwise in some instances the dispensing fee amount on the encounter was reported as $0.00.

Exhibit VII.5
Distribution of Pharmacy Scripts Based on Dispensing Fee Paid
For the HHW, HIP and HCC Programs by MCE
Using Encounters Reported in the EDW for Scripts Filled in CY 2017



	Dispensing Fee Amount						
	$0.00	**$0.50-$0.60**	**$0.70**	**$1.02-$1.11**	**$1.41**	**$1.51**	**$1.99**
All MCEs	486,033	3,616,638	3,846,095	916,448	1,608,181	3,833,825	229,369
Anthem HHW	6,519	110	64	127,086	240,772	527,606	25,703
Anthem HIP	23,252	885	347	497,189	876,991	2,276,461	62,815
Anthem HCC	11,981	884	1,930	292,036	490,418	1,029,100	140,755
CareSource HHW	2,268	32,962	65,807	10	0	26	2
CareSource HIP	16,719	72,592	140,121	8	0	74	4
MDwise HHW	73,515	105	983,975	0	0	16	4
MDwise HIP	212,308	691	2,314,264	51	0	212	21
MDwise HCC	22,699	409	338,841	12	0	42	8
MHS HHW	22,034	765,152	38	1	0	11	1
MHS HIP	62,665	1,707,563	92	44	0	220	7
MHS HCC	32,073	1,035,285	616	11	0	57	49

* MDwise exited the HCC program on 3/31/.17.

B&A also analyzed the average dispensing fee paid to the top pharmacies that served the HHW, HIP and HCC programs based on volume. There were 14.6 million encounters reported for pharmacy scripts in

CY 2017. Of these, 13.8 million encounters had a dispensing fee reported on the encounter. Among the 13.8 million encounters, 85.3 percent came from the top 10 providers. A total of 68.0 percent came from the top three pharmacies alone (CVS, Walgreens and Wal-Mart). In Exhibit VII.6 below, B&A found that the average dispensing fee for the top 10 providers was an even $1.00. Seven of the top ten had an average payment between $0.97 and $1.10. The two low outliers were Walgreens ($0.72) and Rite Aid ($0.82). The one high outlier was Genoa ($1.19).

Exhibit VII.6
Average Dispensing Fee Paid in OMPP's Managed Care Programs
For the Top 10 Pharmacies Based on Volume
in the HHW, HIP and HCC Programs Combined

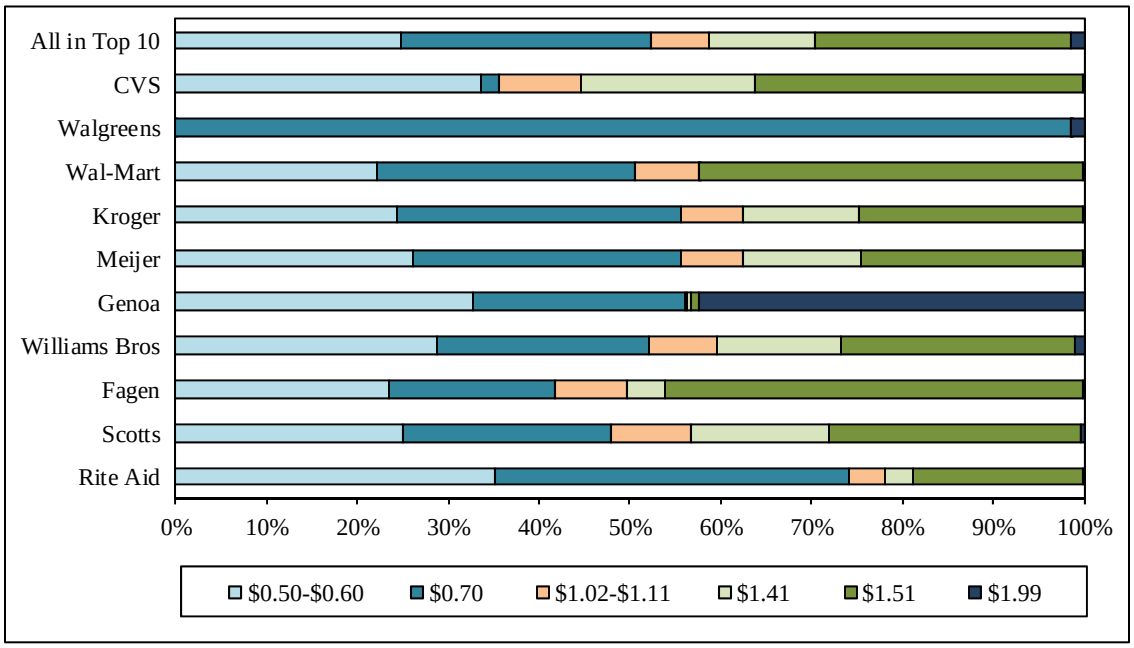
MCE/Program	Average Dispensing Fee	Total Encounters	Pct of All Encounters Statewide
All Pharmacy Encounters in CY 2017*		**13,841,612**	**100.0%**
All in Top 10	**$1.00**	**11,801,055**	**85.3%**
CVS	$1.10	5,661,064	40.9%
Walgreens	$0.72	1,946,236	14.1%
Wal-Mart	$1.03	1,800,778	13.0%
Kroger	$0.97	1,249,455	9.0%
Meijer	$0.97	455,940	3.3%
Genoa	$1.19	311,224	2.2%
Williams Bros	$0.99	110,484	0.8%
Fagen	$1.09	93,246	0.7%
Scotts	$1.02	88,782	0.6%
Rite Aid	$0.82	83,846	0.6%

*Encounters with dispensing fee shown as $0.00 were excluded.

Similar to the analysis completed by MCE/program, B&A also analyzed the distribution of the dispensing fees paid across all encounters within each of the top 10 pharmacies in CY 2017. The results are shown in Exhibit VII.7 on the next page. Among the top 10 pharmacies, all but Walgreens are receiving an array of dispensing fee amounts in Indiana's managed care programs. Walgreens appears to the exception since they are only contracted in the MDwise and CareSource networks and MDwise's PBM is MedImpact. CareSource had relatively low volume in CY 2017 since they just entered the programs at the start of the year.

This exhibit also explains further why Genoa's average dispensing fee of $1.19 is higher than its peers. Unlike all of the other pharmacies that received a dispensing fee of $1.99 on a minimal number of their scripts, Genoa received this amount on 42.5 percent of its encounters.

Exhibit VII.7
Distribution of Pharmacy Scripts Based on Dispensing Fee Paid
For the Top 10 Pharmacies Based on Volume in the HHW, HIP and HCC Programs Combined
Using Encounters Reported in the EDW for Scripts Filled in CY 2017



	Dispensing Fee Amount					
	$0.50-$0.60	**$0.70**	**$1.02-$1.11**	**$1.41**	**$1.51**	**$1.99**
All in Top 10	2,930,687	3,236,871	773,562	1,353,450	3,332,357	174,128
CVS	1,901,658	112,669	505,284	1,093,588	2,042,603	5,262
Walgreens	21	1,917,705	10	0	34	28,466
Wal-Mart	397,830	514,463	123,722	2,324	759,186	3,253
Kroger	304,627	389,124	86,260	161,168	305,638	2,638
Meijer	119,238	134,382	30,834	59,868	111,070	548
Genoa	101,931	72,535	715	1,412	2,367	132,264
Williams Bros	31,765	25,921	8,166	15,192	28,316	1,124
Fagen	21,960	16,958	7,464	3,869	42,824	171
Scotts	22,194	20,337	7,807	13,456	24,733	255
Rite Aid	29,463	32,777	3,300	2,573	15,586	147

Encounters with dispensing fee shown as $0.00 were excluded.

Recommendations to the MCEs

In the interviews conducted with each MCE, it was evident to the EQR Review Team that each MCE has extensive documentation and sophisticated data analytics driving their management of the pharmacy benefit on behalf of their members. Given this finding, B&A offers the following recommendations in the spirit of recommendations for continuous quality improvement.

1. With the introduction in CY 2018 of new services and provider types with the State's Substance Use Disorder waiver with CMS, the MCEs are encouraged to develop specific outreach and education to these providers about its authorization process, its PDL and its medication adherence programs.

2. B&A saw examples of how providers are notified about their patient's medication adherence rates for selected conditions. The MCEs are encouraged to continue its efforts to build more user-friendly reports to prescribers on adherence-related measures including attempts to refill too soon.

3. B&A recommends that the MCEs build a reporting mechanism that trends authorization denial rates by prescriber so that it can prioritize those prescribers that have a higher-than-average denial rate and may benefit from additional education from the MCE on authorization processes.

4. The rate of PADs missing NDCs was found to be relatively low for MDwise and MHS but high for Anthem and CareSource. B&A suggests that Anthem and CareSource conduct a root cause analysis on the reason why the NDC was missing. The highest priority is to Anthem in those situations where the MCE made a payment for the PAD (there were instances where CareSource had a missing NDC but the payment was still $0).

Recommendations to the OMPP

1. The OMPP should consider requiring the MCEs to break out the quarterly reporting of the number of authorization requests, their final disposition status, and average turnaround time on a separate report from the quarterly report currently submitted where the pharmacy authorizations are embedded with other medical authorizations. This is merited due to the volume of pharmacy authorization requests made, the different turnaround time requirement from other authorizations, and the fact that all of the MCEs are using a PBM for the majority of authorization requests.

2. The OMPP should provide more guidance on its current QR-PHARM A1 quarterly report that the MCEs submit on pharmacy audits. In particular:

    a. The format of the form should be standardized for easier compilation of results by the OMPP.
    b. The actual audit findings should be reported for each audit conducted.
    c. A pass/fail percentage should be reported each quarter based on the total number of claims reviewed.

3. The current guidance released by the OMPP on procedure codes that require NDCs is helpful for claims adjudication editing. But some MCEs mentioned that the guidance related to the specific NDCs that are allowable for each PAD is not always current. The OMPP is encouraged to ensure that its contractor maintains and publishes a timely release of the procedure code-to-specific allowed NDC crosswalk.

4. The move to a unified PDL across all programs is a positive step. To that end, the OMPP may also want to consider the development of a unified over-the-counter approved list.

SECTION VIII: EXAMINATION OF PROVIDER NETWORK ADEQUACY

Introduction

The Office of Medicaid Policy and Planning (OMPP) has contractual requirements that mandate that each managed care entity (MCE) maintain a provider network that ensures that members in the Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC) have access to an array of provider specialties to meet their medical needs. The OMPP requires that each MCE submit geoaccess maps to ensure that its members in each OMPP program have access to providers. Some of the providers for which geoaccess requirements have been set are shown in Exhibit VIII.1.

Exhibit VIII.1
Provider Specialties in the Study and OMPP Access Standard for Each Specialty

Primary Care	1 provider within 30 miles	General Dentist	1 provider within 30 miles
Behavioral Health (other than Psychiatrist, e.g. community mental health center)			1 provider within 45 miles
Cardiologist	2 providers within 60 miles	Optometrist	2 providers within 60 miles
Gastroenterologist	2 providers within 60 miles	Orthopedist	2 providers within 60 miles
General Surgeon	2 providers within 60 miles	Otolaryngologist	2 providers within 60 miles
Nephrologist	2 providers within 60 miles	Psychiatrist	2 providers within 60 miles
Neurologist	2 providers within 60 miles	Pulmonologist	2 providers within 60 miles
OB-GYN	2 providers within 60 miles	Urologist	2 providers within 60 miles
Ophthalmologist	2 providers within 60 miles		

For this External Quality Review (EQR), Burns & Associates, Inc. (B&A) identified members enrolled in HHW, HIP and HCC and identified their utilization for dates of service in Calendar Year (CY) 2017 for each of the 17 provider specialties listed in Exhibit VIII.1. B&A tested the accessibility of each MCE's provider network by measuring the average driving distance for members to each specialty type. In doing this, B&A is imposing a more restrictive requirement than the actual contractual requirement. That is, the distance was computed to the specialty provider that the member accessed care as opposed to the provider that may be closest in proximity to the member's home. It is understood that members have access to the full array of providers in the MCE's network. Members may choose to access a provider that is a further distance to their home than the provider that is the closest proximity to their home.

B&A was provided encounter extracts from the OMPP's Enterprise Data Warehouse (EDW) for services rendered to members in each of the three programs. The encounters were segmented by MCE and program (HHW, HIP or HCC) for analytical purposes. When a provider enrolls in Indiana Health Coverage Programs (IHCP), the provider is identified by provider type and specialty. The provider is assigned a specialty code based on their enrollment information. This specialty code is associated with the provider on all encounters representing services delivered by the provider.

B&A used the EDW provider specialty code to identify the specialist services that would be considered in this study. With the exception of primary care and behavioral health, this is a 1-to-1 mapping.

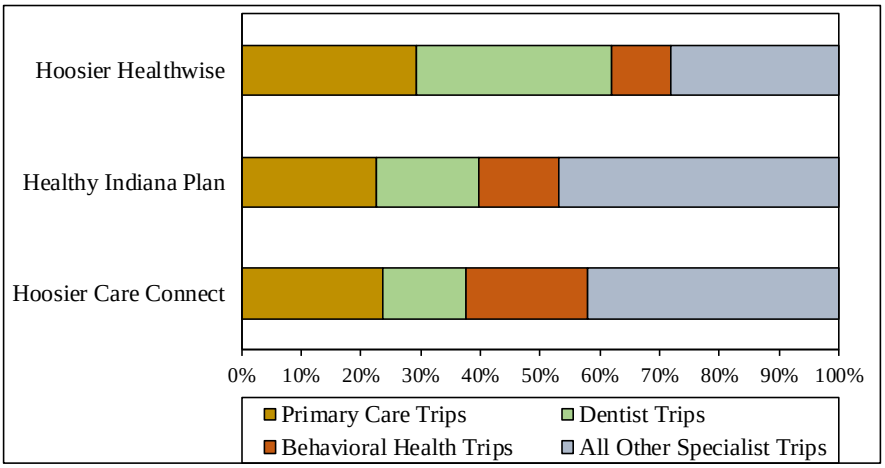
From the full data extract received, B&A limited the encounters dataset to the members in the study and the 17 specialty categories for the study period of CY 2017. For the limitation by specialty category, the rendering provider ID was used on each claim (as opposed to the billing ID).

In-state individuals enrolled in HHW, HIP and HCC were mapped to one of Indiana's 92 counties based on their home address in the enrollment file provided to B&A from the EDW. The latitude and longitude coordinates of each member's home address were plotted. Likewise, the latitude and longitude coordinates of every provider specialty with a claim in the study database was plotted.

The average distance travelled was computed by taking the average distance for all encounters within the specialty for members' utilization within a county. The data for this tabulation was limited to a single pairing of member-to-provider. For example, a single member may have had five visits to a primary care provider during CY 2017. Of these visits, three were to the same provider, the fourth was to a second provider, and the fifth was to a third provider. In B&A's analysis, only three of these claim distances was computed—the first visit of three to provider #1, the only visit (4th overall visit for the member) to provider #2, and the only visit (5th overall visit for the member) to provider #3.

Geocoding software (either the Google Distance Matrix web service or BING Maps web service) was used to map the driving distance from the member's home to the provider's office[13]. Some exclusions were applied due to the fact that the latitude/longitude coordinates were missing or not valid for either the member's home or the rendering provider's office. Non-valid coordinates were defined if the computed driving distance was either less than 0.2 miles or more than 100.0 miles between the member's home and provider's office. The final total number of trips in the study after exclusions were applied was 2,220,530 trips—for HHW, there were 1,116,557 trips; for HIP, there were 821,870 trips; and for HCC, there were 282,103 trips. A distribution of the trips studied within each program appears in Exhibit VIII.2.

Exhibit VIII.2
Proportion of Trips in the Network Adequacy Study
by Program and Major Provider Type



	Primary Care Trips	Dentist Trips	Behavioral Health Trips	All Other Specialist Trips	Total
Hoosier Healthwise	327,876	365,183	108,116	315,382	1,116,557
Healthy Indiana Plan	186,292	140,062	109,204	386,312	821,870
Hoosier Care Connect	66,871	39,490	57,072	118,670	282,103

[13] Note that B&A computes the driving distance (turn by turn) as opposed to a crow flies' distance.

The average distance for each county was then computed as the total miles across all non-excluded trips divided by the total trips for members to the specific specialty. B&A created a four-scale range for the specialties with the 30-mile requirement (primary care and dental), the 45-mile requirement (behavioral health), and the 60-mile requirement (all other specialties examined). The scales are not intended to relate specifically to quartiles. Rather, the ranges within each scale are intended to assess the relative variation in the average distance travelled by members across the 92 counties in the state.

Findings from Review of Access to Services by Provider Specialty

Exhibits VIII.3 through VIII.8 that appear on the following pages examine the access thresholds for different provider specialties based on the OMPP's contractual requirements. Exhibits VIII.3 and VIII.4 examine primary care and general dentistry, respectively. For each of these specialties, the OMPP requires access to providers within 30 miles of the member's home. Exhibit VIII.5 examines behavioral health providers (other than psychiatrists). The OMPP requirement for this provider specialty is 45 miles. Exhibits VIII.6 through VIII.8 examine other provider specialties for which the OMPP has set a 60-mile access requirement.

The exhibits are displayed in a similar manner. Each box with stacked bars displayed represents one of the OMPP programs. The sections of the horizontal stacked bar represent the number of counties (out of 92) that had an average driving distance within the range of miles specified. All bars end at 92 because there are 92 counties in Indiana. The portions of the stacked bar colored blue represent compliance by the MCE with the OMPP standard. The darker the blue, the lower the average miles value. The portion of the stacked bar in salmon represents non-compliance by the MCE; that is, the average driving distance for members in these counties exceeds the OMPP standard. Some stacked bars also have a gray portion. This represents counties in which the volume was so low (less than 10 trips) that B&A did believe it was fair to present the county's average mileage value. There is often gray seen on the specialist stacked bars in Exhibits VIII.6 through VIII.8 for this reason. Also, CareSource has more gray portions on its rows than the other MCEs because it just began as an MCE in CY 2017 and does not have the volume of the other three MCEs.

In Exhibit VIII.3, the results show that there are a number of rural counties in Indiana where members travelled more than 30 miles, on average, to access primary medical providers. This was less true in the HIP program than in the HHW and HCC programs, however. It should be noted that for more than half of these counties, the average distance travelled was between 30 and 40 miles. Further, although the count of counties may be higher than expected, it does not always represent a large volume of the trips made. In the lower-right box of Exhibit VIII.3, the percentage of total trips in CY 2017 for the counties with an average mileage greater than 30 miles are shown by MCE and by program. The MCE/program with the greatest percentage of trips under this criterion is Anthem HCC with 19.4 percent of trips in counties with an average greater than 30 miles. But, alternatively, MHS HHW had only 0.6 percent of their trips and MDwise HHW had only 4.9 percent of their trips under this criterion.

Exhibit VIII.4 displays the same type of information as VIII.3 but for dental services. There were fewer counts of counties with an average mileage that exceeded the OMPP 30-mile threshold than was found for primary care. Further, the lower right box of the exhibit shows that, with the exception of Anthem HCC, all other MCEs had less than eight percent of their total dental visits in counties with an average distance greater than 30 miles.

Exhibit VIII.5 shows the information for behavioral health providers. For this specialty group, the OMPP has a standard of 45 miles. There are fewer counties that had an average mileage above the standard for this specialty than was found for primary care or dental services. The percentage of total trips was also

lower. The total trips in counties above the standard were in the range of 2.4 percent (Anthem HHW) to 6.1 percent (CareSource HHW) of the MCE's total trips for behavioral health services.

Exhibits VIII.6 (HHW), VIII.7 (HIP) and VIII.8 (HCC) display the results found for each MCE for 13 different physician specialties for which the OMPP requires the MCEs to have two practitioners within 60 miles of each member's home. In Exhibit VIII.6, it was found that there was often low utilization in many counties for a number of these specialties as evidenced by the gray portions of the horizontal bars. There is little salmon color on the bars which is indicative of the number of counties in which the average driving distance exceeded 60 miles in CY 2017. The two specialties where this was most likely to occur across all of the MCEs was neurology and urology. From a prevalence of visits perspective, these high-average counties represented 10 percent of all neurology visits (exception: MDwise was 20%) and eight percent of urology visits (exception: MDwise was 27%).

The findings in Exhibit VIII.7 for HIP were similar to what was seen for HHW with the exception that more counties had sufficient volume to review data. This is because the HIP population is comprised only of adults and the adults are more likely to access many of these provider specialties than children. There were few specialties in which any MCE had a significant number of counties outside of the OMPP standard. The most prevalent specialty where this occurred was cardiology. From a prevalence of visits perspective, these high-average counties represented 11 percent of all cardiology visits. This statistic was similar across the MCEs.

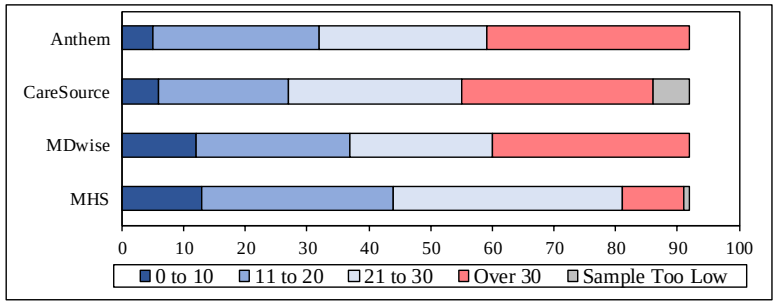
Exhibit VIII.8 shows the same information in CY 2017 for the HCC program which includes both children and adults. Once again, low volume was often seen mostly because the total population in HCC is much smaller (about 90,000) than in HHW or HIP (approximately 650,000 and 415,000 respectively). There were few counties that had volume that the MCE was outside of the 60-mile standard set by the OMPP. As was seen in the HHW findings, the most common occurrence of this was neurology. From a prevalence of visits perspective, these high-average counties represented only five percent of all neurology visits in HCC.

Exhibit VIII.3
Access to Primary Medical Providers

The blue colors on the bar show the counties where the MCE meets the contractual compliance. The salmon shows non-compliance. The gray indicates counties with insufficient sample (less than 10 trips by members) to make a fair assessment of compliance.

Hoosier Healthwise

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range

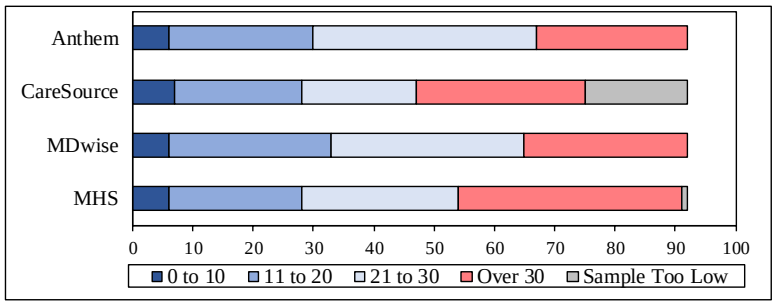


Number of Counties with Average Mileage in Each Range

Managed Care Entity	0 to 10	11 to 20	21 to 30	Over 30	Sample Too Low
Anthem	5	27	27	33	0
CareSource	6	21	28	31	6
MDwise	12	25	23	32	0
MHS	13	31	37	10	1

Healthy Indiana Plan 2.0

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range

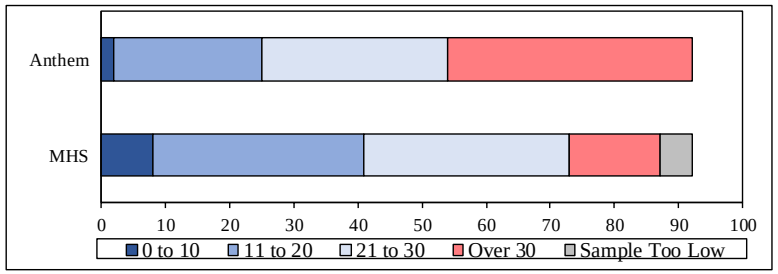


Number of Counties with Average Mileage in Each Range

Managed Care Entity	0 to 10	11 to 20	21 to 30	Over 30	Sample Too Low
Anthem	6	24	37	25	0
CareSource	7	21	19	28	17
MDwise	6	27	32	27	0
MHS	6	22	26	37	1

Hoosier Care Connect

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range



Number of Counties with Average Mileage in Each Range

Managed Care Entity	0 to 10	11 to 20	21 to 30	Over 30	Sample Too Low
Anthem	2	23	29	38	0
MHS	8	33	32	14	5

Proportion of Trips in Counties with Average Mileage Exceeding OMPP's Standard of 30 Miles

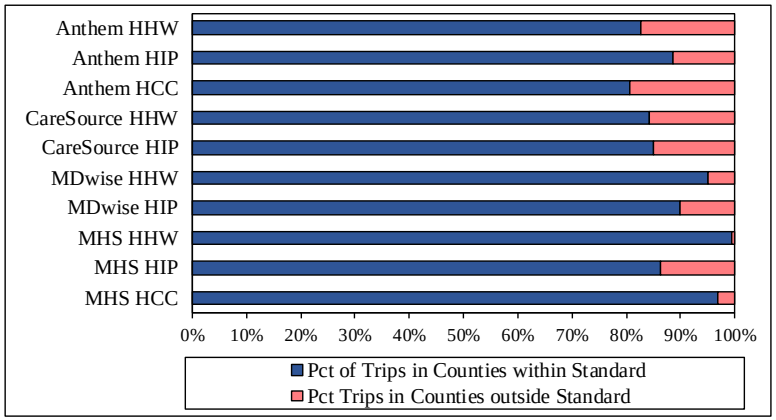
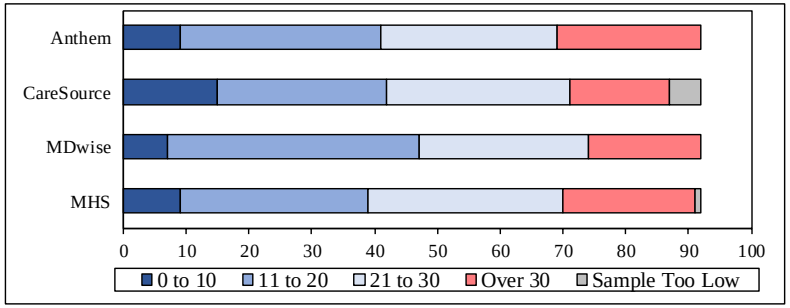


Exhibit VIII.4
Access to Dentists

The blue colors on the bar show the counties where the MCE meets the contractual compliance. The salmon shows non-compliance. The gray indicates counties with insufficient sample (less than 10 trips by members) to make a fair assessment of compliance.

Hoosier Healthwise

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range

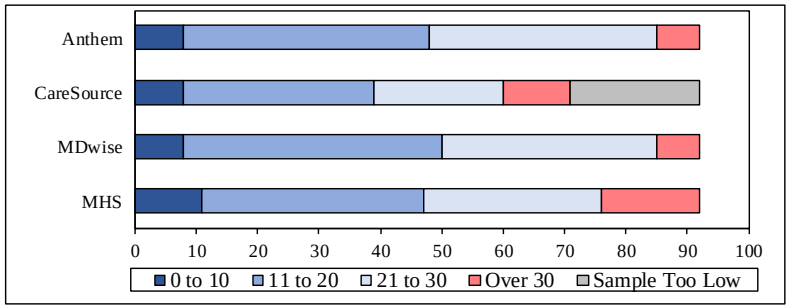


Number of Counties with Average Mileage in Each Range

Managed Care Entity	0 to 10	11 to 20	21 to 30	Over 30	Sample Too Low
Anthem	9	32	28	23	0
CareSource	15	27	29	16	5
MDwise	7	40	27	18	0
MHS	9	30	31	21	1

Healthy Indiana Plan 2.0

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range

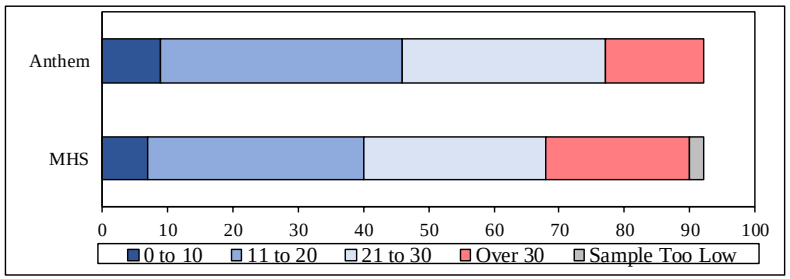


Number of Counties with Average Mileage in Each Range

Managed Care Entity	0 to 10	11 to 20	21 to 30	Over 30	Sample Too Low
Anthem	8	40	37	7	0
CareSource	8	31	21	11	21
MDwise	8	42	35	7	0
MHS	11	36	29	16	0

Hoosier Care Connect

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range



Number of Counties with Average Mileage in Each Range

Managed Care Entity	0 to 10	11 to 20	21 to 30	Over 30	Sample Too Low
Anthem	9	37	31	15	0
MHS	7	33	28	22	2

Proportion of Trips in Counties with Average Mileage Exceeding OMPP's Standard of 30 Miles

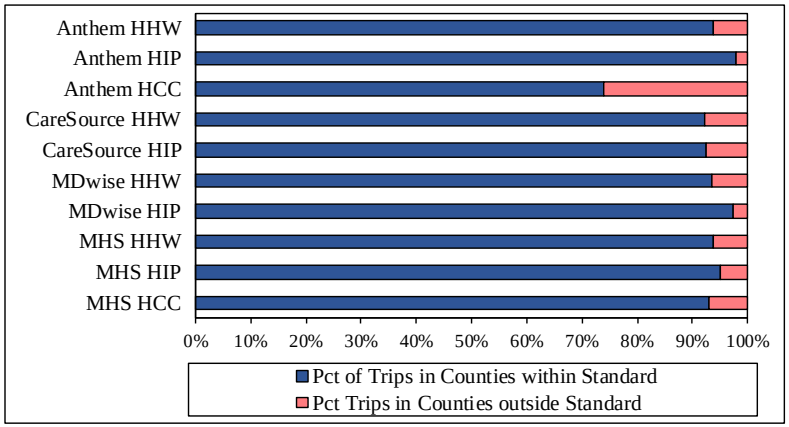
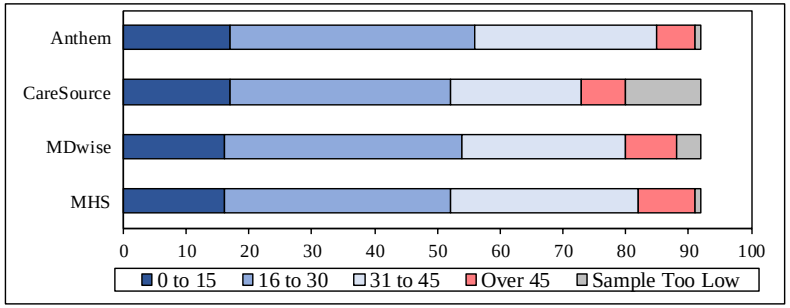


Exhibit VIII.5
Access to Behavioral Health Providers

The blue colors on the bar show the counties where the MCE meets the contractual compliance. The salmon shows non-compliance. The gray indicates counties with insufficient sample (less than 10 trips by members) to make a fair assessment of compliance.

Hoosier Healthwise

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range

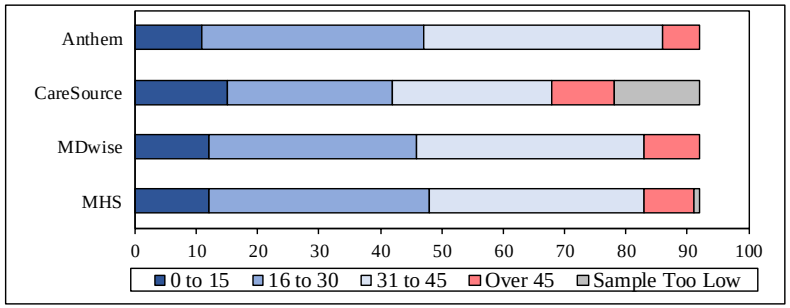


Number of Counties with Average Mileage in Each Range

Managed Care Entity	0 to 15	16 to 30	31 to 45	Over 45	Sample Too Low
Anthem	17	39	29	6	1
CareSource	17	35	21	7	12
MDwise	16	38	26	8	4
MHS	16	36	30	9	1

Healthy Indiana Plan 2.0

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range

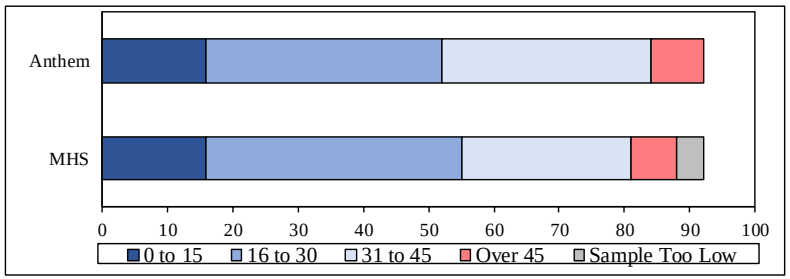


Number of Counties with Average Mileage in Each Range

Managed Care Entity	0 to 15	16 to 30	31 to 45	Over 45	Sample Too Low
Anthem	11	36	39	6	0
CareSource	15	27	26	10	14
MDwise	12	34	37	9	0
MHS	12	36	35	8	1

Hoosier Care Connect

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range



Number of Counties with Average Mileage in Each Range

Managed Care Entity	0 to 15	16 to 30	31 to 45	Over 45	Sample Too Low
Anthem	16	36	32	8	0
MHS	16	39	26	7	4

Proportion of Trips in Counties with Average Mileage Exceeding OMPP's Standard of 45 Miles

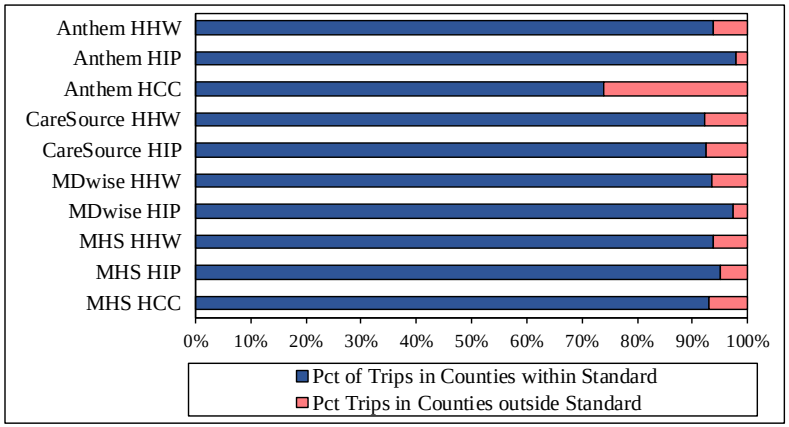
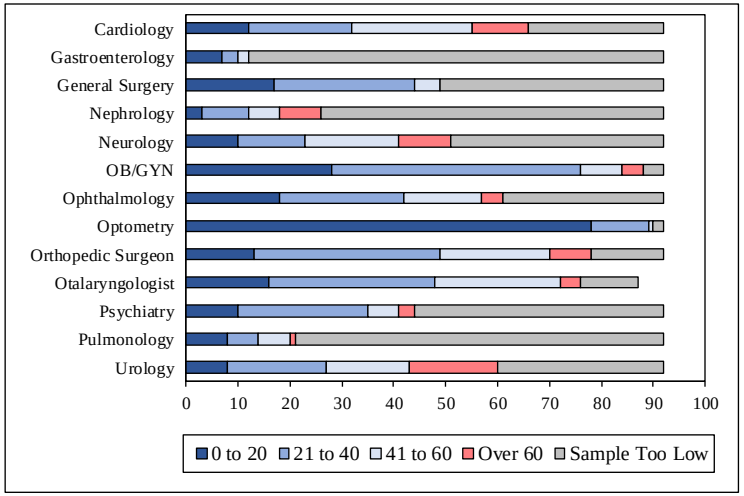


Exhibit VIII.6
Access to Specialists in Hoosier Healthwise

The blue colors on the bar show the counties where the MCE meets the contractual compliance. The salmon shows non-compliance. The gray indicates counties with insufficient sample (less than 10 trips by members) to make a fair assessment of compliance.

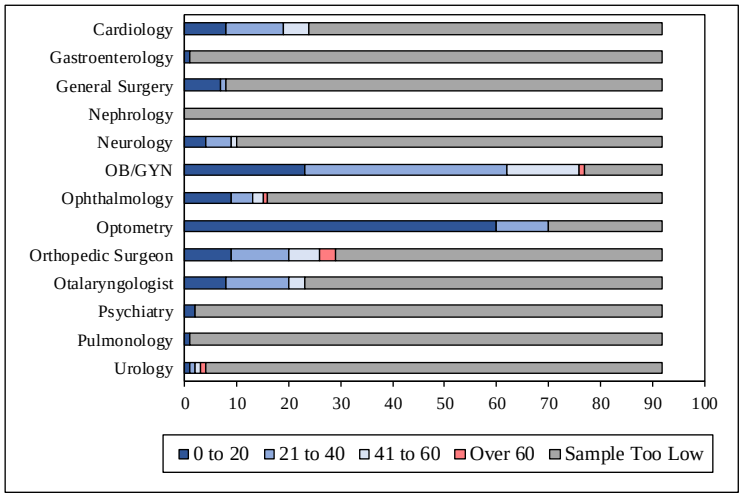
Anthem

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range



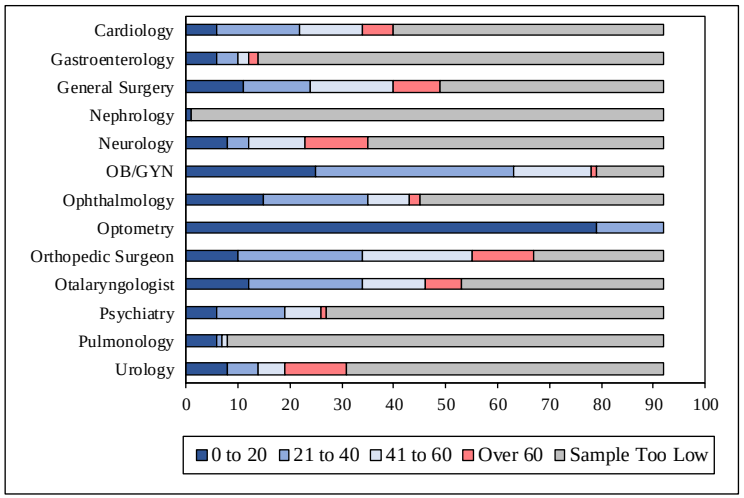
CareSource

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range



MDwise

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range



MHS

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range

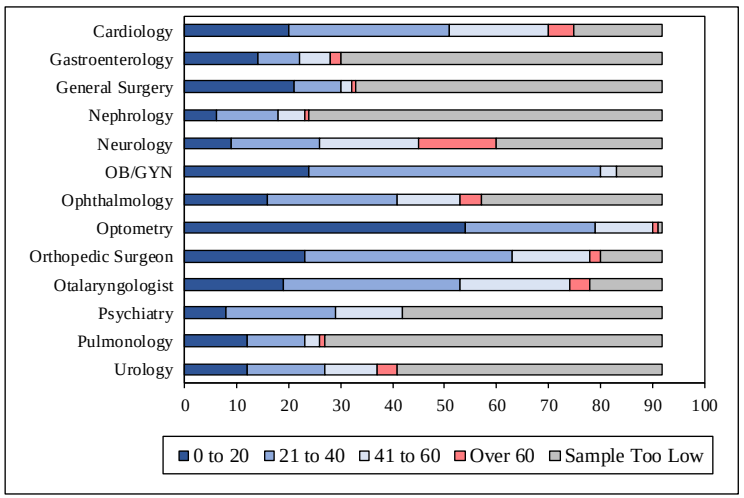
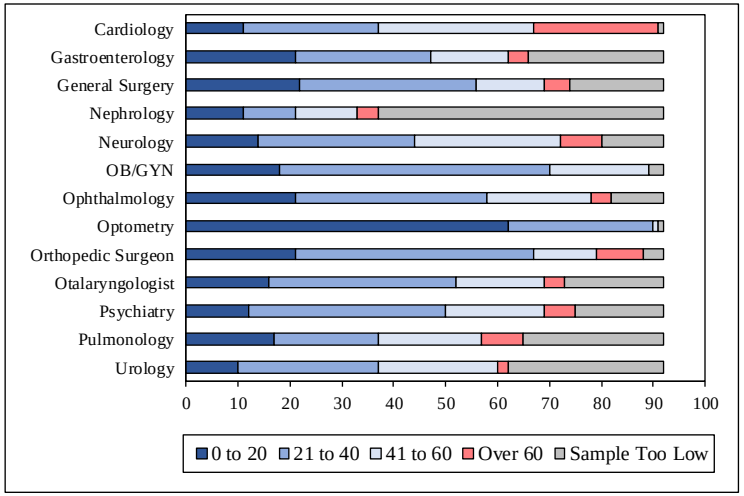


Exhibit VIII.7
Access to Specialists in Healthy Indiana Plan 2.0

The blue colors on the bar show the counties where the MCE meets the contractual compliance. The salmon shows non-compliance. The gray indicates counties with insufficient sample (less than 10 trips by members) to make a fair assessment of compliance.

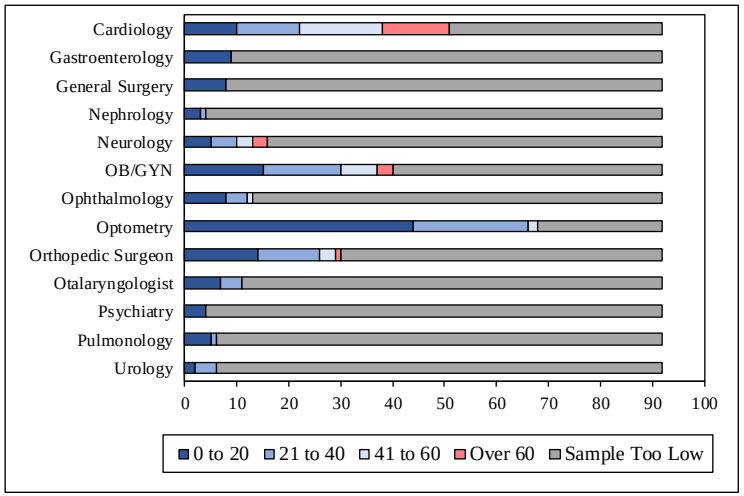
Anthem

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range



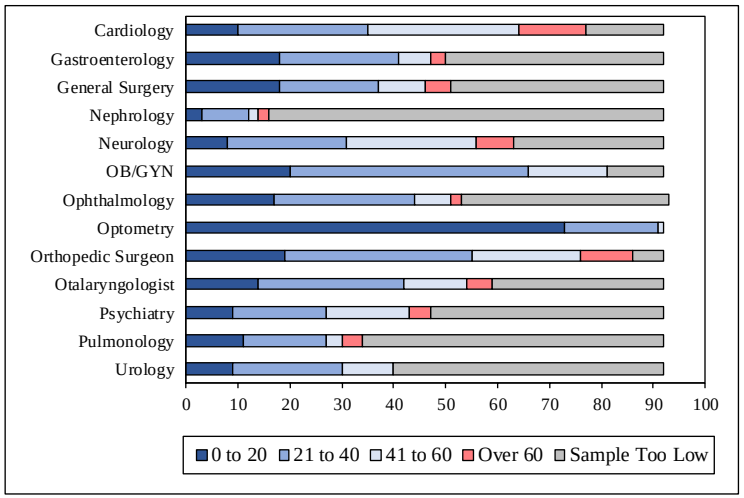
CareSource

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range



MDwise

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range



MHS

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range

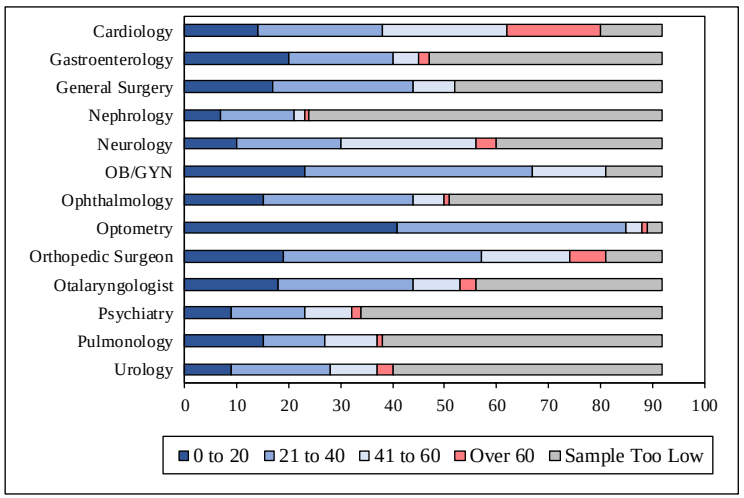
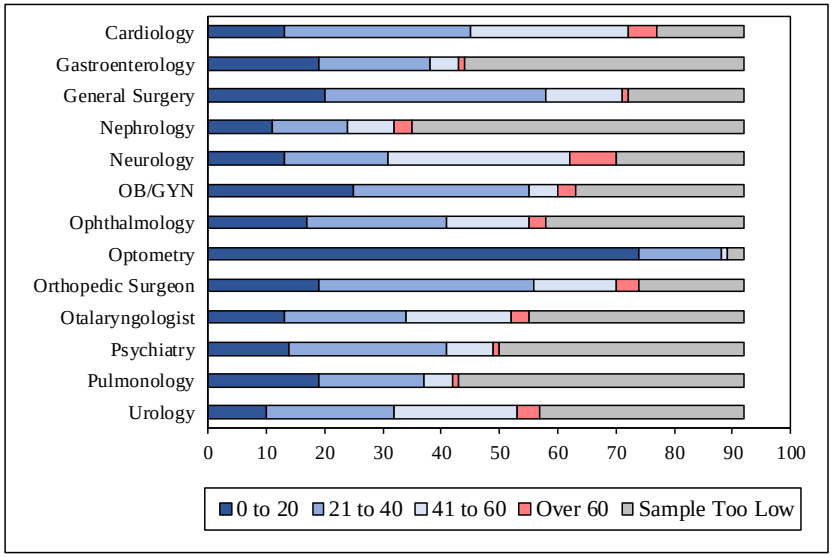


Exhibit VIII.8
Access to Specialists in Hoosier Care Connect

The blue colors on the bar show the counties where the MCE meets the contractual compliance. The salmon shows non-compliance. The gray indicates counties with insufficient sample (less than 10 trips by members) to make a fair assessment of compliance.

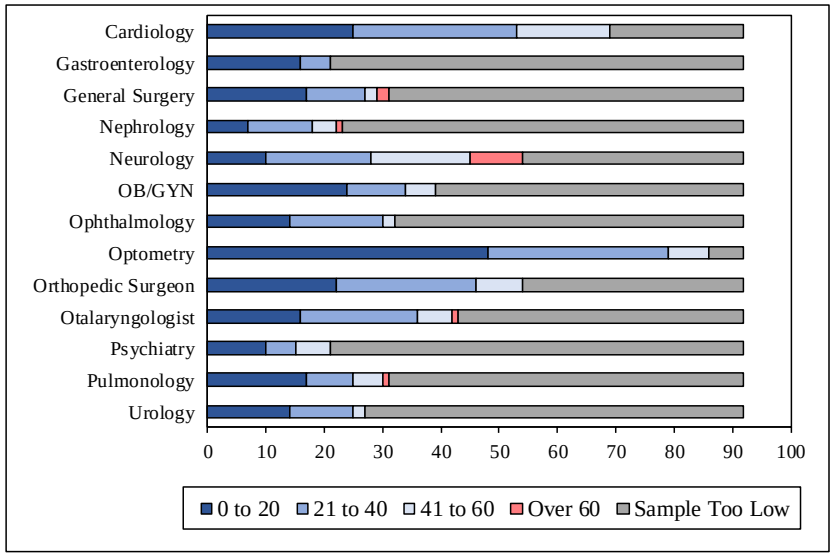
Anthem

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range



MHS

Colored Bars Plot Number of Counties (out of 92) in Each Avg. Distance Range



Recommendation to the OMPP

Although the MCEs are in almost all cases meeting the OMPP requirements with respect to having various provider specialties within a driving distance of the member's home, this requirement is measured by the closest provider in proximity as compared to the provider that the member actually accessed. The MCEs do not presently submit information to the OMPP on where members actually access services.

1. The OMPP is encouraged to require an annual report that is more refined than the current geoaccess reports that measures actual distances travelled (using claims) instead of measuring distance using member rosters against provider rosters. This will account for any potential situations where the closest provider to a member may not be accepting new members.

Recommendations to the MCEs

B&A used the data available to us in the study—namely—member and provider addresses off of reference files in the State's data warehouse. Data that appeared to be erroneous (i.e. distances in excess of 100 miles) was excluded from the analysis. But some erroneous data may remain.

1. In the situations where the average driving distance for members in a county for a specific MCE/program/specialty exceeded the OMPP standard, the MCE should investigate first to determine if this is actually true and, if so, if this can be mitigated. Specifically,

    a. B&A used the rendering provider on each claim to assign the location of the provider. There may be instances where the address for the rendering provider was a home office and not the physical location where the member went to seek services. If so, the average distance may be overstated by B&A. The MCEs can examine the actual providers where members in these counties sought services and confirm if the address on file is the provider's servicing address.
    b. The average driving distance is just that—an average. Some members very likely received services within the OMPP standard distance while others did not. The MCEs are encouraged to drill into the observations specific to the members with miles above the standard. For example, this in-depth investigation may show that a portion of a county is well addressed from an access perspective while another portion of the county is not.

2. All of the MCEs (with the exception of MHS for the HHW and HCC programs and MDwise for HHW) should focus on the results for primary care since this was the specialty that had the lowest compliance with the OMPP standard both from the number of counties and the percentage of visits perspective.

3. Anthem should conduct an in-depth investigation of where its HCC members are seeking dental services since this MCE/program had a much higher percentage of visits in counties outside of the OMPP standard than the other MCEs and even Anthem's other programs with OMPP for dental services.

SECTION IX: FOLLOW-UP FROM PREVIOUS YEAR'S EQR STUDY

Introduction

In the External Quality Review (EQR) conducted by Burns & Associates (B&A) in Calendar Year (CY) 2017 (Review Year CY 2016), the following topics were addressed:

- Validation of Performance Measures
- Validation of Performance Improvement Projects
- Focus Study on Lead Testing and Related Outreach Efforts
- Focus Study on Medication Adherence
- Focus Study on Potentially Preventable Readmissions
- Focus Study on Claims Processing

B&A repeated the analysis conducted in the focus study with updated data from CY 2017 and compared this to the results reported for CY 2016. The results of this updated study are shown in this section. A brief summary of updates from other topics in the CY 2017 EQR appear at the end of this section.

Update on Lead Testing Results

The focus study on lead testing examined not only the rate of testing among children who should be tested for lead but also the processes that the OMPP, the Indiana State Department of Health (ISDH) and the managed care entities (MCEs) use to capture data on the prevalence of lead tests being conducted and the results from these tests.

Since the findings of B&A's study were shared with the OMPP and the MCEs in November 2017, the following actions have taken place:

1. The OMPP made lead test reporting one of the measures in its Pay for Outcomes (P4O) program with the MCEs in the HHW contract.

2. A workgroup has been maintained and meets ongoing that includes representatives from the ISDH, the MCEs and the OMPP with its focus on improving data collection of both lead testing and immunizations for Medicaid children.

3. The ISDH, in coordination with an analyst at the OMPP, continues to release reports and person-specific files to each MCE on individual children who received a lead test as evidenced by provider submissions to the state-mandated ISDH lead testing database.
    a. The ISDH has created additional nuanced management reports at the MCE level.
    b. The MCEs are using the files from ISDH to compare to the tests billed to the MCE on claims to capture missed opportunities.

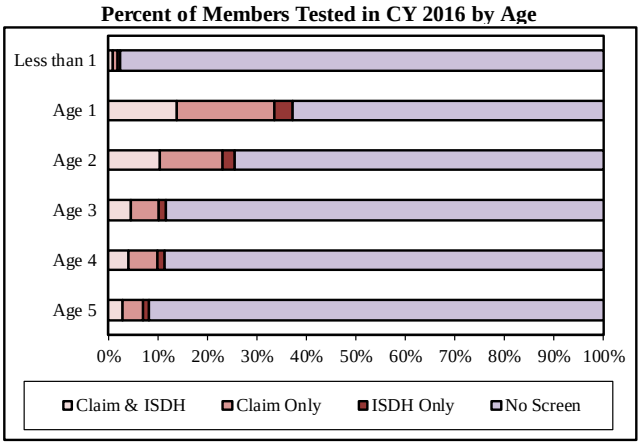
B&A compiled information from the ISDH database for Medicaid children where there was evidence of a lead test in CY 2017. The results of the tests are also captured in the ISDH database and these were analyzed by B&A. Separately, B&A compiled all encounters submitted by the MCEs for lead tests as evidenced by the presence of CPT 83655 or HCPCS T1029 (for public health agencies). The information from CY 2017 tests was compared to what was reported for CY 2016 tests among Medicaid children.

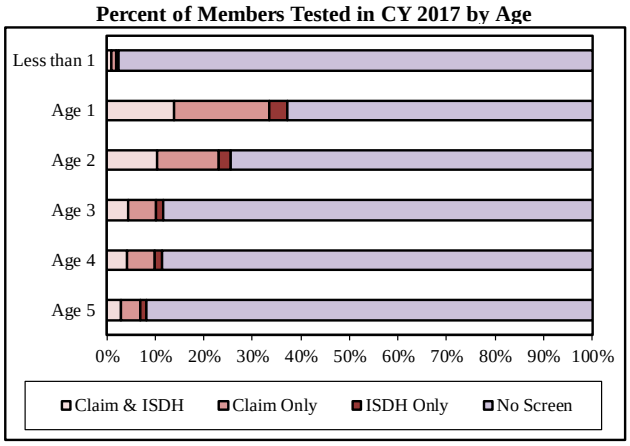
Exhibit IX.1 shows the percentage of Medicaid children tested for lead and not tested in CYs 2016 and 2017. Within each age group, the count of members tested by source is shown; that is, whether there was the presence of both an MCE claim and a test reported in the ISDH database, only a claim reported, or only a test reported in the ISDH database.

The percentage of children with proof of a lead test improved slightly between CYs 2016 and 2017 for children age 1 and age 2. The percentage of 1-year-olds with no screen was 62.9 percent in CY 2016 and it was 59.3 percent in CY 2017. The percentages for 2-year-olds during these two years were 74.4 percent and 69.9 percent, respectively.

This improvement appears to be due to improved provider reporting in the ISDH database. The percentage of tests in the ISDH by age improved across-the-board from CY 2016 to CY 2017. For the 1-year-olds, 56 percent of all lead tests found in CY 2017 were in the ISDH database and 44 percent were only in claims. In CY 2016, only 47 percent of all lead tests found were in the ISDH database. The percent of all lead tests for 2-year-olds also improved. In CY 2016, 50 percent of tests for this age were in the ISDH database; in CY 2017, it was 57 percent.

Exhibit IX.1
Percent of Medicaid Children Tested By Data Source Used to Track Tests





	Data Source to Find Screening (# Members)			
	Claim & ISDH	**Claim Only**	**ISDH Only**	**No Screen**
Less than 1	421	523	175	47,534
Age 1	7,395	10,562	1,964	33,722
Age 2	4,891	6,030	1,167	35,205
Age 3	2,035	2,585	645	39,947
Age 4	1,801	2,551	702	39,175
Age 5	1,278	1,707	527	39,831

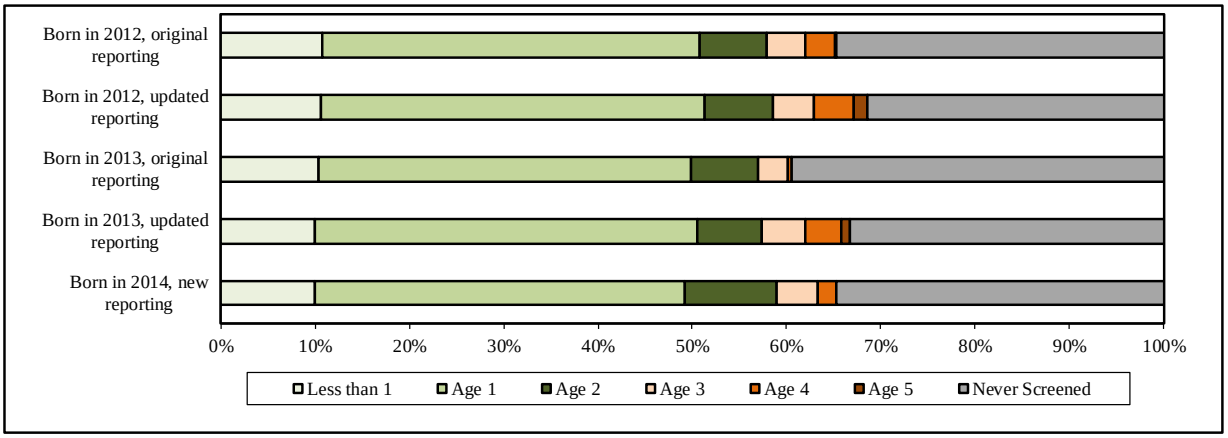
	Data Source to Find Screening (# Members)			
	Claim & ISDH	**Claim Only**	**ISDH Only**	**No Screen**
Less than 1	472	386	146	47,077
Age 1	9,552	9,138	1,864	29,924
Age 2	6,614	6,031	1,352	32,503
Age 3	2,831	2,363	843	40,683
Age 4	2,691	1,730	928	38,908
Age 5	1,713	1,345	593	39,931

The study last year found that some Medicaid children are ultimately tested for lead but not getting tested by the age of two. B&A examined children continuously enrolled over time to determine if the child ever received a lead test. In the original study, B&A examined children born in 2011, 2012 and 2013. In this revised study, we re-examined the children born in 2012 and 2013 and added children born in 2014.

Exhibit IX.2 on the next page shows the updated results of the percentage of continuously enrolled Medicaid children and when they received a lead test (if ever). The counts for the children born in 2012 and 2013 have been updated because the continuous enrollment has been taken to December 2018.

Exhibit IX.2 shows that the percentage of continuously enrolled in Medicaid who have never been tested improved for the children born in 2012 and 2013 from the original study. For children born in 2011, the value had been 34.7 percent; the revised value is 31.4 percent. For children born in 2012, the value had been 39.5 percent; the revised value is 33.3 percent. For the new cohort of children born in 2014, the value is 34.8 percent.

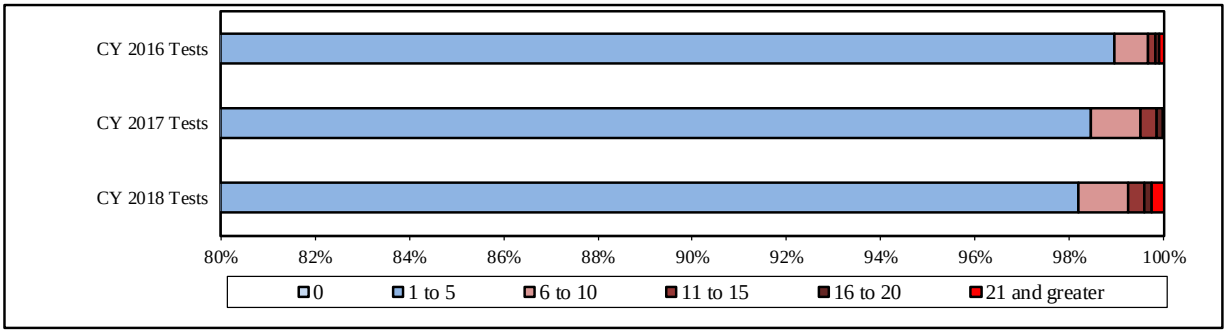
Exhibit IX.2
For Children Continuously Enrolled in Medicaid and Tested for Lead, Age of First Screening



Medicaid Children, Birth Year	Less than 1	Age 1	Age 2	Age 3	Age 4	Age 5	Never Screened	Total
Born in 2012, original reporting	2,330	8,648	1,531	902	665	28	7,508	**21,612**
Born in 2012, updated reporting	1,722	6,606	1,163	706	698	234	5,092	**16,221**
Born in 2013, original reporting	2,633	10,122	1,795	801	107	n/a	10,084	**25,542**
Born in 2013, updated reporting	1,880	7,630	1,284	879	724	158	6,267	**18,822**
Born in 2014, new reporting	2,276	8,995	2,243	1,002	444	n/a	7,970	**22,930**

Exhibit IX.3 shows the lead levels reported among all tests submitted to the ISDH database. The original study compared CY 2013 data through the first half of CY 2017. The revised analysis compares CY 2016, CY 2017 and CY 2018 data. As seen below, the percentage of tests with a value greater than 5 micrograms per deciliter was 1.1 percent in CY 2017. With the updated data, the value is 1.5 percent for CY 2017 and 1.8 percent for CY 2018. It is assumed that, at minimum, the value for CY 2018 will go down when additional tests conducted in CY 2018 are submitted to the ISDH with lower levels.

Exhibit IX.3
Lead Levels Reported Among Medicaid Children in ISDH Database



Measured as micrograms/deciliter	0	1 to 5	6 to 10	11 to 15	16 to 20	21 and greater	Total
CY 2016 Tests	5,113	22,086	200	40	22	27	**27,488**
CY 2017 Tests	8,043	23,182	338	106	42	5	**31,716**
CY 2018 Tests	8,697	24,412	361	110	52	88	**33,720**

The maps shown on the next four pages have been updated from what was shown in the original study of lead testing for Medicaid children in Indiana. In the original study, lead testing rates at the county level were shown for CY 2016 among Medicaid children who turned age one or two in 2016. These revised maps show the results at the county level for CY 2017 among Medicaid children who turned age one or two in 2017.

A summary of the changes between the CY 2016 and CY 2017 data appears in Exhibit IX.4 below. Over two-thirds of the counties saw a higher rate of 1-year-old and 2-year-old Medicaid children with lead tests in CY 2017 than in CY 2016. This was also true for members enrolled with each MCE. Additionally, each MCE had a higher number of counties that had more than 30 percent of their members age 1 and 2 that have evidence of a lead test.

Exhibit IX.4
Change in Percent of Children Tested for Lead for Children Age 1 and 2
By MCE and County

	Number of Counties within each Category				
	Statewide	**Anthem**	**MDwise**	**MHS**	**CareSource**
Number of Counties Improved from CY 2016 to CY 2017	69	65	62	64	not under contract with OMPP in CY 2016
Number of Counties Worsened from CY 2016 to CY 2017	23	27	30	28	

	Statewide		**Anthem**		**MDwise**		**MHS**		**CareSource**	
Percent of Children Tested	**CY 2016**	**CY 2017**	**CY 2016**	**CY 2017**	**CY 2016**	**CY 2017**	**CY 2016**	**CY 2017**	**CY 2016**	**CY 2017**
Less than 10% in the County	3	2	6	2	7	5	9	4	not under contract with OMPP	18
10.1 to 20% in the County	18	13	12	9	15	10	21	14		27
20.1 to 30% in the County	29	23	26	24	27	21	25	26		23
More than 30% in the County	42	54	48	57	43	56	37	48		24

- Exhibit IX.5 shows that for 54 of Indiana's 92 counties, more than 30 percent of their Medicaid members age one or two had been tested. For two counties, less than 10 percent of the members had been tested (Daviess and Dubois).

- Exhibits IX.6 (Anthem and MHS) and IX.7 (MDwise and CareSource) on pages IX-6 and IX-7 compares this same statistic by MCE. The total number of counties where more than 30 percent of the members ages one or two had been tested was 57 for Anthem, 48 for MHS, 56 for MDwise and 24 for CareSource. On the other extreme, the number of counties where less than 10 percent of members were tested was two for Anthem, four for MHS, five for MDwise and 18 for CareSource (note, however, that CareSource has small sample sizes in many of these counties). Three MCEs had Daviess County, Dubois County and LaGrange County in this category.

- In Exhibit IX.8, B&A focused on tests that were given in CY 2017 to Medicaid children (any age) where the result showed a blood lead level greater than 5 micrograms per deciliter. These children were analyzed to determine their home county. The data shown is limited to what was reported in the ISDH database because this is the only source for the results of the tests. Only one county—Noble—had more than five percent of its members in this age group with elevated lead levels. There are 14 of the 92 counties shown in gray in the exhibit because B&A did not believe it was appropriate to include the results from these counties in our totals since the sample size in each county was less than 50 Medicaid members.

Exhibit IX.5
Percent of Medicaid Children Age 1 or 2 who had a Lead Test in CY 2017, by County

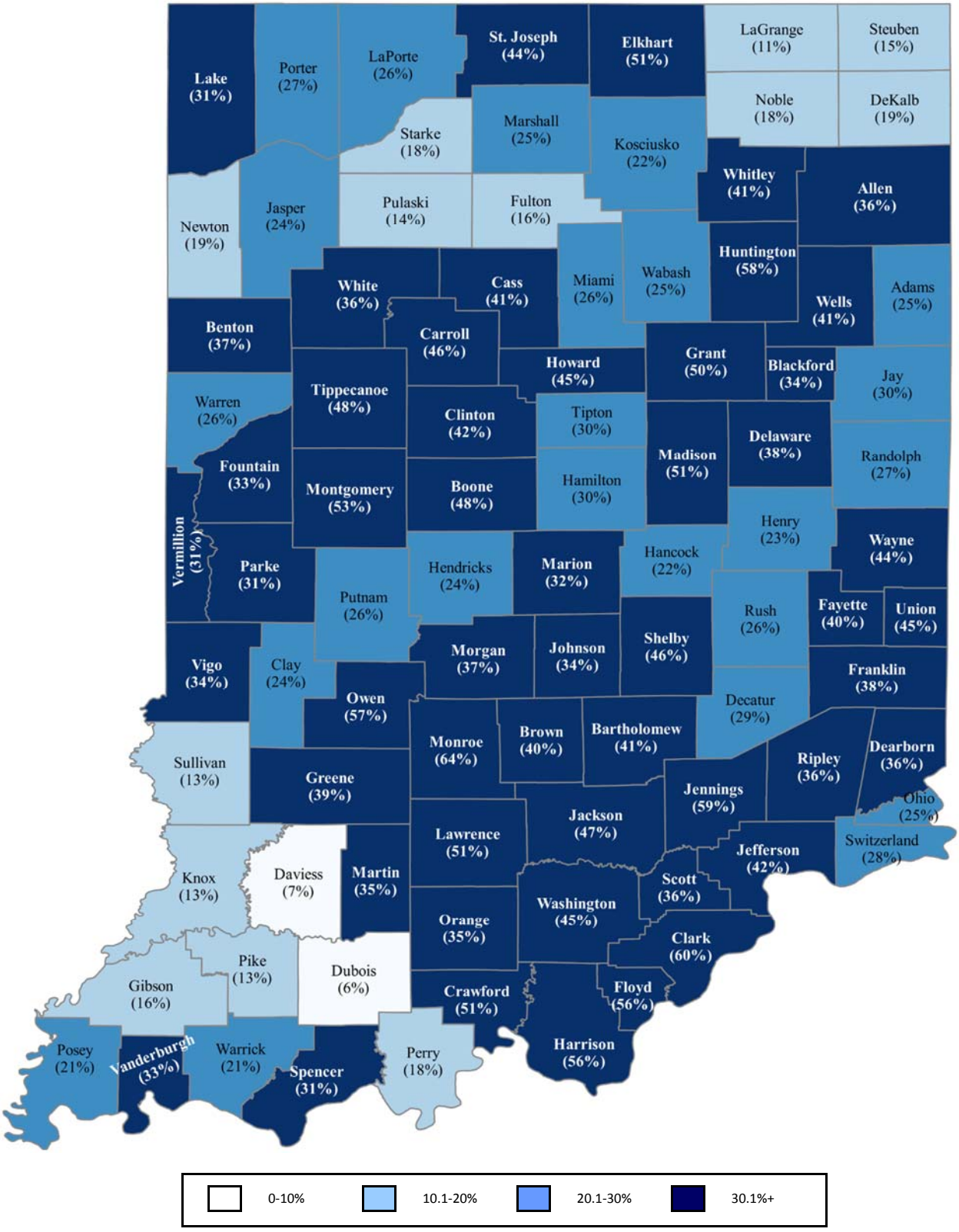
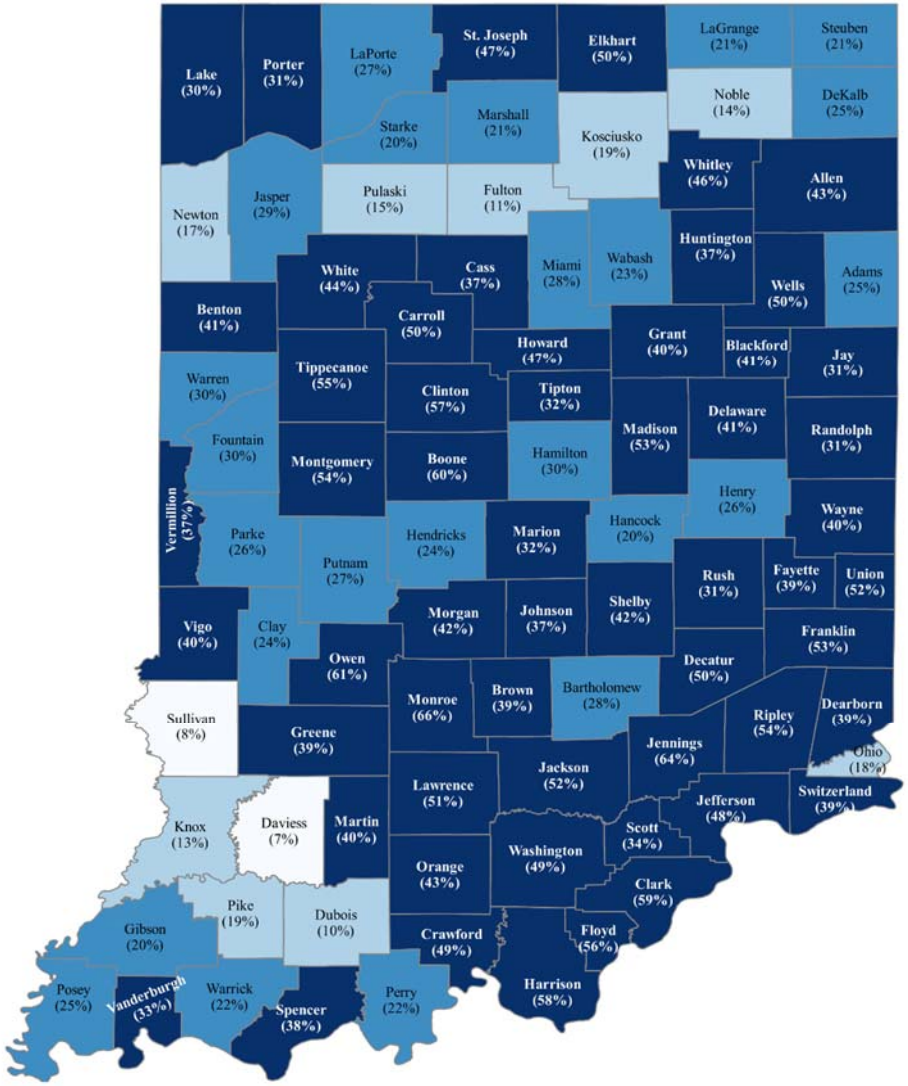
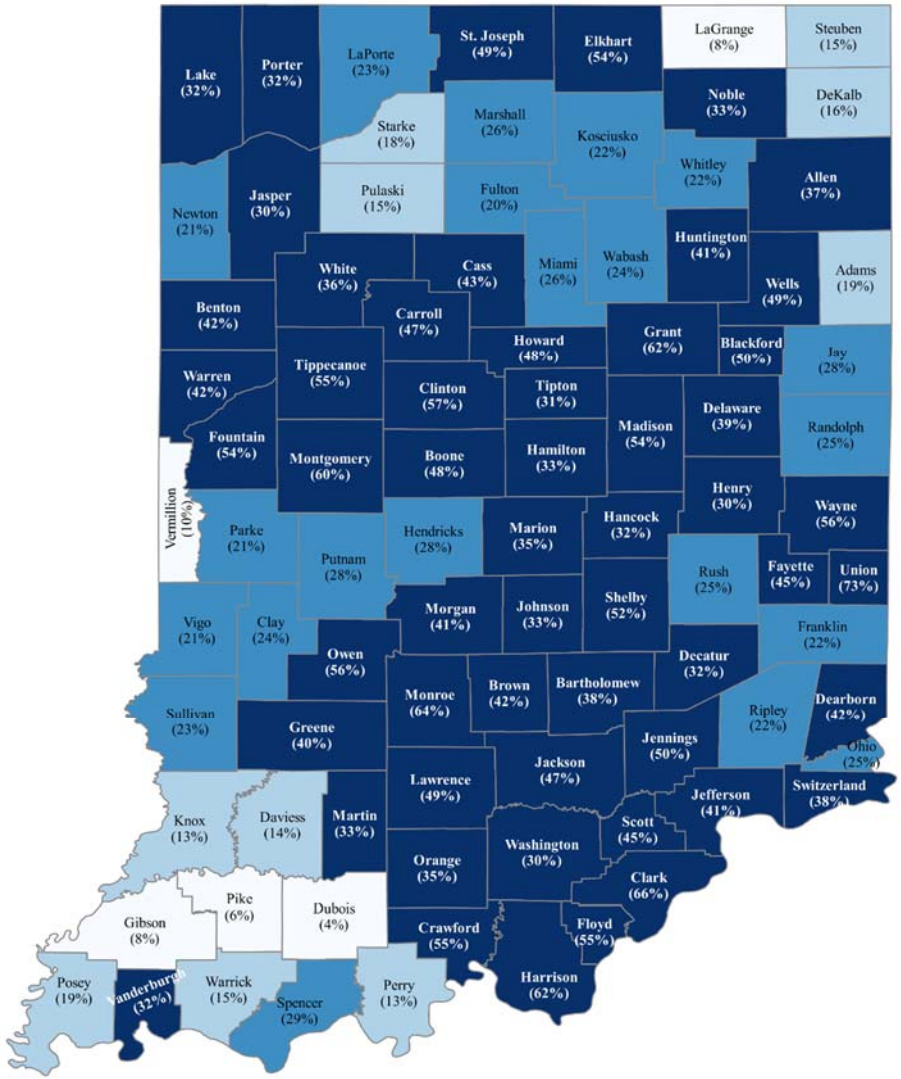


Exhibit IX.6
Percent of Medicaid Children Age 1 or 2 who had a Lead Test in CY 2017, by MCE/County

Anthem



MHS

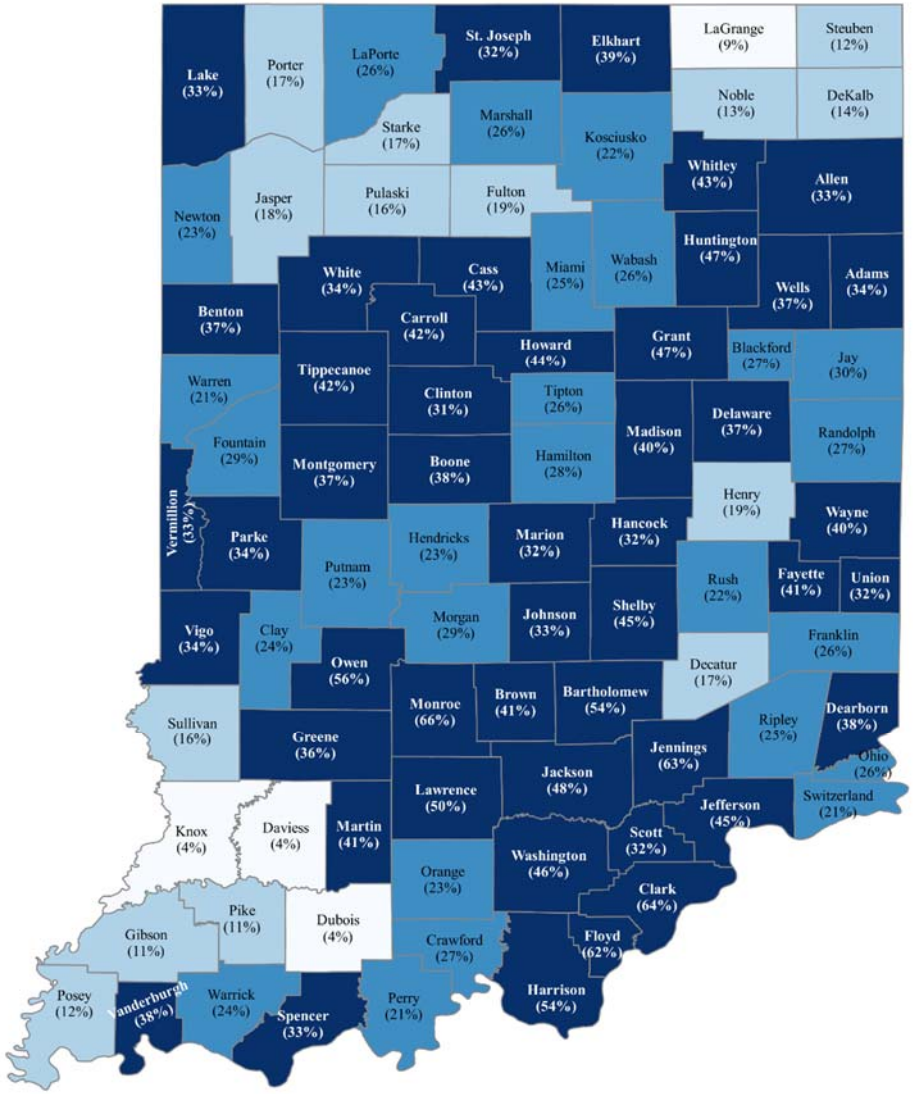


0-10% | 10.1-20% | 20.1-30% | 30.1%+

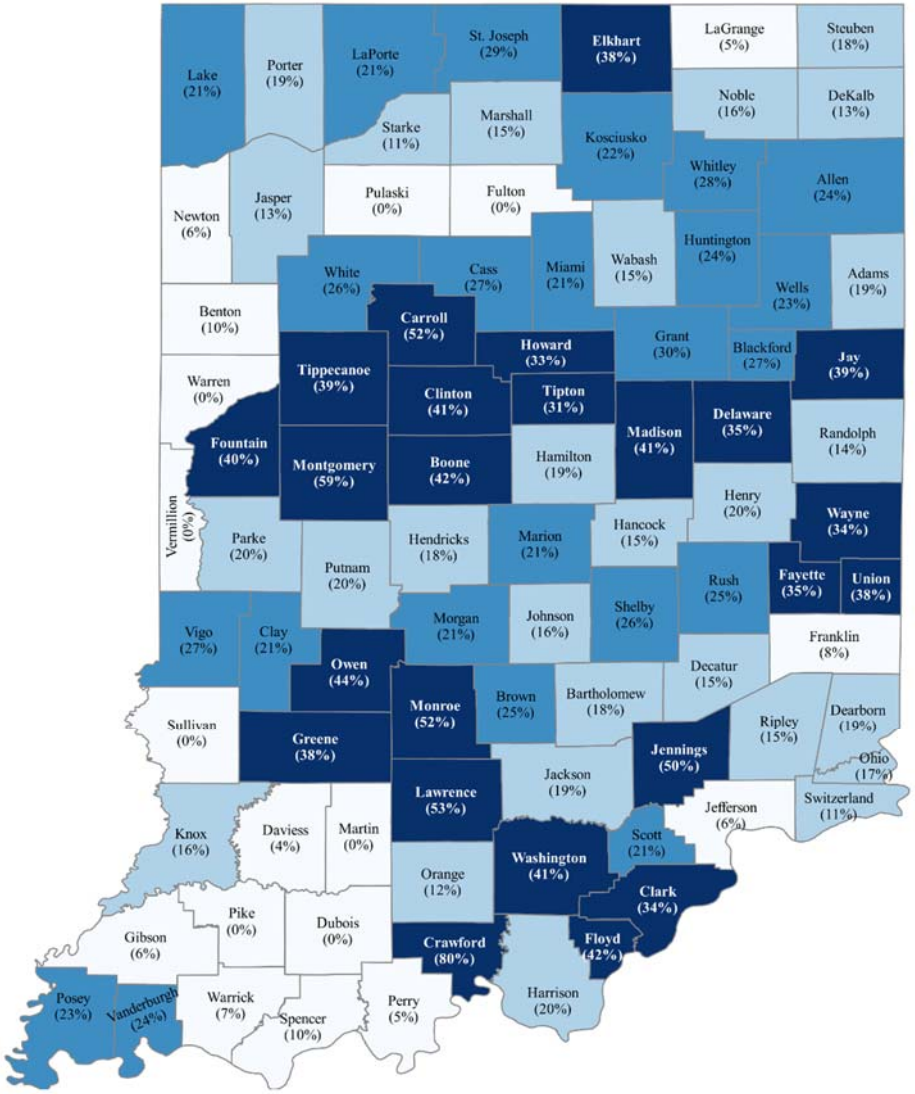
Exhibit IX.7

Percent of Medicaid Children Age 1 or 2 who had a Lead Test in CY 2017, by MCE/County

MDwise

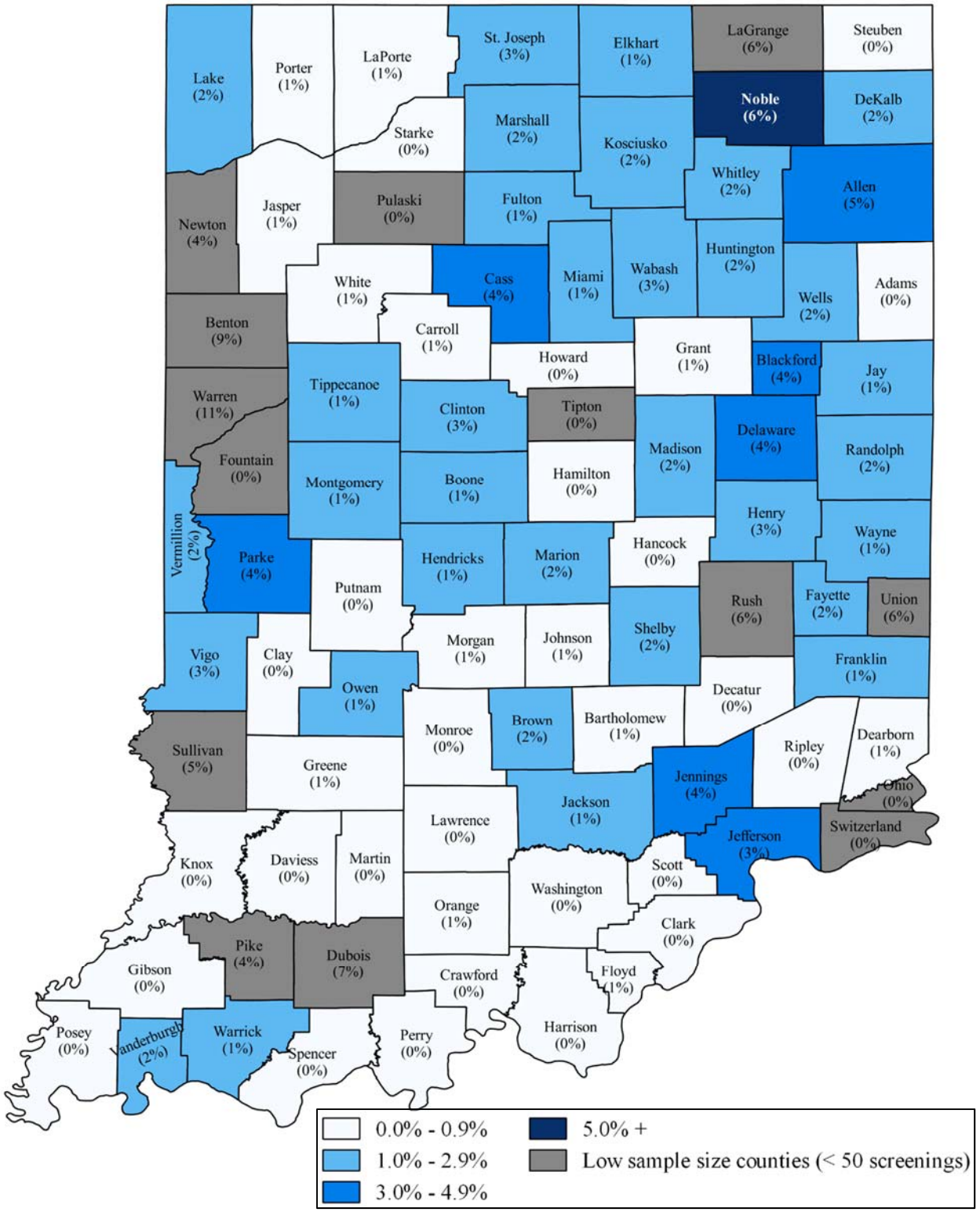


CareSource



0-10% 10.1-20% 20.1-30% 30.1%+

Exhibit IX.8
Percent of Medicaid Children in ISDH Database Having a Lead Test in CY 2017 with Blood Lead Level Greater than 5ug/dL



Update on Other Aspects of the CY 2017 EQR

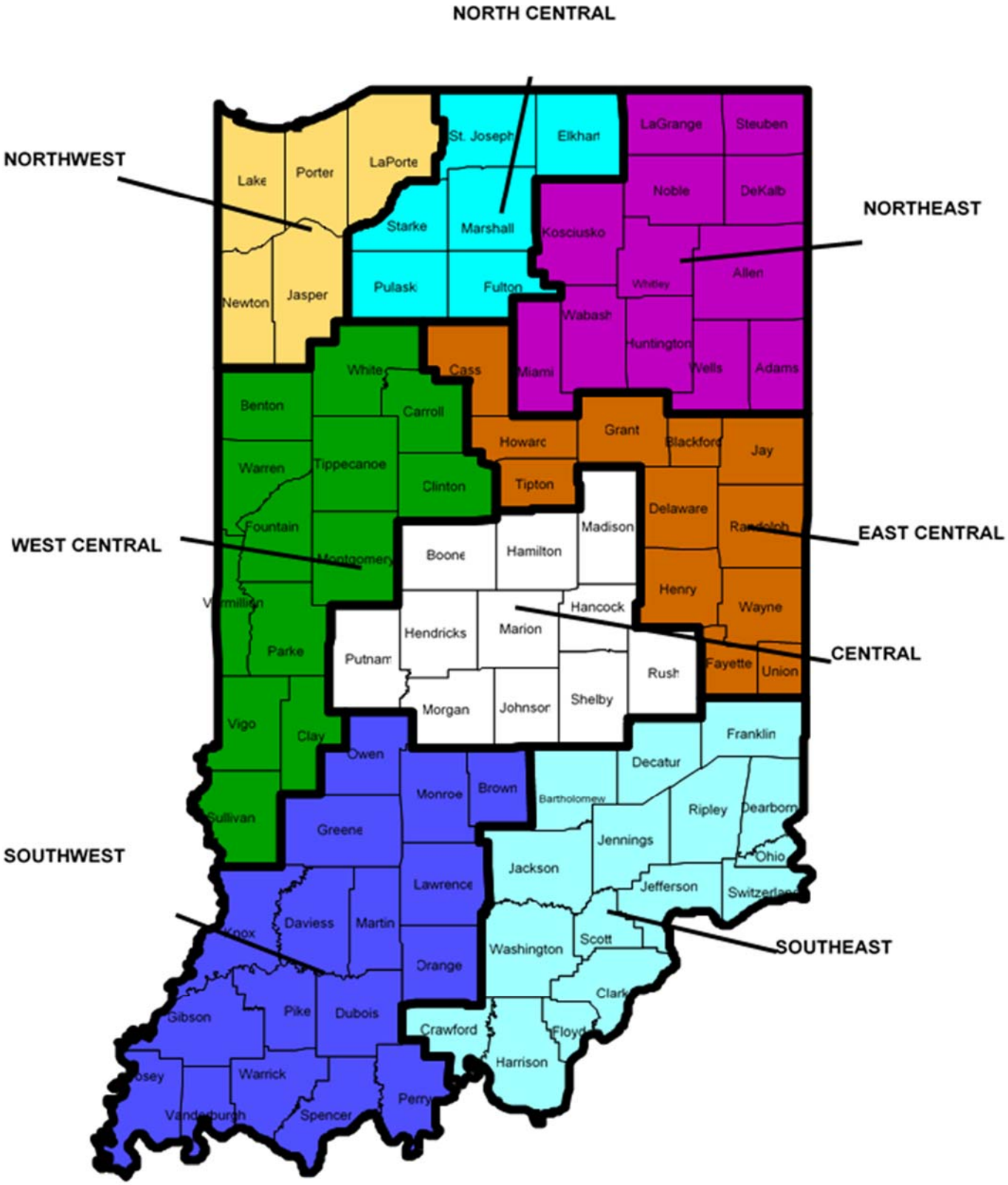
In addition to the lead testing initiative, there has been action on a number of other items reported on in the CY 2017 EQR. A summary of these items is listed below.

- With respect to the Validation of Performance Measures, B&A had recommended to the OMPP that the report template and instructions for the MCEs to report complex case and care management activities be updated to give more clarification on what is expected. This template and accompanying instructions were released in early CY 2018 and the MCEs have been using it for reporting purposes.

- With respect to the Validation of Performance Improvement Projects (called Quality Improvement Projects, or QIPs, in Indiana), B&A suggested that the OMPP convene the MCEs in a QIP "pre-meeting" prior to the new calendar year as a way to peer review the measures and interventions in each MCE's QIPs. This meeting was held in December 2018 for the QIPs effective in CY 2019. In its role as the EQRO, B&A also provided feedback to each MCE from a desk review conducted of the QIP submissions to the OMPP for CY 2019.

- With respect to the focus study on claims processing, B&A suggested that the OMPP adopt updates to the claims adjudication reports that it requires each MCE to submit for each program it is under contract with the OMPP. This includes adding reporting on encounter submissions to tie to the claims adjudication reports. The OMPP accepted these recommendations. B&A convened the OMPP and the MCEs in the development of new claims adjudication and encounter submission reports that will be effective in CY 2019.

Appendix A
Map of Indiana's 92 Counties to Eight Regions



APPENDIX B

2018 EXTERNAL QUALITY REVIEW GUIDE FOR THE HOOSIER HEALTHWISE, HOOSIER CARE CONNECT AND HEALTHY INDIANA PLAN 2.0 PROGRAMS (Review of CY 2017 Operations)

TABLE OF CONTENTS

Separate Excel File:

A. Summary of This Year's Topics, Timeline and Review Team

Overview

Burns & Associates, Inc. (B&A) was hired by Indiana's Office of Medicaid Policy and Planning (OMPP) to conduct an External Quality Review (EQR) for its three health coverage programs—Hoosier Healthwise (HHW), Hoosier Care Connect (HCC) and Healthy Indiana Plan 2.0 (HIP).

The 2018 EQR will encompass both mandatory activities required by the Centers for Medicare and Medicaid (CMS) as well as optional activities, in particular, focus studies.

B&A met with OMPP to determine the topics selected for this year's EQR which include the following:

- Topic #1: A desk and onsite review of MCE operations and compliance with federal regulations regarding Medicaid managed care plans
- Topic #2: The validation of performance measures
- Topic #3: The validation of performance improvement projects (known in Indiana as Quality Improvement Projects, or QIPs)
- Topic #4: Focus study on review of MCE pharmacy claims processing
- Topic #5: Encounter validation focus study

This review will encompass activities in Calendar Year (CY) 2017 for all activities. For the encounter validation study, information from the start of CY 2018 may also be reviewed. All topics will be reviewed for the HHW, HCC and HIP populations.

Timeline

The OMPP is requesting that B&A deliver the draft report for this EQR by September 30. The final report is due October 31. The schedule effectively begins with the release of this EQR Guide. The first items that are being requested from the MCEs are due April 26. Onsite meetings are scheduled in the months of May, June, July and August. All data collection activities and MCE responsibilities are scheduled to be concluded by August 31. A full schedule may be found in Section C of this Guide.

There will be an opportunity for the MCEs to provide accessory information if B&A needs further clarification on a specific review item after the onsite meetings are concluded.

The OMPP has customarily asked B&A to offer a debriefing session with each MCE. The dates for these sessions have yet to be determined. Each MCE will also receive a copy of the final EQR report that will be delivered to CMS.

The B&A Review Team

This year's EQR Review Team consists of the following members:

- Mark Podrazik, Project Director, B&A: Mark has previously conducted 12 EQRs of the HHW program, nine EQRs of the HIP and two EQRs of HCC as well as a review of its predecessor, Care Select. He will oversee the entire project, participate in activities related to each focus area, and will serve as primary author of the final report.

- Kara Suter, Project Manager, B&A: Kara joins the EQR team for the first time where her focus will be on the review of MCE pharmacy claims pricing. Since joining B&A in 2015, Kara's focus is on the design and reimbursement of new programs. Prior to joining B&A, she served as the Director of Payment Reform for Vermont's Medicaid program. She has a Master of Science in Pharmaceutical Sciences and had previously consulted with clients on drug pricing reforms.

- Karl Matzinger, Project Manager, B&A: Karl joins the EQR team for the first time where his focus will be on the desk and onsite review of MCE operations as well as the validation of performance measures. Since joining B&A in 2015, Karl has worked with five state agencies on the development of rate and individualized budgets for persons with intellectual and developmental disabilities and developing formulae for federal grant funding. Prior to B&A, Karl served in management positions for 21 years within Arizona's state government focusing on housing and other human services.

- Dr. Linda Gunn, PhD, Subcontractor: Linda has assisted B&A on nine previous EQRs encompassing all three of OMPP's programs. This includes a review of MCE operations across all functional areas. In this EQR, she will work on the desk and onsite review of MCE operations.

- Kristy Lawrance, Subcontractor: Kristy assisted on five previous EQRs encompassing all three of OMPP's programs. She has also been working as a contractor to the OMPP overseeing the implementation of the *Core*MMIS system and had worked as a staff member at the OMPP years ago. In this EQR, she will work on the desk and onsite review of MCE operations, the encounter validation project and the Validation of QIPs.

- Jesse Eng, SAS Programmer, B&A: Jesse has conducted programming and analytic support on B&A's engagements with OMPP since 2009, in particular, B&A's Independent Evaluation of Indiana's CHIP and the annual EQRs. He will primarily work on activities related to the encounter validation study and the validation of performance measures.

- Akhilesh Pasupulati, SAS Programmer, B&A: Akhilesh joined B&A in 2016. In last year's EQR, he served as the lead programmer on the medication adherence study. In this year's EQR, he will lead the programming effort on the pharmacy claims pricing study and assist in the encounter validation study.

- Ryan Sandhaus, SAS Programmer, B&A: Ryan joined B&A in 2016. Since then, he has worked on Indiana projects including the 2016 and 2017 EQRs, the 2017 Independent Assessment of HCC and the CY 2018 CHIP report to the Legislature. Ryan will primarily work on activities related to the encounter validation study and the validation of performance measures.

- Barry Smith, Data Analyst, B&A: Barry has over 12 years of experience with data analysis and data mining. He has assisted in analytics for B&A's Independent Evaluation of Indiana's CHIP as well as the External Quality Reviews in Indiana since 2009. He will primarily work on activities related to the validation of performance measures and the encounter validation study.

B. Details on Topics in this Year's EQR

Topic #1—A desk and onsite review of MCE operations

Overview

B&A will conduct a general review of all aspects of MCE compliance with contractual requirements and federal Medicaid managed care regulations. We will use two documents as a reference for specific items to cover in our review:

- CMS EQR Protocol 1, Assessment of Compliance with Medicaid Managed Care Regulations (updated September 2012) and
- The Scope of Work sections of the HHW, HIP 2.0 and HCC contracts

As has been done in the past, the B&A EQR Review Team will conduct a desk review of items that will be requested for submission to the Sharepoint site. A detailed listing of the items that we are requesting for this desk review appears in the Excel file that accompanies this EQR Guide. B&A conducts the desk review and develops questions that will be asked of all MCEs related to a specific topic. Questions that are specific to your MCE may also be asked if they are triggered based on information gleaned from the desk review. Onsite interviews will be scheduled with staff members that work in each of the MCE functional areas that will be covered in the review.

Our approach is to not rely on the desk review items alone to score a particular item in the tool; rather, we use the desk materials and other documentation (e.g., Reporting Manual submissions) as reference for discussion points in the onsite interviews.

Eight modules have been created to cover all of the primary functional areas related to MCE operations:

- Module 1: Information Systems and Reporting to OMPP
- Module 2: POWER Account Tracking and HIP Reporting
- Module 3: Administrative Oversight, Subdelegated Oversight, Financial Oversight
- Module 4: Utilization Management, Prior Authorizations, Program Integrity
- Module 5: Member Services, Grievances & Appeals
- Module 6: Provider Contracting, Provider Relations, Provider Network
- Module 7: Disease Management, Case Management, Complex Care Management
- Module 8: Quality Management

There will be four onsite meetings at each MCE over the course of the review related to Topic #1. During each meeting, two of the eight modules referenced above will be covered.

To ensure inter-rater reliability, two B&A team members are assigned to each topic area. Separately, they will conduct the desk review, develop interview questions, and score each review item that they are

responsible for. Jointly, they will conduct the interview onsite and obtain consensus on the scoring of each item in the topic area.

Depending upon the results of the desk review, B&A may also require additional analysis of ancillary documents that will be reviewed while at each MCE site. Any documents required for review will be requested at least 10 days prior to the onsite visit.

B&A will assign scores to each MCE to measure compliance within each module. The scoring is conducted as follows:

1. Within each module, individual items to be scored will be identified. These will directly tie to language in the Scope of Work.
2. Each item will be independently scored as "fully met", "partially met" or "not met".

Fully Met	2 points
Partially Met	1 point
Not Met	0 points

   A *Fully Met* score means that the MCE met at least 90% of the criteria evaluated.

   A *Partially Met* score means that the MCE met at least 50% of the provisions of the criteria evaluated. This could occur if the CFR requires a policy to be put in place which was completed but B&A did not find evidence that this policy was always put into practice. Another situation could be if the MCE is required to complete a variety of activities to meet the provisions of the criteria evaluated and most, but not all, items in the list were met.

   A *Not Met* score means that the MCE did not meet at least 50% of the requirements of the criteria evaluated.

3. Recognizing that review items are not weighted equally in terms of relative importance in MCE operations, each review item will be given a weight in the Review Tool. As an example, the scoring is envisioned as follows.

   Each specific review item is given a weight between one and five. Therefore, if Review Item #1 has a weight of one, then the possible scores for that item are equal to 0, 1 or 2. If Review Item #2 has a weight of five, then the possible scores for that item are equal to 0, 5 or 10.

4. The total weighted scores will be compiled for each review item from all team members that score the item. In the event that the two members on the EQR Review Team did not score a review item in the same way (e.g., one scored partially met and the other scored fully met), the team members will discuss these situations and resolve until they reach a consensus score. The final score is not determined until after the onsite interviews have occurred and any ancillary data that was requested and submitted to B&A has been reviewed.

5. The MCE's scores will be published in our report by functional area against the maximum number of points available. The total score across all functional areas will also be shown in the report to CMS. Each MCE will separately be given the scores for each specific review item in the tool as well.

Topic #2—Validation of Performance Measures

The purpose for this review is to validate the results of report submissions for the reporting periods in CY 2017 from the MCEs to the OMPP. B&A will utilize CMS EQR Protocol 2, Validation of Performance Measures Reported by the MCO (updated September 2012), as a reference to report our findings related to the validation of these measures. This will be accompanied by a brief writeup in the EQR report.

The measures that are being validated are all measures reported by the MCEs in reports contained in the HHW, HCC and HIP 2.0 Reporting Manuals. They include the following (the number in the HHW, HCC and HIP 2.0 column references the report number in the Report Catalog in each program's CY 2017 Reporting Manual):

Report Name	**HHW**	**HCC**	**HIP 2.0**
Adults' Access to Preventive Ambulatory Services	66	74	69
Chlamydia Screening in Women	67	77	73
Use of Appropriate Medications for Members with Asthma	68	78	74
Comprehensive Diabetes Care	69	80	76

There are two components to the validation. In the first component, B&A will tabulate the results submitted by each MCE for the four quarter reporting periods for CY 2017. The results will be compiled and viewed side-by-side within and across MCEs for each program in an effort to assess the "face validity" of the results reported.

The second component is where B&A will use the encounters reported to the OMPP and stored in the FSSA's Enterprise Data Warehouse as of March 30, 2018 as the source data to replicate the logic described in the instructions for each report to determine if the results reported by the MCE matches the B&A results.

It is B&A's intention to share our results with each MCE individually and compare to what the MCE submitted. If large differences are found, we will work with the MCE to determine the root cause of the differences.

The discussion of preliminary findings is scheduled in one-on-one onsite meetings with each MCE during meetings to be held either on **August 1 or 2**. These will be in-person meetings at each MCE. Mark Podrazik and Karl Matzinger will represent the EQR team at these onsite meetings.

Topic #3—Validation of Quality Improvement Projects

The purpose for this review is to fulfill our requirement to validate the results of selected performance improvement projects, or PIPs, as they are called by CMS in its protocol. For our purposes, PIPs are synonymous with Quality Improvement Projects, or QIPs, as defined by the OMPP. B&A will utilize CMS EQR Protocol 3, Validating Performance Improvement Projects (updated September 2012), as a reference for reporting our validation of three PIPs (QIPs) at each MCE. This will be accompanied by a brief writeup in the EQR report.

Each MCE may have selected QIPs that differ from one another. Since all MCEs have selected the improvement of Health Needs Screening as a QIP for CY 2017, B&A will select this QIP from every MCE. For the other two QIPs, B&A will select from the list of QIPs in place at the MCE for CY 2017.

As you are aware, B&A has already conducted feedback to the MCEs on the CY 2018 QIPs. But B&A needs verification of the QIPs that were in place in CY 2017 other than Health Needs Screening. This is one of the items in the data request shown in Appendix B.

As in prior years, Mark Podrazik and Kristy Lawrance will be conducting this part of the review. The desk review will be completed in the first half of August after the annual QIP reports have been submitted to the OMPP by July 31, 2018. Onsite meetings will be held at with each MCE on either **August 15 or 16** to go over the QIPs under review. This will include follow-up questions from our desk review as well as a discussion with the relevant staff who had primary responsibility for the interventions that were put in place for the QIPs that were selected. It is expected that the B&A Review Team will spend a half-day with each MCE.

Topic #4—Focus Study on Review of MCE Pharmacy Claims Processing

In the EQR conducted in 2017, B&A reviewed the internal MCE processes related to claims adjudication with a focus on the institutional and professional claim types. B&A also validated the pricing on a sample of HHW, HCC and HIP 2.0 claims that represented 11 different provider types. Pharmacy claims were specifically excluded from the 2017 study. In the 2018 EQR, a focus study will be conducted specifically on pharmacy claims processing.

The study will begin with an in-depth discussion with each MCE on **May 22 or 23** on MCE policies and procedures related to how they manage the pharmacy benefit as well as their day-to-day communications and general oversight of their pharmacy benefit manager. Some information is being requested by B&A in advance of this meeting as part of a desk review. B&A will also share high-level, MCE-specific trend reports on pharmacy utilization based on encounters submitted for scripts filled in CY 2017 in order to level-set where there may be gaps prior to conducting more in-depth analytics. The specific areas that B&A intends to cover during the onsite session include the following:

- The entities that adjudicate pharmacy claims for the MCE in each program, the specific responsibilities of these entities, and any oversight activities that the MCE conducts on these entities;
- A walk through of the process that a pharmacy claim goes through from intake to payment or denial;
- Edits in place to ensure the accuracy and completeness during claims adjudication;
- The interaction, if any, of the claims processing system with other MCE systems (e.g. authorizations);
- Differences, if any, related to the intake and adjudication of physician-administered drugs compared to other pharmacy claims;
- The various methods of pricing used by the MCE (in general terms);
- Procedures to handle and track reversals, resubmissions, overpayments, recoupments and rebates;
- Education or training materials given to pharmacists or physicians about the claims submission process;
- Internal management reporting of the claims adjudication process;
- Internal procedures in place when claim submissions must be reviewed manually;
- Internal procedures in place when Optum returns encounters submitted by the MCE; and
- MCE processes that verify pricing

B&A anticipates about 50 questions as part of this interview. The questions will be sent to the MCEs in advance of the meeting and no later than May 11. If the MCE thinks that other information will be helpful to convey during this session, the MCE may present this as well, but it is not required. For this

onsite session, EQR team members Mark Podrazik and Kara Suter will be present in person and Akhilesh Pasupulati will join by phone.

The B&A team will synthesize the information received in the desk review and onsite interviews. Once this is completed, B&A will convene with the OMPP on developing a targeted study of the pharmacy benefit using both medical and pharmacy claims. Whatever is ultimately decided, the study will be applied to all MCEs in the same way. Follow-up information on the study will be shared with each MCE on the analytic design of the study by June 29. The actual analytics will be completed in July and August.

It is anticipated that B&A may require some additional information from each MCE related to the study. This may include:

- Pricing on a sample of NDCs
- Summary reports tracking the calculation of rebates
- Summary reports tracking the amount of overpayments and recoupments for a sample fiscal quarter in CY 2017

Over the course of the study, B&A may reach out to each MCE to provide feedback on analytic results as they are being compiled in order to give the MCE the opportunity to validate the preliminary findings. If this is found to be necessary, it is anticipated that B&A will schedule a webinar with the MCE to review materials. These webinars are likely to occur in the first half of August.

The MCE will be given a final opportunity to review the information from the study that will be submitted to the OMPP in the draft report prior to its submission to the OMPP. This information is intended to be shared in the first week of September. If necessary, another webinar will be scheduled with the MCE to review the results.

Topic #5—Encounter Validation Focus Study

Introduction

In the CY 2017 External Quality Review, B&A performed a validation of claims adjudication reports that are submitted by each MCE for all three of OMPP's care programs. There were discrepancies found in the volume reported by each MCE for institutional and professional claim types compared to what was captured in the OMPP's data warehouse either as an accepted or rejected encounter. This discrepancy warrants further investigation with regard to the *completeness* of the encounters submitted.

In separate activities performed by the OMPP, it has been revealed by MCEs that not all encounters are being submitted to the OMPP data warehouse, specifically those encounters that are initially rejected for not passing front-end edits applied by DXC or Optum. This finding implies that *accuracy* of encounter submissions can be improved.

Some encounters may ultimately be submitted by the MCEs and ultimately accepted by the OMPP vendors. But this process may require repeated attempts and may take a significant amount of time. This process could indicate in some situations that the *timeliness* of encounter submissions may not be at the rate that OMPP desires.

This encounter validation study, therefore, intends to understand not only the true rate of the **timeliness, accuracy and completeness** of encounter claims but also to understand the root cause in areas where the rates are not at a level that the OMPP expects from its MCEs.

Objectives

1. To track the pace at which encounters are being submitted timely to the OMPP by the MCEs for the HHW, HCC and HIP 2.0 programs.
2. To track the accuracy of key variables on the encounters that are being submitted to the OMPP and to determine if certain key variables are causing an encounter to be rejected.
3. To track the rate of completeness of the encounters that are being submitted that are deemed accepted and those deemed rejected. Further, to track the rate at which encounters that were originally deemed rejected are ultimately accepted into the State's data systems.
4. To assist the OMPP in defining what is a "successful" encounter submission encompassing factors pertaining to timeliness, accuracy and completeness.
5. To identify process improvements that can be completed by DXC and Optum to assist the MCEs with successful encounter submissions.
6. To identify specific areas of opportunity within each MCE to assist them with successful encounter submissions.
7. To provide recommendations to the OMPP to strengthen the oversight and the accountability of the MCEs related to successful encounter submissions.

Summary of Work Plan for this Focus Study

1. *Track Requirements*. Review contractual requirements that the OMPP's contractors must abide by with respect to encounter submission (MCEs) or intake and validation (DXC, Optum).

2. *Track Procedures*. Identify the level of consistency or variation among the MCEs with respect to the procedures on how encounters are handled.

3. *Track Timeliness*. Track three months of claims adjudicated during the 3rd Quarter of Calendar Year 2017 from each of the four MCEs to determine if/how they were submitted as encounters. The encounter files that will be reviewed are for the six month period July 2017 to December 2017. This is to allow for the fact that some encounters get rejected by DXC/Optum upon initial submission. Therefore, the encounters that were adjudicated as claims by the MCEs during 3rd Quarter 2017 will be extracted from the encounter submissions in the 4th Quarter 2017 time period in order to assess the ultimate disposition of each encounter. All analytics will be conducted for the HHW, HCC and HIP 2.0 programs separately. As part of this process,

    a. An assessment of the cadence at which encounters are submitted by program and by claim type will be completed.
    b. Analytics will be conducted to compute the average number of days from (1) the date of receipt by the MCE to adjudication date, (2) the date from adjudication to initial encounter submission, and (3) the date from adjudication date to encounter acceptance by DXC (accounting for the fact that some encounters will be submitted multiple times before being accepted, if ever).
    c. Analytics will be conducted to assess the rate of accepted and rejected encounters submitted and determine if there are patterns in claim types or categories of service that have a higher likelihood of rejection.

4. *Track Accuracy*. Among the encounters submitted, track the rate in which valid and complete values are being submitted on encounters for key variables. An assessment will be made for each item reviewed to determine if any patterns arise by OMPP program, by MCE, by claim type or by provider type with respect to invalid values. Specific areas that will be reviewed include:

a. If MCEs are submitting encounters for valid Medicaid IDs but not their members.
b. The validity and completeness of revenue codes on 837I encounters.
c. The validity and completeness of CPT/HCPCS codes on 837I outpatient hospital encounters and 837P encounters.
d. The validity of ICD-10 diagnosis codes being coded on 837I and 837P encounters.
e. The frequency of ICD-10 diagnosis codes being coded and an assessment of any patterns where ICD-10 codes appear to be fewer than expected on 837I and 837P encounters.
f. Analytics related to the validity of inpatient hospital encounters such as the validity of the admission date compared to the from/to service dates on the encounter, the validity of the DRG and SOI values (and how often blank), and the distribution of inpatient claims to determine if each MCE is reporting DRG/SOIs as expected when compared to Medicaid norms.
g. The completeness of valid NDC codes on pharmacy encounters.
h. The frequency of an MCP Paid value greater than $0 on each encounter.

Two additional detailed analytics will be performed. First, an examination of trends among the 3rd Quarter 2017 encounter submissions will be performed among the encounters that were rejected by DXC for mismatch of the combination of NPI/taxonomy code/billing provider service location. Similarly, analytics will be completed on the NPI/taxonomy code for service provider which is also required in encounter submissions. The analysis will focus on (a) if the mismatch is more prevalent among the billing providers or service providers and (b) if there are patterns on provider types or specific provider groups where the mismatch occurred most often.

The second analysis relates to emergency room encounters. The MCEs are required to distinguish between emergent and non-emergent encounters. As a way to independently assess the rate of non-emergent visits, every ER claim will be submitted to 3M's potentially preventable ER visit (PPV) grouper. The purpose here is to determine which medical visit group assignment each ER encounter was grouped into among 187 medical visit categories and to determine in which categories the PPVs are most prevalent. (The grouper uses the principal diagnosis code to make the PPV assignment.) The PPV assignment can then be compared to the MCE's designation in its encounter submission.

5. *Track Completeness*. The MCEs will be asked to submit a dataset of header-level information on each claim that was adjudicated in their systems during the 3rd Quarter 2017. This will be used to compare against the 837I, 837P and 837D submissions in order to assess the percentage of claims that actually ever get submitted as encounters. As part of this process,

    a. Analytics will be conducted to assess the completeness rate of denied claims submitted and paid claims submitted. This will be conducted at the MCE, OMPP program and claim type level.
    b. A submission-to-accepted encounter ratio will be computed to assess the "churn" rate of encounters from each MCE. This will help to answer questions about encounters that are originally rejected such as
        - How many are never resubmitted?
        - If resubmitted, what are the average days to acceptance?
        - Does this vary by OMPP program, by MCE, by claim type or by provider type?

6. *Write Report and Prepare Databook*. A report of all findings will be submitted to the OMPP as well as a databook that provides more detailed information about each aspect of the project.

7. *Conduct Briefings*. A presentation will be developed on the report findings. The study results will be shared with DXC, Optum and Milliman. Based on the other OMPP contractors' feedback, updates to the report or the presentation may be needed. These updates will be made before B&A presents the findings with the OMPP to the MCEs.

C. Detailed Schedule of Onsite Meetings

The table on the next page presents all onsite meetings scheduled for this year's EQR. A specific topic or topics are covered over a two-day period. Within each day, there is a morning and an afternoon session. With four MCEs, that means that each MCE will be given one of the four slots over the two-day period.

We have flexibility as to which day we visit each MCE. Therefore, in the Excel file labeled 'EQR Guide Accompanying File', in the first tab you will see an option for you to select which of the two days offered that your MCE would prefer to have the meeting on the topic. We will make every effort to accommodate specific MCE requests.

Once the day is secured for each MCE, the morning and afternoon slots will be selected at random. However, over the course of the onsite sessions, we will alternate morning and afternoon sessions at each MCE location.

Please submit the Meeting Schedule Preferences tab in the accompanying file directly to Mark Podrazik no later than **Thursday April 12** at mpodrazik@burnshealthpolicy.com. Specific dates/times for meetings set and the final schedule will be released to the MCEs by **Thursday April 19**.

With the exception of EQR Topic #1, the onsite meetings will only cover the EQR topic as indicated by the color coding. For EQR Topic #1, two of the eight modules will be covered in each onsite meeting. The modules to be covered in each onsite meeting are shown below the date of the meeting.

A typical schedule for an onsite day covering Topic #1 will be set as follows:

Morning Session	1st Module	8:30-10:00
	Break	10:00-10:15
	2nd Module	10:15-11:45
Afternoon Session	1st Module	1:00-2:30
	Break	2:30-2:45
	2nd Module	2:45-4:15

Whereas we will typically assign 90 minutes to discuss each module, in some cases the schedule may be altered such as one topic will be 60 minutes and the other 120 minutes or 75 minutes/105 minutes. Regardless, there will still be a break in between each module so that the MCE can coordinate the appropriate staff to attend each session. If the schedule deviates from the 90 minutes-per-module as outlined above, B&A will notify the MCEs in advance of the meeting of the assigned times for each topic.

Unless specifically requested in advance, MCE staff do not need to bring any materials to the interview sessions. Each session will be customized to this EQR and some MCE-specific questions may be asked to assist B&A in better understanding desk review items provided.

Please note that all onsite interviews will cover all OMPP programs—HHW, HCC and HIP 2.0. The obvious exception is EQR Topic #1, Module 2 related to POWER Account tracking is only relevant to HIP 2.0. If the staff in a functional area differs across the OMPP programs, we ask that representatives from every program attend the interview.

2018 External Quality Review Onsite Meeting Schedule

Week of	Mon	Tues	Wed	Thurs	Fri
	14	*15*	*16*	*17*	*18*
May 14		MCE #1 8:30-11:45 MCE #2 1:00-4:15	MCE #3 8:30-11:45 MCE #4 1:00-4:15	MCE #1 9:00-11:45 MCE #2 1:00-3:45	MCE #3 9:00-11:45 MCE #4 1:00-3:45
		Modules 1 & 2	Modules 1 & 2		
	21	*22*	*23*	*24*	*25*
May 21		MCE #1 9:00-11:45 MCE #2 1:00-3:45	MCE #3 9:00-11:45 MCE #4 1:00-3:45		
	25	*26*	*27*	*28*	*29*
June 25		MCE #1 8:30-11:45 MCE #2 1:00-4:15	MCE #3 8:30-11:45 MCE #4 1:00-4:15		
		Modules 3 & 4	Modules 3 & 4		
	16	*17*	*18*	*19*	*20*
July 16		MCE #1 8:30-11:45 MCE #2 1:00-4:15	MCE #3 8:30-11:45 MCE #4 1:00-4:15	MCE #1 8:30-11:45 MCE #2 1:00-4:15	MCE #3 8:30-11:45 MCE #4 1:00-4:15
		Modules 5 & 6	Modules 7 & 8	Modules 7 & 8	Modules 5 & 6
	30	*31*	*1*	*2*	*3*
July 30			MCE #1 8:30-11:30 MCE #2 1:00-4:00	MCE #3 8:30-11:30 MCE #4 1:00-4:00	
	13	*14*	*15*	*16*	*17*
Aug 13			MCE #1 8:30-11:30 MCE #2 1:00-4:00	MCE #3 8:30-11:30 MCE #4 1:00-4:00	

EQR Topic #1 Onsite interviews regarding MCE operations and compliance with federal regulations
- Module 1: Information Systems and Reporting to OMPP
- Module 2: POWER Account Tracking and HIP Reporting
- Module 3: Administrative Oversight, Subdelegated Oversight, Financial Oversight
- Module 4: Utilization Management, Prior Authorizations, Program Integrity
- Module 5: Member Services, Grievances & Appeals
- Module 6: Provider Contracting, Provider Relations, Provider Network Management
- Module 7: Disease Management, Case Management, Complex Care Management
- Module 8: Quality Management

EQR Topic #2 Validation of performance measures

EQR Topic #3 Validation of QIPs

EQR Topic #4 Focus study on review of MCE pharmacy claims processing

EQR Topic #5 Encounter validation focus study

D. Information Requests Related to the EQR

The table on the next page outlines the due dates for information to be submitted to B&A. Unless otherwise specified, all information should be uploaded to the OMPP Sharepoint site in the *Managed Care\Hoosier Healthwise\2018\EQR* folder. For convenience, all information submitted for this year's EQR, even if it pertains to other OMPP programs, will be uploaded to the Hoosier Healthwise folder.

The information requests are aligned with the EQR topics and the meeting schedule as shown in the previous page. In an effort to reduce the administrative burden on the MCEs, the information being requested will be delivered in four batches to B&A. The first batch of information is due back **April 26**. Subsequent batches of information are due back **May 17**, **June 14** and **August 2**.

Due to the volume of information being requested, a numbering sequence has been developed for each item requested. In the Excel file that accompanies this EQR Guide, the 4th tab in the file provides a table of all desk items being requested for Topic #1 - *Review of MCE operations and compliance with federal regulations regarding Medicaid managed care plans.* B&A has mapped the desk item request to a section in the HHW/HIP Scope of Work to indicate to the MCE how the specific item will be used to evaluate the aspect of the MCE's operations. Although not mapped to the HCC Scope of Work, these desk items will also be used to assess operations in the HCC program.

Please ensure to complete the table in the 4th tab of the Excel file and upload it every time that desk review items are due. Also, please keep the following in mind as you consider the information to submit:

1. The desk items are suggestions of how the MCE can show compliance with the specific contract scope of work item. The MCE is not limited to the desk item as stated in its submission. Likewise, for some desk items requested, the MCE may have nothing to submit.

2. Please place an X in Column F to indicate that you are submitting one or more document related to each desk item on the list. This is B&A's way to ensure that we have accounted for all files that are being submitted.

3. Please do not resubmit the same policy, procedure or other document multiple times. In prior EQRs when this assessment has been completed, we have often found that the same policy or procedure may satisfy multiple requests. If this is the case,
    a. Place an X in both Column F and Column G. This is the indication that your MCE is accounting for submitting a document for the desk item but the document already appears further up in the list of documents.
    b. Copy the name of the file as it was labeled earlier in table on the desk item line that it applies to a second time. This will indicate to B&A which document to refer back to.

4. When naming the files that you are submitting in the desk review, we recommend the following:
    a. Always start the file name with your MCE name.
    b. Then follow this with the desk item number in Column A of the table.
    c. If there is more than one document to submit for a desk item, add a letter after the desk item number, e.g. 1A, 1B, 1C, etc.
    d. Then use any free form text to describe the contents of the file or your internal policy number. By preserving your internal file name within the file name submitted to B&A, it will be easier for us to reference with you in case questions arise.

    Example: [MCE Name] 5A Training Schedule 1.docx
    [MCE Name] 5B Training Schedule 2.pdf

2018 External Quality Review Desk Review Submission Schedule

Week of	Mon	Tues	Wed	Thurs	Fri
	9	*10*	*11*	*12*	*13*
April 9				Email Meeting Preference Form to Mark Podrazik	
	23	*24*	*25*	*26*	*27*
April 23				Encounter Validation policies and procedures File containing list of all Q3 2017 adjudicated claims Submissions for Pharmacy Study Submissions for EQR Topic #1, Module 1 Submissions for EQR Topic #1, Module 2	
				Submit all items due this week to the OMPP Sharepoint site	
	14	*15*	*16*	*17*	*18*
May 14				Submissions for EQR Topic #1, Module 3 Submissions for EQR Topic #1, Module 4	
				Submit all items due this week to the OMPP Sharepoint site	
	11	*12*	*13*	*14*	*15*
June 11				Submissions for EQR Topic #1, Module 5 Submissions for EQR Topic #1, Module 6 Submissions for EQR Topic #1, Module 7 Submissions for EQR Topic #1, Module 8	
				Submit all items due this week to the OMPP Sharepoint site	
	30	*31*	*1*	*2*	*3*
July 30				QIP Final Reports - email directly to Mark Podrazik	

EQR Topic #1 Desk Review items regarding MCE operations and compliance with federal regulations
Refer to next tab for an inventory of what is being requested by module.
Module 1: Information Systems and Reporting to OMPP
Module 2: POWER Account Tracking and HIP Reporting
Module 3: Administrative Oversight, Subdelegated Oversight, Financial Oversight
Module 4: Utilization Management, Prior Authorizations, Program Integrity
Module 5: Member Services, Grievances & Appeals
Module 6: Provider Contracting, Provider Relations, Provider Network Management
Module 7: Disease Management, Case Management, Complex Care Management
Module 8: Quality Management

EQR Topic #2 Validation of performance measures - no desk review items required

EQR Topic #3 Validation of QIPs - submission of final QIP report in QIP Report template with any accompanying reports

EQR Topic #4 Focus study on review of MCE pharmacy claims processing - policies and procedures

EQR Topic #5 Encounter validation focus study - policies and procedures

Information Being Requested for Topics #3, #4 and #5

For Topic #3, the files that will be submitted on August 2 are the Excel files containing the completed Annual QIP Report along with any files either embedded in the Excel file or attached separately that relate to the QIP evaluation.

Information for Topics #4 and #5 are requested to be uploaded to Sharepoint on April 26. For Topic #4 (focus study on pharmacy pricing), the MCE has discretion on the items that it believes would be helpful to inform the onsite meeting to be held on this topic on May 22 or 23. The MCE is encouraged to review the bullets listed on page 7 of the EQR Guide as guidance as to the materials that B&A would like to receive in the desk review submissions.

For Topic #5, there are two specific items that are being requested. The first relates to policies and procedures that the MCE has in place related to encounter validation. The MCE has discretion on the items that it believes would be helpful to inform the onsite meeting to be held on this topic on May 17 or 18. With that in mind, B&A is specifically interested in learning about any procedures that address the following:

- What procedures are conducted, if any, when preparing adjudicated claims to submit in an encounter batch?
- What review process, if any, is conducted on claims adjudicated by subdelegated vendors and submitted to the MCE for inclusion in encounter submissions?
- Does the MCE have a particular schedule for submitting encounters (since one is not specified by the OMPP other than a minimum of one batch per week)?
- How does the MCE use any feedback reports from DXC or Optum that identify encounters rejected entry into the DXC system?
- What is the MCE's process to "work" rejected encounters? Does this differ between encounters generated by the MCE directly and those generated by a subdelegated entity?
- What is the MCE's process to resolve denial reason codes for encounters that are accepted by DXC but hit DXC fee-for-service edits? What have you learned in the last six months?
- How does the MCE track the completeness rate of encounter submissions to OMPP, if at all?
- How does the MCE track the timeliness of encounter submissions to OMPP, if at all?
- What procedures does the MCE have in place to assess the accuracy of encounter submissions?

For both Topics #4 and #5, please be sure to complete the table that appears in the 5th tab of the Excel file that accompanies this EQR Guide. Submit this tab when uploading the files to the Sharepoint site by April 26.

The second item that is being requested related to encounter validations can be submitted separately from the information mentioned above. This second item is a report of every claim that was adjudicated by the MCE during the time period July 1, 2017 – September 30, 2017. By using the term adjudicated, B&A refers to both paid and denied claims by the MCE but excludes rejected and suspended claims by the MCE. This report is not an inventory of the encounters submitted to DXC during this time; rather, it is the claims adjudicated by the MCE (and any subdelegated entities) during this time period, regardless of provider submission date or date of service.

The purpose of this file is to match it to files representing the encounters submitted by the MCE that correspond to these adjudicated claims. B&A recognizes that this file may contain hundreds of thousands of records. Do not send all detail lines on a claim, just a header record. The MCE also has the option to submit multiple files. For example, the MCE may:

- Submit one file for each claim type (institutional, professional, pharmacy dental) for all programs
- Submit one file for each program (HHW, HCC, HIP) for all claim types
- Submit one file by claims processor (if the MCE uses more than one) for all programs/claim types

Regardless of how the MCE chooses to submit its report, the following data elements should appear in the file:

- Unique claim identifier (one that is also included in any encounter submission so that B&A can track against the encounter files)
- Adjudication status (paid or denied)
- OMPP program (if the files are not separated out as described above)
- Claim type—institutional, professional, pharmacy or dental (if the files are not separated out as described above)

The file(s) may be submitted in .xlsx, .csv, or .txt format.
Please contact Mark Podrazik directly at 703-785-2371 or by email if you have specific questions.

2018 External Quality Review Desk Review Request for Topic #1: Review of MCE Operations

Remember to put your MCE name in all file names.

Desk Item	Module	HHW Contract Scope Section	HIP Contract Scope Section	Scope of Work Section Title	Item Being Requested	X if the MCE is submitting a document(s)	X if the relevant document is listed above	File(s) Name
1	3	2.2	2.2	National Committee for Quality Assurance (NCQA) Accreditation	Current NCQA Accreditation Certification			
2	3	2.3	2.3	Administrative and Organizational Structure	MCE Organizational Chart in place for CY 2017. Insert in the org chart or in a separate table the total FTEs in each functional area. Add a notation of any material change since the end of CY 2017			
3	3	2.4	2.4	Staffing	Listing of each person currently in the following positions: CEO, CFO, Compliance Officer, IS Coordinator, Medical Director, Member Services Manager, Provider Services Manager, Special Investigation Unit Manager, Quality Improvement Management Manager, Utilization Management Manager, Behavioral Health Manager, Data Compliance Manager, Pharmacy Director, Grievance and Appeals Manager, and Claims Manager. Specify if the individual serves in this capacity for more than one OMPP program that the MCE is contracted under.			
4	3	2.4	2.4	Staffing	Identify all key functions performed outside of the State of Indiana. Write a paragraph that describes how you ensure a seamless integration of these functions with your Indiana-based operations.			
5	3	2.4	2.4	Staffing	Documentation of the schedule of training sessions provided to staff during CY 2017 with a phrase describing the training topic			
6	3	2.4	2.4	Staffing	Proof of documentation for training of utilization management staff at a minimum on a quarterly basis with the topic covered at each session held in CY 2017			
7	3	2.4	2.4	Staffing	Copy of orientation materials given in training to all new staff, regardless of position			
8	3	2.4	2.4	Staffing	Policy or procedure that address the routine monitoring of staff positions and subcontractors for individuals barred or excluded			
9	3	2.6	2.6	Financial Stability	Proof of reinsurance from a commercial reinsurer with specified limits			
10	3	2.6	2.6	Financial Stability	Policy or procedure on financial record retention			
11	3	2.7	2.7	Subcontracts	List of all subcontractors that are not IHCP providers, that serve as a subdelegated entity, and that have an annual contract with the MCE greater than $100,000			
12	3	2.7	2.7	Subcontracts	Copies of agreements with subcontractors meeting the requirements above			
13	3	2.7	2.7	Subcontracts	Policy or procedure which demonstrates oversight of subdelegated entities			
14	3	2.7	2.7	Subcontracts	The most recent annual report or other document that demonstrates oversight of each subdelegated entity (this could have occurred in early CY 2018)			
15	5	2.8	2.8	Confidentiality of Member Medical Records and Other Information	Policy or procedure outlining member medical records and confidentiality			
16	5	2.9	2.9	Internet Quorum (IQ) Inquiries	Procedures identifying how the MCE intakes and addresses IQ inquiries and responds to OMPP in a timely manner			

Desk Item	Module	HHW Contract Scope Section	HIP Contract Scope Section	Scope of Work Section Title	Item Being Requested	X if the MCE is submitting a document(s)	X if the relevant document is listed above	File(s) Name
17	2		3.1-3	HIP Plus	Policy or procedure that identifies individuals eligible for HIP Plus, HIP Basic and HIP State Plan			
18	2		3.1-3	HIP Basic	Procedure to track members who move across HIP packages			
19	2		3.3	HIP State Plan	Policy or procedure that identifies individuals as medically frail			
20	2		3.3	HIP State Plan	Policy or procedure notifying the member of his/her medically frail status			
21	2		3.4	Pregnancy Coverage in HIP (HIP Maternity)	Policy or procedure that outlines how the MCE quickly identifies pregnant HIP members			
22	2		3.4	Pregnancy Coverage in HIP (HIP Maternity)	Sample letter or notifications to members regarding options to remain in HIP or receive State Plan benefits through MAGP			
23	2		3.5	Presumptive Eligibility	Policy or procedure related to initial notifications to presumptively eligible members			
24	2		4.1	Individual and Cost-Sharing Obligations	Documentation, such as a work flow, that shows the MCE's process to support billing, collecting and applying applicable POWER Account contributions			
25	2		4.1	Individual and Cost-Sharing Obligations	Example of a communication to member that outlines cost sharing obligations (this may be in a Welcome Letter)			
26	2		4.3	Third Party POWER Account Contributions	Policy or procedure for tracking third party POWER account contributions			
27	2		4.4	Recalculations	Policy or procedure for assessing when and how recalculations for POWER account contributions are required			
28	2		4.5	Billing and Collections	Policy or procedure for billing and collections of POWER account contributions			
29	2		4.6	Enrollment and Initial POWER Account Contributions	Copy of Welcome Letter to individuals explaining the benefits and rights individuals have before the first payment is made			
30	2		4.6	Enrollment and Initial POWER Account Contributions	Policy or procedure for fast track eligible applicants			
31	2		4.7	Non-Payment Penalty Exceptions	Documentation showing notification to OMPP of disenrollment due to non-payment			
32	2		4.7	Non-Payment Penalty Exceptions	Documentation showing notification to OMPP of reinstatement			
33	2		5.2	Use of POWER Account Funds	Policy or procedure for members use of POWER Account funds			
34	2		5.3	POWER Account Balance Information	Policy or procedure to maintain up-to-date member POWER Account balance information			
35	2		5.3	POWER Account Balance Information	Mockup of a member's POWER account statement showing contributions into, and deductions from, the POWER account (an actual statement with redacted member name can be provided)			
36	2		5.5	Audit Requirement	Copy of latest external annual audit report of the MCE's POWER Account operations and administration			
37	2		5.6	Redetermination and Roll Over	Process for tracking when a member renews his or her eligibility in HIP at the end of a benefit period and the POWER Account reconciliation process			
38	2		5.7	Termination of Eligibility	Policy or procedure for closing the member POWER Account and refunding the State and member share of the remaining POWER Account balance			

Desk Item	Module	HHW Contract Scope Section	HIP Contract Scope Section	Scope of Work Section Title	Item Being Requested	X if the MCE is submitting a document(s)	X if the relevant document is listed above	File(s) Name
39	2		5.7	Termination of Eligibility	Policy or procedure that addresses the reconciliation process of overpayments or underpayments made by the member to POWER Accounts			
40	2		5.8	POWER Account Debt Collection Process	Policy or procedure regarding transmission of POWER Account Reconciliation File (PRF) and what triggers a PRF submission			
41	4	3.2	6.2	Self-referral Services	Policy or procedure that outlines self-referral services and use of providers for self-referral services			
42	7	3.8	6.8	Disease Management	Policy or other document describing the conditions included in the MCE's disease management program			
43	7	3.8	6.8	Disease Management	Policy or procedure for identifying members with each of the conditions of interest			
44	7	3.8	6.8	Disease Management	Protocol for referring members to disease management, care management and complex case management, including all triggers used			
45	7	3.8	6.8	Disease Management	Examples of communications to members in CY 2017 who were enrolled in disease management			
46	7	3.8	6.8	Disease Management	Documentation that MCE provides case management services for any member at risk for inpatient psychiatric or substance abuse hospitalization, for no fewer than ninety (90) calendar days following inpatient hospitalization			
47	7	3.8	6.8	Disease Management	Screen shot(s) of the basic information stored in the care management software for a member enrolled in case or care management			
48	7	3.8	6.8	Disease Management	Example of a report used by the manager of care coordinators to track either volume of calls, touchpoints or other measures in case or care management			
49	7	3.8	6.8	Disease Management	Provide educational and/or experience background of the individuals who are providing case or complex care management to members			
50	7	3.8	6.8	Disease Management	Policy or procedure regarding the information flow between physical and behavioral health care providers and how the MCE aims to coordinate between providers for case/care management members			
51	7	3.8	6.8	Disease Management	Process for handling members new to the MCE or who are transitioning to another MCE who are in case or care management			
52	4	3.9	6.9	24-hour Nurse Call Line	Example of a report from the 24-Hour Nurse Call Line showing calls from the prior evening (redact any PHI identifiable to a specific member)			
53	4	3.9	6.9	24-hour Nurse Call Line	Any procedure on how the MCE utilizes the daily Nurse Call Line report			
54	4	3.11	6.11	Carved-out Services	Policies and procedures on how the MCE tracks carve-out services used by its members			
55	7	3.13	6.13	Continuity of Care	Policy or procedure related to how the MCE ensures the continuity of care of members coming into or out of the MCE			
56	5	4.1	7.1	Marketing and Outreach	Submit a copy of the MCE's CY 2017 marketing plan submitted to OMPP			
57	5	4.2.1	7.2.1	Member Enrollment	Submit a copy of a new member Welcome Packet for HHW			
58	5	4.2.1	7.2.1	Member Enrollment	Submit a copy of a new member Welcome Packet for HCC			
59	5	4.2.1	7.2.1	Member Enrollment	Submit a copy of a new member Welcome Packet for HIP 2.0			

Desk Item	Module	HHW Contract Scope Section	HIP Contract Scope Section	Scope of Work Section Title	Item Being Requested	X if the MCE is submitting a document(s)	X if the relevant document is listed above	File(s) Name
60	5	4.2.2	7.2.2	PMP Selection	Report the number of members—HHW, HCC and HIP separately—of the total number of new members in CY 2017 and, of these, the number that were auto-assigned to PMP			
61	5	4.2.2	7.2.2	PMP Selection	Policy or procedure for auto-assigning a member to a PMP (i.e., how is the specific PMP selected for each member).			
62	5	4.2.3	7.2.3	Health screening	Policy or procedure for conducting initial health screenings (HNS)			
63	5	4.2.3	7.2.3	Health screening	Policy or procedure for conducting comprehensive health assessments (CHAT)			
64	5	4.2.4	7.2.4	Children with Special Health Care Needs	Policy or procedure related to the provision of care for special needs populations			
65	5	4.2.4	7.2.4	Children with Special Health Care Needs	Policy or procedure related to the use of the Living with Illness Measures (LWIM) screener			
66	5	4.3	7.3	Member-Contractor Communications	Provide example of training materials provided to new Member Services staff			
67	5	4.3	7.3	Member-Contractor Communications	Submit a report of the total number of calls received, by week day, during the week of October 23-27, 2017. Separate the number of calls during business hours and non-business hours. Report the total number of Member Services call center staff that worked and total cumulative hours of phone coverage (i.e. sum of all hours of all staff) that worked each day of this week. If a standard report is available, please remit it. If no standard report is available, please generate one with these data elements.			
68	5	4.4	7.4	Member Information, Outreach and Education	Policy regarding availability of interpretive or translation services to members			
69	5	4.4	7.4	Member Information, Outreach and Education	Example of educational information sent to members in CY 2017 regarding EPSDT services			
70	5	4.4	7.4	Member Information, Outreach and Education	Policy or procedures to ensure the accuracy and comprehension level of materials released to members			
71	5	4.4.1	7.4.1	Member Handbook	Submit a copy of the CY 2017 Member Handbook for HHW			
72	5	4.4.1	7.4.1	Member Handbook	Submit a copy of the CY 2017 Member Handbook for HCC			
73	5	4.4.1	7.4.1	Member Handbook	Submit a copy of the CY 2017 Member Handbook for HIP 2.0			
74	5	4.6	7.6	Redetermination Assistance	If the MCE provides eligibility redetermination assistance to members, provide the policy and procedure related to this assistance			
75	5	4.7	7.7	Member-Provider Communications	Policy or procedure regarding provider-enrollee communications			
76	5	4.8	7.8	Member Rights	Policy regarding protecting member rights as per 42 CFR 438.100			
77	5	4.9	7.9	Member Grievances and Appeals	Policy and procedure regarding the process of handling member grievances and appeals			
78	5	4.9	7.9	Member Grievances and Appeals	Summary report of the number of grievances and appeals recorded for all of CY 2017 for each of the programs that the MCE contracts with OMPP			
79	5	4.9	7.9	Member Grievances and Appeals	Copy of the Notice of Action letters sent to members and providers showing reversal of MCE decision			

Desk Item	Module	HHW Contract Scope Section	HIP Contract Scope Section	Scope of Work Section Title	Item Being Requested	X if the MCE is submitting a document(s)	X if the relevant document is listed above	File(s) Name
80	5	4.9	7.9	Member Grievances and Appeals	Copy of the Notice of Action letters sent to members and providers showing that an MCE decision was upheld			
81	5	4.11	7.11	Cultural Competency	Work plan or copies of agendas for meetings of the MCE's CLAS committee (or whatever committee is responsible for CLAS provisions)			
82	5	4.12	7.12	Advance Directives	Policy or procedure regarding advance directives			
83	6	5.1	8.1	Network Development	Policy or procedure for how the MCE tracks its provider network			
84	6	5.2	8.2	Network Composition Requirements	Any analyses or studies conducted to determine network capacity or adequacy (other than the reports from the MCE Reporting Manual)			
85	6	5.2	8.2	Network Composition Requirements	Policy, procedure or contract provision with providers that ensures that physician's availability to members is no less than it is for commercial patients			
86	6	5.2	8.2	Network Composition Requirements	Policy and procedure regarding the completion of the annual 24-hour availability audit			
87	6	5.2	8.2	Network Composition Requirements	Results from the most recent 24-hour availability audit conducted in CY 2017			
88	6	5.3	8.3	Provider Enrollment and Disenrollment	Policy or procedure for working with enrollees when their PMP terminates from the program			
89	6	5.3	8.3	Provider Enrollment and Disenrollment	Policy or procedure for reporting provider disenrollments to the State's fiscal agent			
90	6	5.4	8.4	Provider Agreements	Copy of a standard contract with an individual practitioner or group practice			
91	6	5.5	8.5	Provider Credentialing	Policy or procedure for provider credentialing and re-credentialing			
92	6	5.5	8.5	Provider Credentialing	Copy of a completed standard provider credentialing form used during the credentialing process (the provider's name and identifying information can be blacked out)			
93	6	5.6	8.6	Medical Records	Policy or procedure showing the requirements for the maintenance of medical records			
94	6	5.7	8.7	Provider Education and Outreach	Copy of the Provider Policies and Procedures Manual			
95	6	5.8.1	8.8.1	Provider Website	Please provide us with a dummy provider ID so that we can access the provider section of your website to review the materials available to providers online			
96	6	5.9	8.9	Payment for Health Care-Acquired Conditions and Provider-Preventable	Policy or procedure regarding the treatment of hospital acquired infections or never events			
97	8	6.1	9.1	Quality Management and Improvement Program	Policy or procedure for the coordination and implementation of the Quality Management and Improvement Program			
98	8	6.1	9.1	Quality Management and Improvement Program	Copy of the CY 2017 Quality Management and Improvement Program			
99	8	6.1	9.1	Quality Management and Improvement Program	Copy of the most recent Quality Management and Improvement Program self-evaluation completed			
100	8	6.1	9.1	Quality Management and Improvement Program	Documentation of internal Quality Management and Improvement Committee including membership, responsibilities, and meeting schedule			
101	8	6.1	9.1	Quality Management and Improvement Program	Minutes from CY 2017 Quality Management and Improvement Committee meetings			

Desk Item	Module	HHW Contract Scope Section	HIP Contract Scope Section	Scope of Work Section Title	Item Being Requested	X if the MCE is submitting a document(s)	X if the relevant document is listed above	File(s) Name
102	8	6.2	9.2	Incentive Programs	Description of MCE's provider incentive program and the results from 2017 program (may be preliminary)			
103	8	6.2	9.2	Incentive Programs	Policy or procedure and methodologies for member incentive programs			
104	8	6.2	9.2	Incentive Programs	Copy of materials sent to members for incentive programs			
105	8	6.2	9.2	Incentive Programs	Copy of materials sent to providers for incentive programs			
106	4	6.3	9.3	Utilization Management Program	Policy or procedure of prospective utilization management program that meet NCQA standards for reporting and monitoring			
107	4	6.3	9.3	Utilization Management Program	Documentation of internal Utilization Management Committee including membership, responsibilities, and meeting schedule			
108	4	6.3	9.3	Utilization Management Program	Policy or procedure for the Right Choices Program			
109	4	6.3	9.3	Utilization Management Program	Policy or procedure for monitoring access to preventive care			
110	4	6.3	9.3	Utilization Management Program	Policy or procedure documenting emergency service notifications by providers to the MCE			
111	4	6.3	9.3	Utilization Management Program	Policy or procedure for behavioral health utilization management			
112	4	6.3	9.3	Utilization Management Program	Methods used to track inappropriate emergency department utilization			
113	4	6.3	9.3	Utilization Management Program	Policy or procedure for the determination of authorization requests			
114	4	6.3	9.3	Utilization Management Program	Roster of clinical staff conducting authorization reviews as of 12/31/17. Indicate each person's credential (e.g., RN, MD). Indicate any training each staff member received in CY 2017 related to authorization reviews.			
115	4	6.3	9.3	Utilization Management Program	Copy of notices sent to any party for service denial (redact member name from any example provided)			
116	4	6.3	9.3	Utilization Management Program	Copy of notices sent to any party for an authorization that is an amount, duration or scope that is less than requested (redact member name from example)			
117	4	6.3	9.3	Utilization Management Program	Policy or procedure for second opinions			
118	4	7.1	10.1	Program Integrity Plan	Copy of MCE Program Integrity Plan			
119	4	7.2	10.2	Program Integrity Operations	Copy of surveillance and utilization control programs and procedures to safeguard Medicaid funds against improper payments and unnecessary or inappropriate us of Medicaid			
120	4	7.2	10.2	Program Integrity Operations	Copy of policy or procedure for internal controls in place that are designed to prevent, detect, and report known or suspected waste, fraud and abuse activities			
121	4	7.2	10.2	Program Integrity Operations	Policy or procedure for fraud and abuse data mining, provider profiling and member service utilization			
122	4	7.4	10.4	Program Integrity Overpayment Recovery	Policy or procedure on overpayment recovery			
123	4	7.5	10.5	Audit Program Integrity Operations	Policy or procedure of MCEs Special Investigation Unit that addresses audit activities from FSSA			

Desk Item	Module	HHW Contract Scope Section	HIP Contract Scope Section	Scope of Work Section Title	Item Being Requested	X if the MCE is submitting a document(s)	X if the relevant document is listed above	File(s) Name
124	1	8.0	11.0	Information Systems	Provide a flow chart or other schematic the describes all of your information systems and they integrate or not (e.g., claims processing, authorization management, case management, member services call tracking, provider services call tracking, claims data warehouse)			
125	1	8.1	11.1	Disaster Recovery Plans	Policy or procedure that outlines information system contingency planning which includes processes for full and complete back up of copies of data and software			
126	1	8.1	11.1	Disaster Recovery Plans	Copy of the MCE's most recent Business Continuity and Disaster Recovery plan			
127	1	8.2	11.2	Member Enrollment Data Exchange	Policy or procedure on verifying member eligibility data and reconciling with capitation payments for each eligible member			
128	1	8.3	11.3	Provider Network Data	Policy or procedure on submitting provider network information to DXC and storing of accurate provider enrollment and disenrollment			
129	1	8.6	11.7	Third Party Liability (TPL) Issues	Policy or procedure to address coordination of benefits and cost avoidance			
130	1	8.6	11.7	Third Party Liability (TPL) Issues	Policy or procedure for maintaining records regarding third party liability collections and report collections to OMPP			

Appendix C.1
Validation of Performance Measures
Trend Report Measures Reviewed in the HHW Program

cells highlighted green mean that the MCE's value is more than 10 percentage points above median

cells highlighted peach mean that the MCE's value is more than 10 percentage points below median

	Median Value	Anthem HHW As reported by MCE to OMPP				CareSource HHW As reported by MCE to OMPP				MDwise HHW As reported by MCE to OMPP				MHS HHW As reported by MCE to OMPP			
Reporting Period >>		Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Experience Period Ends Last Day of		Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Adults' Access to Preventive/ Ambulatory Services																	
Percentage of preventive or ambulatory visits, by age group																	
Ages 20 - 44 years	60.8%	71.0%	67.8%	64.3%	71.2%	16.6%	33.0%	25.0%	34.0%	66.6%	69.4%	65.6%	73.6%	52.3%	56.6%	55.4%	57.3%
Ages 45 - 64 years																	
Ages ≥65 years																	
Chlamydia Screening																	
Percentage of women who had a chlamydia screening, by age group																	
Ages 16-20 years	41.0%	38.7%	38.4%	42.7%	42.9%	15.2%	24.6%	28.0%	34.9%	42.9%	40.2%	40.7%	41.3%	47.4%	49.2%	50.2%	50.2%
Ages 21-25 years	51.2%	44.0%	42.4%	43.7%	47.4%	56.9%	64.2%	63.0%	75.5%	45.4%	48.7%	47.1%	50.0%	52.3%	55.4%	54.2%	56.9%
Use of Appropriate Medications for Members with Asthma																	
Percentage of members dispensed at least one prescription for a preferred therapy, by age group																	
Ages 5-9 years	89.1%	92.3%	91.8%	91.2%	89.1%	#	54.0%	54.0%	61.0%	90.9%	86.3%	85.5%	87.3%	88.5%	89.5%	89.3%	89.9%
Ages 10-17 years	86.7%	88.0%	89.0%	89.1%	89.1%	#	58.0%	48.0%	48.0%	86.7%	89.9%	90.3%	89.6%	77.6%	77.9%	79.6%	79.8%
Ages 18-56 years	72.7%	76.1%	78.8%	80.4%	78.7%	#	20.0%	18.0%	19.0%	72.4%	88.9%	92.4%	94.0%	72.7%	46.7%	69.6%	69.2%
Comprehensive Diabetes Care																	
Percentage of members with diabetes ages 18-75 who received																	
An HbA1c testing	74.2%	57.5%	56.0%	82.7%	74.2%	#	31.0%	33.0%	32.0%	55.0%	76.9%	79.4%	83.3%	72.4%	75.7%	77.3%	81.8%
A LDL-C screening	24.8%	18.3%	19.6%	37.3%	27.4%	#	4.5%	4.0%	50.0%	20.6%	36.5%	36.3%	35.1%	31.4%	22.9%	21.2%	24.8%
An annual eye exam	41.7%	44.4%	41.0%	25.3%	24.2%	#	#	#	0.0%	43.1%	49.0%	47.1%	45.6%	40.5%	39.6%	41.7%	42.1%
Medical attention for Nephropathy	76.5%	75.1%	73.1%	90.7%	96.8%	#	54.0%	56.0%	61.0%	72.0%	80.8%	83.3%	77.2%	75.7%	77.8%	76.5%	81.0%

Due to its introduction in the program in January 2017, CareSource did not have reportable values (low sample size) on some measures until later in 2017.

Appendix C.2
Validation of Performance Measures
Trend Report Measures Reviewed in the HCC Program

cells highlighted green mean that the MCE's value is more than 10 percentage points above median

cells highlighted peach mean that the MCE's value is more than 10 percentage points below median

	Median Value	Anthem HCC As reported by MCE to OMPP				MHS HCC As reported by MCE to OMPP			
Reporting Period >>		Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Experience Period Ends Last Day of		Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Adults' Access to Preventive/ Ambulatory Services									
Percentage of preventive or ambulatory visits, by age group									
Ages 20 - 44 years	70.6%	70.9%	70.2%	74.9%	76.8%	72.8%	60.9%	66.9%	70.1%
Ages 45 - 64 years	84.9%	80.1%	84.8%	88.2%	89.0%	85.8%	76.3%	82.8%	85.1%
Ages ≥65 years	74.3%	70.3%	73.8%	78.2%	80.0%	74.8%	63.6%	71.8%	75.0%
Chlamydia Screening									
Percentage of women who had a chlamydia screening, by age group									
Ages 16-20 years	43.0%	36.6%	35.3%	45.4%	48.1%	40.7%	39.0%	46.5%	46.8%
Ages 21-25 years	51.8%	44.7%	41.9%	50.4%	51.3%	53.6%	52.3%	54.3%	54.0%
Use of Appropriate Medications for Members with Asthma									
Percentage of members dispensed at least one prescription for a preferred therapy, by age group									
Ages 5-9 years	88.9%	87.1%	83.5%	92.5%	94.3%	84.5%	90.0%	87.8%	90.9%
Ages 10-17 years	85.2%	80.0%	81.4%	88.8%	88.2%	89.7%	85.9%	84.6%	84.5%
Ages 18-56 years	66.9%	58.6%	61.2%	71.4%	72.6%	63.9%	66.9%	66.9%	71.7%
Comprehensive Diabetes Care									
Percentage of members with diabetes ages 18-75 who received									
An HbA1c testing	79.2%	69.5%	68.3%	83.4%	84.1%	79.1%	70.4%	79.3%	83.4%
A LDL-C screening	59.2%	54.0%	50.0%	68.1%	68.5%	63.3%	50.1%	56.6%	61.7%
An annual eye exam	47.8%	68.6%	65.7%	50.7%	50.5%	45.2%	37.1%	41.8%	45.0%
Medical attention for Nephropathy	85.4%	82.3%	81.6%	88.1%	87.7%	86.6%	81.6%	84.2%	87.4%

Due to its introduction in the program in January 2017, CareSource did not have reportable values on some measures until later in 2017.

Appendix C.3
Validation of Performance Measures
Trend Report Measures Reviewed in the HIP Plus Program

cells highlighted green mean that the MCE's value is more than 10 percentage points above median

cells highlighted peach mean that the MCE's value is more than 10 percentage points below median

	Median Value	Anthem - HIP Plus				CareSource - HIP Plus				MDwise - HIP Plus				MHS - HIP Plus			
		As reported by MCE to the OMPP				As reported by MCE to the OMPP				As reported by MCE to the OMPP				As reported by MCE to the OMPP			
Reporting Period >>		Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Experience Period Ends on Last Day of		Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Adults' Access to Preventive/ Ambulatory Services																	
Percentage of preventive or ambulatory visits, by age group																	
Ages 20 - 44 years	72.2%	69.2%	74.3%	75.7%	75.7%	9.9%	29.0%	40.0%	16.0%	66.6%	72.4%	73.4%	73.6%	70.1%	72.0%	73.9%	75.4%
Ages 45 - 64 years	81.1%	80.8%	83.1%	84.4%	84.7%	14.9%	39.0%	52.0%	22.0%	77.0%	81.4%	82.3%	81.7%	78.2%	79.9%	81.8%	83.0%
Chlamydia Screening																	
Percentage of women who had a chlamydia screening, by age group																	
Ages 19-24 years	46.7%	42.1%	42.8%	48.0%	47.9%	6.1%	19.4%	28.0%	21.7%	42.7%	46.3%	47.7%	47.0%	53.3%	54.3%	56.3%	56.0%
Use of Appropriate Medications for Members with Asthma																	
Percentage of members dispensed at least one prescription for a preferred therapy, by age group																	
Ages 19-64 years	76.3%	75.6%	76.2%	78.8%	78.5%	#	44.0%	41.0%	40.0%	76.8%	87.7%	85.4%	84.0%	75.2%	78.9%	76.3%	75.6%
Comprehensive Diabetes Care																	
Percentage of members with diabetes ages 19-64 who received																	
An HbA1c testing	81.5%	72.8%	74.7%	87.1%	87.5%	#	26.5%	33.0%	34.7%	70.4%	85.4%	85.9%	86.7%	80.1%	81.5%	83.1%	84.7%
A LDL-C screening	58.5%	57.4%	58.5%	72.9%	*	#	15.2%	23.0%	*	53.2%	67.9%	49.7%	*	65.5%	67.1%	68.5%	*
An annual eye exam	48.3%	68.5%	70.1%	47.2%	*	#	#	#	*	69.6%	46.8%	48.3%	*	44.2%	47.5%	50.4%	*
Medical attention for Nephropathy	83.5%	77.4%	76.7%	83.5%	83.9%	#	41.7%	43.0%	46.4%	78.6%	84.5%	84.5%	84.4%	83.4%	83.7%	84.1%	86.2%

* The OMPP ceased requiring the MCEs from reporting the measure as of Q1 2018.
# Due to its introduction in the program in January 2017, CareSource did not have reportable values on some measures until later in 2017.

Appendix C.4
Validation of Performance Measures
Trend Report Measures Reviewed in the HIP Basic Program

cells highlighted green mean that the MCE's value is more than 10 percentage points above median

cells highlighted peach mean that the MCE's value is more than 10 percentage points below median

	Median Value	Anthem - HIP Basic				CareSource - HIP Basic				MDwise - HIP Basic				MHS - HIP Basic			
		As reported by MCE to the OMPP				As reported by MCE to the OMPP				As reported by MCE to the OMPP				As reported by MCE to the OMPP			
Reporting Period >>		Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Experience Period Ends on Last Day of		Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Adults' Access to Preventive/ Ambulatory Services																	
Percentage of preventive or ambulatory visits, by age group																	
Ages 20 - 44 years	46.3%	47.9%	47.3%	49.8%	50.8%	3.6%	8.0%	12.0%	46.0%	42.9%	46.5%	48.4%	47.4%	35.8%	39.0%	45.3%	48.2%
Ages 45 - 64 years	49.1%	52.3%	51.7%	53.8%	55.9%	6.4%	12.0%	16.0%	58.0%	42.9%	48.5%	51.5%	49.1%	37.4%	41.6%	49.1%	51.4%
Chlamydia Screening																	
Percentage of women who had a chlamydia screening, by age group																	
Ages 19-24 years	44.7%	40.3%	40.7%	44.1%	45.1%	4.0%	12.4%	18.0%	34.4%	44.4%	47.2%	46.1%	45.7%	50.1%	49.6%	51.0%	50.3%
Use of Appropriate Medications for Members with Asthma																	
Percentage of members dispensed at least one prescription for a preferred therapy, by age group																	
Ages 19-64 years	63.0%	58.1%	61.4%	63.0%	66.0%	#	14.0%	18.0%	25.0%	66.4%	92.7%	92.3%	90.9%	55.0%	62.1%	63.6%	66.2%
Comprehensive Diabetes Care																	
Percentage of members with diabetes ages 19-64 who received																	
An HbA1c testing	55.8%	48.6%	50.5%	68.9%	67.7%	#	16.9%	23.0%	26.3%	50.3%	66.4%	67.0%	67.6%	53.5%	55.8%	66.4%	70.9%
A LDL-C screening	36.7%	31.3%	32.6%	46.8%	*	#	10.0%	13.0%	*	36.7%	46.1%	39.0%	*	35.6%	40.2%	48.1%	*
An annual eye exam	24.5%	41.7%	42.5%	22.1%	*	#	#	#	*	45.1%	24.5%	24.9%	*	13.1%	17.9%	23.0%	*
Medical attention for Nephropathy	69.4%	63.4%	64.9%	72.2%	73.1%	#	32.3%	39.0%	39.0%	68.3%	72.7%	75.8%	75.1%	65.9%	69.4%	76.5%	77.6%

* The OMPP ceased requiring the MCEs from reporting the measure as of Q1 2018.

Due to its introduction in the program in January 2017, CareSource did not have reportable values on some measures until later in 2017.

Appendix C.5
Validation of Performance Measures
Trend Report Measures Reviewed in the HIP State Plan Program

cells highlighted green mean that the MCE's value is more than 10 percentage points above median

cells highlighted peach mean that the MCE's value is more than 10 percentage points below median

	Median Value	Anthem - HIP State Plan As reported by MCE to the OMPP				CareSource - HIP State Plan As reported by MCE to the OMPP				MDwise - HIP State Plan As reported by MCE to the OMPP				MHS - HIP State Plan As reported by MCE to the OMPP			
Reporting Period >>		Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Experience Period Ends on Last Day of		Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Adults' Access to Preventive/ Ambulatory Services																	
Percentage of preventive or ambulatory visits, by age group																	
Ages 20 - 44 years	77.1%	78.1%	79.1%	79.6%	80.0%	11.1%	21.0%	27.0%	33.0%	72.5%	77.4%	78.1%	79.2%	74.2%	75.7%	76.9%	77.3%
Ages 45 - 64 years	91.0%	92.2%	92.7%	92.7%	92.2%	22.0%	39.0%	46.0%	54.0%	88.5%	92.0%	92.0%	92.2%	89.7%	90.2%	91.1%	90.9%
Chlamydia Screening																	
Percentage of women who had a chlamydia screening, by age group																	
Ages 19-24 years	50.5%	48.3%	48.2%	50.2%	50.9%	8.7%	19.8%	20.0%	25.6%	48.4%	51.8%	52.4%	52.7%	55.3%	57.6%	57.7%	55.6%
Use of Appropriate Medications for Members with Asthma																	
Percentage of members dispensed at least one prescription for a preferred therapy, by age group																	
Ages 19-64 years	68.3%	68.2%	68.3%	75.6%	76.1%	#	30.0%	25.0%	25.0%	70.2%	87.4%	86.2%	85.6%	63.8%	66.8%	65.9%	68.3%
Comprehensive Diabetes Care																	
Percentage of members with diabetes ages 19-64 who received																	
An HbA1c testing	82.4%	76.8%	77.4%	85.0%	85.2%	#	22.7%	29.0%	33.1%	69.3%	83.5%	84.8%	84.5%	81.2%	82.4%	83.5%	84.8%
A LDL-C screening	57.9%	57.9%	57.9%	66.6%	*	#	21.2%	20.0%	*	51.7%	62.7%	47.4%	*	63.8%	64.1%	65.5%	*
An annual eye exam	51.8%	69.6%	69.2%	49.9%	*	#	#	#	*	68.5%	49.2%	51.8%	*	48.0%	49.8%	53.3%	*
Medical attention for Nephropathy	86.5%	84.1%	83.7%	87.5%	86.9%	#	30.3%	41.0%	45.0%	81.8%	88.0%	88.5%	87.6%	86.1%	86.5%	88.9%	88.6%

* The OMPP ceased requiring the MCEs from reporting the measure as of Q1 2018.

Due to its introduction in the program in January 2017, CareSource did not have reportable values on some measures until later in 2017.

Appendix D
Detailed Scoring for MCE Compliance with OMPP Contract Provisions and Federal Regulations

Scoring: 0 = Not Met; 1 = Partially Met; 2 = Fully Met

Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
	Module 1: Information Systems							
1	Information system contingency planning shall be developed in accordance with 45 CFR 164.308 which relates to administrative safeguards. Contingency plans shall include: Data Backup plans, Disaster Recovery plans and Emergency Mode of Operation plans.	11.1	3.00	6.00	6.00	6.00	6.00	6.00
2	Specific elements required in the MCE's fully tested IT business continuity/disaster recovery plan (ITBCP):							
	2.1 The ITBCP will, at a minimum, meet the requirements of NIST SP800-34.	11.1	0.25	0.50	0.50	0.50	0.50	0.50
	2.2 At a minimum, the Recovery Time Objectives will be no more than 48 hours.	11.1	0.25	0.50	0.25	0.50	0.50	0.50
	2.3 At a minimum, the Recovery Point Objectives will be no more than 24 hours.	11.1	0.25	0.50	0.00	0.50	0.50	0.50
	2.4 These Objectives will be reviewed and, as necessary, modified on an annual basis.	11.1	0.25	0.50	0.50	0.50	0.50	0.50
	2.5 The MCE will coordinate its ITBCP with OMPP's own IT business continuity/disaster recovery plans, including other State solutions with which the MCE's system interfaces to assure appropriate, complete, and timely recovery.	11.1	0.25	0.50	0.00	0.00	0.50	0.00
	2.6 The ITBCP will be based on the agreed upon Recovery Point Objectives and Recovery Time Objectives, and a comprehensive assessment of threat and risk to be performed by the MCE, with such threat and risk assessment updated on no less than annually.	11.1	0.25	0.50	0.00	0.25	0.50	0.50
	2.7 The State expects the MCE's ITBCP to be tested by MCE no less than annually.	11.1	0.25	0.50	0.50	0.50	0.50	0.50
	2.8 The MCE will provide the State with an annual report regarding the MCE's (no less than) annual testing and updating of its ITBCP, including the results of the annual test, including failure points and corrective action plans.	11.1	0.25	0.50	0.50	0.50	0.50	0.50
3	The MCE shall be responsible for verifying member eligibility data and reconciling with capitation payments for each eligible member. The MCE shall reconcile its eligibility and capitation records monthly.	11.2	3.00	6.00	6.00	6.00	6.00	6.00
4	The MCE shall submit provider network information to the State fiscal agent via the Portal. The MCE shall keep provider enrollment and disenrollment information up-to-date. The MCE shall enter updates into the Portal no less frequently than on the 1st and 15th day of each month.	11.3	2.00	4.00	4.00	4.00	4.00	4.00
5	The MCE must develop policies and procedures to monitor claims adjudication accuracy.	11.4.1	5.00	10.00	10.00	10.00	10.00	10.00
6	The MCE shall comply with the claims processing standards and confidentiality standards under IC 12-15-13-1.6 and IC 12-15-13-1.7, and any applicable federal regulations, including HIPAA regulations.	11.4.2	2.00	4.00	4.00	4.00	4.00	4.00
7	The MCE shall pay providers for covered medically necessary services rendered to the MCE's members in accordance with the standards set forth in IC 12-15-13-1.6 and IC 12-15-13-1.7, unless the MCE and provider agree to an alternate payment schedule and method.	11.4.2	2.00	4.00	4.00	4.00	4.00	4.00
8	The MCE shall pay or deny electronically filed clean claims within 21 calendar days of receipt and paper claims within 30 calendar days of receipt.	11.4.3	5.00	10.00	10.00	10.00	10.00	10.00
9	The MCE shall provide real-time access to member POWER Account balances in a secure format.	11.4.5	2.00	4.00	4.00	4.00	0.00	4.00

Appendix D
Detailed Scoring for MCE Compliance with OMPP Contract Provisions and Federal Regulations

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Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
10	The MCE shall submit an encounter claim to the State fiscal agent for every service rendered to a member for which the MCE either paid or denied reimbursement.	11.6.1	5.00	10.00	10.00	10.00	10.00	10.00
11	The MCE shall submit via secure FTP at least one batch of encounter data for paid and denied institutional, pharmacy and professional claims before 5 p.m. Eastern on Wednesday each week.	11.6.2	3.00	6.00	6.00	6.00	6.00	6.00
12	The MCE must have written policies and procedures to address its submission of encounter claims to the State.	11.6.3	3.00	6.00	6.00	6.00	6.00	6.00
13	The MCE shall submit one hundred percent (100%) of adjudicated claims within thirty (30) calendar days of adjudication.	11.6.3	5.00	10.00	5.00	10.00	5.00	10.00
14	The MCE shall correct and resubmit any encounter claims that do not pass the pre-cycle edits.	11.6.3	3.00	6.00	6.00	6.00	6.00	6.00
15	The MCE shall demonstrate that it implements policies and procedures to ensure that encounter claims submissions are accurate; that is, that all encounter claims detail being submitted accurately.	11.6.3	4.00	8.00	8.00	8.00	8.00	8.00
16	The MCE shall have in place a system for monitoring and reporting the completeness of claims and encounter data received from providers.	11.6.3	4.00	8.00	8.00	8.00	8.00	8.00
17	At least annually, or on a schedule determined at the discretion of the State, the MCE must submit an encounter claims work plan that addresses the MCE's strategy for monitoring and improving encounter claims submission. This includes internal standards for measuring completeness, the results of any completeness studies, and any corrective action plans developed to address areas of non-compliance.	11.6.3	3.00	6.00	6.00	6.00	6.00	6.00
18	The MCE shall maintain records regarding third party liability collections and report these collections to OMPP in the timeframe and format determined by OMPP.	11.7.2	2.00	4.00	4.00	4.00	4.00	4.00
19	When the MCE is aware of other insurance coverage prior to paying for a health care service for a member, it should avoid payment by rejecting a provider's claim and direct that the provider first submit the claim to the appropriate third party.	11.7.3	2.00	4.00	4.00	4.00	4.00	4.00
	Module 2: POWER Account Tracking and Reporting							
20	The MCE shall be responsible for billing, collecting and applying the POWER Account contributions for members receiving HIP Plus or HIP State Plan Plus benefits.	4.0	4.00	8.00	8.00	8.00	8.00	8.00
21	Collection services shall include:							
	21.1 Creating and maintaining HIPAA compliant POWER Account contribution billing services	4.0	0.25	0.50	0.50	0.50	0.50	0.50
	21.2 Generating and mailing invoices, although members may opt-in to receiving electronic invoices	4.0	0.25	0.50	0.50	0.50	0.50	0.50
	21.3 Receiving and posting payments	4.0	0.25	0.50	0.50	0.50	0.50	0.50
	21.4 Monitoring and tracking missed payments	4.0	0.50	1.00	1.00	1.00	1.00	1.00
	21.5 Processing returned checks	4.0	0.25	0.50	0.50	0.50	0.50	0.50
	21.6 Stopping or placing collections on hold as directed by the State	4.0	0.25	0.50	0.50	0.50	0.50	0.50
	21.7 Generating past due notices and other notifications	4.0	0.25	0.50	0.50	0.50	0.50	0.50
	21.8 Generating other informational materials as requested by the State	4.0	0.25	0.50	0.50	0.50	0.50	0.50
	21.9 Providing documentation of account activities and other financial reports	4.0	0.25	0.50	0.50	0.50	0.50	0.50

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Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
	21.10 Processing and mailing fast track prepayment and/or POWER Account contribution refunds	4.0	0.25	0.50	0.50	0.50	0.50	0.50
	21.11 Transferring collected funds as requested by the State	4.0	0.25	0.50	0.50	0.50	0.50	0.50
	21.12 Documentation and reconciliation of funds received and transferred	4.0	0.25	0.50	0.50	0.50	0.50	0.50
	21.13 Establishing and handling a lockbox for HIP payments	4.0	0.25	0.50	0.50	0.50	0.50	0.50
	21.14 Date stamping mail received	4.0	0.25	0.50	0.50	0.50	0.50	0.50
	21.15 Forwarding all change of address notifications and mail returned as undeliverable as specified by the S	4.0	0.25	0.50	0.50	0.50	0.50	0.50
22	The MCE shall develop and mail invoices for HIP members that includes:							
	22.1 Name of the MCE	4.5	0.25	0.50	0.50	0.50	0.50	0.50
	22.2 First name, last name and address of the payer	4.5	0.25	0.50	0.50	0.50	0.50	0.50
	22.3 First names of the members	4.5	0.25	0.50	0.50	0.50	0.50	0.50
	22.4 Current monthly POWER Account contribution owed	4.5	0.50	1.00	1.00	1.00	1.00	1.00
	22.5 POWER Account contribution past due amount	4.5	0.50	1.00	1.00	1.00	1.00	1.00
	22.6 Overpayment shown as credit	4.5	0.25	0.50	0.50	0.50	0.50	0.50
	22.7 POWER Account contribution due date	4.5	0.25	0.50	0.50	0.50	0.50	0.50
	22.8 Payer RID of the person responsible for the payment	4.5	0.25	0.50	0.50	0.50	0.50	0.50
	22.9 Consequences of not paying the POWER Account contribution	4.5	0.25	0.50	0.50	0.50	0.50	0.50
	22.10 Notice to send payment in all accepted forms	4.5	0.25	0.50	0.50	0.50	0.50	0.50
	22.11 How to notify the MCE of an address change	4.5	0.25	0.50	0.50	0.50	0.50	0.50
	22.12 How to report any change in household or household income	4.5	0.25	0.50	0.50	0.50	0.50	0.50
	22.13 How to notify the MCE when there are billing questions or concerns	4.5	0.25	0.50	0.50	0.50	0.50	0.50
	22.14 Legal statement regarding bankruptcy, if applicable	4.5	0.25	0.50	0.50	0.50	0.50	0.50
23	The Contractor shall translate invoices into Spanish, as well as any other languages that are spoken by at least three percent (3%) of the general population in the Contractor's service area.	4.5	1.00	2.00	0.00	0.00	1.00	1.00
24	The Contractor shall provide members the option to sign-up and receive invoices via e-mail.	4.5	1.00	2.00	2.00	2.00	2.00	2.00
25	The MCE must notify members when the member fails to make a POWER Account contribution by the due date. The MCE shall provide at least two written notices of the delinquent payment as a reminder, the first of which shall be sent on or before the seventh (7th) calendar day of non-payment.	4.5	3.00	6.00	6.00	6.00	6.00	6.00
26	The Contractor shall develop a program to publicize to members and employers that an employer and other third parties may contribute to the member's POWER Account.	4.5.2	1.00	2.00	2.00	0.00	2.00	2.00
27	Within three (3) business days of receiving the conditional eligibility file, the MCE shall send a Welcome Letter and initial invoice to the individual for their first POWER Account contribution.	4.6.1	3.00	6.00	6.00	6.00	6.00	6.00
28	Fast track eligible applicants will be provided the opportunity to pay a ten dollar ($10.00) initial fast track POWER Account prepayment that expedites enrollment into the HIP Plus plan once an individual has been determined eligible by the State.	4.6.2	2.00	4.00	4.00	4.00	4.00	4.00

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Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
29	The Contractor shall notify the State, through the Indiana Client Eligibility System (ICES), when a member does not pay their initial fast track prepayment by its due date, or their POWER Account contribution within sixty (60) calendar days of its due date.	4.7	2.00	4.00	4.00	4.00	4.00	4.00
30	POWER account information must also be available online via a secure member portal. The information shall reflect real-time changes in the member's POWER Account, as evidenced by paid claims.	5.3	2.00	4.00	4.00	4.00	4.00	4.00
31	The MCE shall give members an opportunity to elect to receive e-mail alerts about updated POWER Account balance information on the member's secure member portal, in addition to or as an alternative to receiving the information by mail.	5.3	1.00	2.00	2.00	2.00	2.00	2.00
32	The MCE must engage an external entity to conduct an annual audit of its POWER Account operations and administration.	5.5	2.00	4.00	4.00	4.00	4.00	4.00
33	The MCE must notify members of any roll over amounts, as well as any changes in their monthly POWER Account contribution due to roll over amounts.	5.6.1	1.00	2.00	2.00	2.00	2.00	2.00
34	The MCE must send preventive service reminders to their members throughout the benefit period, including in the monthly POWER Account Statements and redetermination correspondence.	5.6.3	1.00	2.00	1.00	2.00	2.00	2.00
35	The MCE must have mechanisms in place to monitor when a member has obtained the preventive care services recommended for his or her age and gender, as well as pre-existing conditions, and report this information on the PRF one hundred and twenty (120) calendar days following the end of the member's benefit period.	5.6.3	2.00	4.00	4.00	4.00	4.00	4.00
36	The MCE must send a letter to the member informing the member of its assessment if the assessment indicates that the member has not received the recommended preventive care. This letter must go out within the 90 calendar days prior to the end of the benefit period.	5.6.3	2.00	4.00	4.00	4.00	4.00	4.00
37	The member's share of the remaining POWER Account balance must be refunded within 120 calendar days of the member's date of termination from HIP. The State share must be reported 120 calendar days following the member's termination from HIP.	5.7	1.00	2.00	2.00	2.00	2.00	2.00
38	The Contractor shall submit an initial Power Account Reconciliation File (PRF) at 30 days after the end of the member's benefit period or transfer to another MCE	5.7.3	3.00	6.00	6.00	6.00	6.00	6.00

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Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
	Module 3, Part I: Administrative Oversight							
39	The MCE must employ the key staff members listed in Section 2.4.1 of the Scope of Work on a full-time basis and have position descriptions for each staff position.							
	39.1 Chief Executive Officer	2.4.1	1.00	2.00	2.00	2.00	2.00	2.00
	39.2 Chief Financial Officer	2.4.1	1.00	2.00	2.00	2.00	2.00	2.00
	39.3 Compliance Officer	2.4.1	1.00	2.00	2.00	2.00	2.00	2.00
	39.4 Information Systems Manager	2.4.1	1.00	2.00	2.00	2.00	2.00	2.00
	39.5 Medical Director	2.4.1	1.00	2.00	2.00	2.00	2.00	2.00
	39.6 Member Services Manager	2.4.1	1.00	2.00	2.00	2.00	2.00	2.00
	39.7 Provider Services Manager	2.4.1	1.00	2.00	2.00	2.00	2.00	2.00
	39.8 Special Investigations Unit Manager	2.4.1	1.00	2.00	2.00	2.00	2.00	2.00
	39.9 Quality Manager	2.4.1	1.00	2.00	2.00	2.00	2.00	2.00
	39.10 Utilization Management Manager	2.4.1	1.00	2.00	2.00	2.00	2.00	2.00
	39.11 Behavioral Health Manager	2.4.1	1.00	2.00	2.00	2.00	2.00	2.00
	39.12 Data Compliance Manager	2.4.1	1.00	2.00	2.00	2.00	2.00	2.00
	39.13 Pharmacy Director	2.4.1	1.00	2.00	2.00	2.00	2.00	2.00
	39.14 Grievance and Appeals Manager	2.4.1	1.00	2.00	2.00	2.00	2.00	2.00
	39.15 Claims Manager	2.4.1	1.00	2.00	2.00	2.00	2.00	2.00
40	For all functions conducted outside of the State of Indiana, the MCE must ensure a seamless integration of its operations.	2.4.1	3.00	6.00	6.00	6.00	6.00	6.00
41	On an ongoing basis, the MCE must ensure that each staff person, including subcontractors' staff, has appropriate education and experience to fulfill the requirements of their position, as well as ongoing training.	2.4.3	3.00	6.00	6.00	6.00	6.00	6.00
42	Utilization management staff must receive ongoing training regarding interpretation and application of the MCE's utilization management guidelines. The ongoing training must, at minimum, be conducted on a quarterly basis and as changes to the MCE's utilization management guidelines and policies and procedures occur.	2.4.3	3.00	6.00	6.00	6.00	6.00	3.00
43	The MCE must maintain documentation to confirm its internal staff training, curricula, schedules and attendance.	2.4.3	3.00	6.00	6.00	6.00	6.00	6.00
44	The MCE has a procedure in place to routinely monitor staff positions and subcontractors for individuals debarred or excluded by Federal agencies.	2.4.4	3.00	6.00	6.00	6.00	6.00	6.00
45	The MCE has obtained reinsurance from a commercial reinsurer and shall obtain reinsurance as outlined in Section 2.6.3.	2.6.3	2.00	4.00	4.00	4.00	4.00	4.00
46	The MCE retains separate accounting records for all lines of business that it is under contract with the OMPP (HHW, HIP, HCC).	2.6.4	2.00	4.00	4.00	4.00	4.00	4.00
47	The MCE shall maintain financial records pertaining to the Contract, including all claim records, for 3 years following the termination year of the contract.	2.6.4	3.00	6.00	6.00	6.00	6.00	6.00

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Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
48	The MCE shall ensure that member medical records, as well as any other health and enrollment information that contains individual PHI, is used and disclosed in accordance with HIPAA privacy requirements.	2.8	3.00	6.00	6.00	6.00	6.00	6.00
	Module 3, Part II: Subdelegated Oversight							
49	The MCE must evaluate prospective subcontractor abilities to perform delegated activities prior to contracting with the subcontractor to perform services associated with the HHW, HIP and/or HCC programs.	2.7	5.00	10.00	10.00	10.00	10.00	5.00
50	The MCE must have a written agreement in place that specifies the subcontractor's responsibilities and provides an option for revoking delegation or imposing other sanctions if performance is inadequate.	2.7	5.00	10.00	10.00	10.00	10.00	10.00
51	The MCE must collect performance and financial data from its subcontractors and monitor delegated performance on an ongoing basis and conduct formal, periodic and random reviews.	2.7	5.00	10.00	10.00	10.00	10.00	10.00
52	The MCE must identify areas for its subcontractor's improvement when appropriate and must take corrective action if deficiencies are identified.	2.7	5.00	10.00	10.00	10.00	10.00	10.00
53	The MCE must have policies and procedures addressing auditing and monitoring subcontractor's data, data submissions and performance.	2.7	5.00	10.00	10.00	10.00	10.00	10.00
54	The MCE must integrate subcontractors' financial and performance data (as appropriate) into its information system to accurately and completely report MCE performance and confirm contractor compliance.	2.7	5.00	10.00	10.00	10.00	10.00	10.00
	Module 4, Part I: Utilization Management							
55	The MCE must establish, maintain and periodically review medical management criteria and practice guidelines in accordance with state and federal regulations that are based on valid and reliable clinical evidence or consensus among clinical professionals.	6.3	5.00	10.00	10.00	10.00	10.00	10.00
56	The MCE must consult with contracting health care professionals in developing practice guidelines and must have mechanisms in place to ensure consistent application of review criteria for authorization decisions and consult with the provider that requested the services when appropriate.	6.3	3.00	6.00	6.00	6.00	6.00	6.00
57	The MCE shall periodically review the guidelines, update the guidelines and distribute the guidelines to providers and make them available to members upon request.	6.3	2.00	4.00	4.00	4.00	4.00	4.00
58	UM staff must receive ongoing training regarding interpretation and application of the utilization management guidelines.	6.3	5.00	10.00	10.00	10.00	10.00	10.00
59	The MCE conducts prudent layperson review to determine whether an emergency medical condition exists and the review must not have more than a high school education nor medical training.	6.3	3.00	6.00	6.00	6.00	6.00	6.00
60	The MCE must maintain a UM program that integrates with other functional units as appropriate and supports the Quality Management and Improvement Program.	6.3	3.00	6.00	6.00	6.00	6.00	6.00
61	The UM program must have P&Ps and systems in place to assist UM staff to:							
	61.1 Identify instances of over- and under-utilization of emergency room services and other health care services	6.3	1.00	2.00	2.00	2.00	2.00	2.00
	61.2 Identify aberrant provider practice patterns	6.3	1.00	2.00	2.00	2.00	2.00	2.00
	61.3 Ensure active participation of a utilization review committee	6.3	1.00	2.00	2.00	2.00	2.00	2.00
	61.4 Evaluate efficiency and appropriateness of service delivery	6.3	1.00	2.00	2.00	2.00	2.00	2.00

Appendix D
Detailed Scoring for MCE Compliance with OMPP Contract Provisions and Federal Regulations

Scoring: 0 = Not Met; 1 = Partially Met; 2 = Fully Met

Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
	61.5 Incorporate subcontractor's performance data	6.3	1.00	2.00	2.00	2.00	2.00	2.00
	61.6 Facilitate program management and long-term quality	6.3	1.00	2.00	2.00	2.00	2.00	2.00
	61.7 Identify critical quality of care issues	6.3	1.00	2.00	2.00	2.00	2.00	2.00
62	The MCE's utilization management program must link members to disease management, case management and care management.	6.3	3.00	6.00	6.00	6.00	6.00	6.00
63	The MCE must identify those members that are high utilizers of emergency room services and/or other services and perform the necessary outreach and screening to assure the member's services are coordinated and that the member is aware of and participating in the appropriate disease management, case management or care management services.	6.3	2.00	4.00	4.00	4.00	4.00	4.00
64	MCEs shall monitor access to preventive care, specifically to identify members who are not accessing appropriate preventive care services in accordance with accepted standards such as AAP or ACOG.	6.3	3.00	6.00	6.00	6.00	6.00	6.00
65	The MCE must ensure that a physician, pharmacist or nurse confirms the appropriateness of the enrollment of a member into the Right Choices Program before the enrollment occurs.	6.3.1	3.00	6.00	6.00	6.00	6.00	6.00
66	The MCE shall evaluate and monitor the compliance of Right Choices Program members with his/her treatment plan to determine if RCP restrictions should terminate or continue.	6.3.1	3.00	6.00	6.00	6.00	6.00	6.00
67	Only licensed physicians and nurses may deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested.	6.3.2	5.00	10.00	10.00	10.00	10.00	10.00
68	The MCE must comply with all member requests for a second opinion from a qualified professional.	6.3.2	2.00	4.00	4.00	4.00	4.00	4.00
69	The MCE must notify members of standard authorization decisions in not to exceed 7 calendar days after the request for services.	6.3.2	5.00	10.00	10.00	10.00	10.00	10.00
70	The MCE must make an expedited authorization decision no later than 3 business days after receipt of the request for service.	6.3.2	5.00	10.00	10.00	10.00	10.00	10.00
71	For all denials of prior authorization requests, the MCE shall maintain a record of:							
	71.1 Name of caller	6.3.2	0.50	1.00	1.00	1.00	1.00	1.00
	71.2 Title of caller	6.3.2	0.50	1.00	1.00	1.00	1.00	1.00
	71.3 Date and time of call	6.3.2	0.50	1.00	1.00	1.00	1.00	1.00
	71.4 Clinical synopsis inclusive of: 1) timeframe of illness or condition; 2) diagnosis; and 3) treatment plan	6.3.2	0.50	1.00	1.00	1.00	1.00	1.00
	71.5 Clinical guideline(s) or other rationale supporting the denial	6.3.2	0.50	1.00	1.00	1.00	1.00	1.00
72	The MCE must provide a written notice to the member and provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice must contain the following:							
	72.1 The action the MCE or its MCE has taken or intends to take.	6.3.2	1.00	2.00	2.00	2.00	2.00	2.00
	72.2 The reasons for the action.	6.3.2	1.00	2.00	2.00	2.00	2.00	2.00
	72.3 The member's right to file an appeal with the MCE and the process for doing so.	6.3.2	0.50	1.00	1.00	1.00	1.00	1.00

Appendix D
Detailed Scoring for MCE Compliance with OMPP Contract Provisions and Federal Regulations

Scoring: 0 = Not Met; 1 = Partially Met; 2 = Fully Met

Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
	72.4 The member's right to request a State Fair Hearing and the process for doing so (after the member has exhausted the MCE's appeal process).	6.3.2	0.50	1.00	1.00	1.00	1.00	1.00
	72.5 Circumstances under which expedited resolution is available and how to request it.	6.3.2	0.25	0.50	0.50	0.50	0.50	0.50
	72.6 The member's right to have benefits continue pending the resolution of the appeal, how to request continued benefits and the circumstances under which the member may have to pay the costs of these services.	6.3.2	0.25	0.50	0.50	0.50	0.50	0.50
73	Letters to members indicating denial of an authorization request must be written at a fifth grade reading level.	6.3.2	2.00	4.00	4.00	4.00	4.00	4.00
74	The MCE must have a utilization management committee directed by the MCE's Medical Director.	6.3.4	3.00	6.00	6.00	6.00	6.00	6.00
	Module 4, Part II: Program Integrity							
75	Staffing levels for program integrity shall be, at minimum, equal to one FTE for every 100,000 members in addition to the Special Investigations Unit Manager and the Compliance Director.	7.0	3.00	6.00	6.00	6.00	6.00	6.00
76	Pursuant to 42 CFR 438.608, the MCE must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse and includes:							
	76.1 Written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all applicable state and federal standards.	7.1	2.00	4.00	4.00	4.00	4.00	4.00
	76.2 Designation of a SIU Manager, a Compliance Officer and Compliance Committee.	7.1	1.00	2.00	2.00	2.00	2.00	2.00
	76.3 The type and frequency of training (minimum annual) and education for the SIU Manager, Compliance Officer and the organization's employees who will be provided to detect fraud.	7.1	2.00	4.00	4.00	4.00	4.00	4.00
	76.4 Provision for internal monitoring and auditing.	7.1	2.00	4.00	4.00	4.00	4.00	4.00
	76.5 Procedures designed to prevent and detect fraud and abuse in the administration and delivery of services under this contract.	7.1	2.00	4.00	4.00	4.00	4.00	4.00
	76.6 A description of the specific controls in place for prevention and detection of fraud and abuse.	7.1	2.00	4.00	4.00	4.00	4.00	4.00
	76.7 Provision for prompt response to detected offenses and for development of corrective action initiatives.	7.1	2.00	4.00	4.00	4.00	4.00	4.00
	76.8 Program integrity-related goals, objectives and planned activities for the upcoming year.	7.1	2.00	4.00	4.00	4.00	4.00	4.00
77	The MCE shall have internal controls and policies and procedures in place that are designed to prevent, detect and report known or suspected waste, fraud and abuse activities.	7.2	2.00	4.00	4.00	4.00	4.00	4.00
78	The MCE conducts data mining, analytics and predictive modeling for the identification of potential overpayments and aberrant payments/providers warranting further investigation.	7.2	5.00	10.00	10.00	10.00	10.00	10.00
79	The MCE conducts provider profiling and peer comparisons of all provider types and specialties, at minimum annually.	7.2	3.00	6.00	6.00	6.00	6.00	6.00
80	The MCE has a procedure in place to comply with the submission of the quarterly Audit Report due to the FSSA PI Unit and the elements required.	7.3	2.00	4.00	4.00	4.00	4.00	4.00

Appendix D
Detailed Scoring for MCE Compliance with OMPP Contract Provisions and Federal Regulations

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Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
	Module 5, Part I: Member Services and Enrollee Rights							
81	Within five (5) calendar days of a new member's full enrollment, the MCE shall send the new member a Welcome Packet. The Welcome Packet shall include:							
	81.1 A new member letter	4.2.1	2.00	4.00	4.00	4.00	4.00	4.00
	81.2 Explanation of where to find information about the MCE's provider network	4.2.1	2.00	4.00	4.00	4.00	4.00	4.00
	81.3 The Member Handbook	4.2.1	2.00	4.00	4.00	4.00	4.00	4.00
	81.4 Member's ID Card	4.2.1	2.00	4.00	4.00	4.00	4.00	4.00
82	A member must be assigned to a PMP within 30 miles of their residence, and the MCE should consider any prior provider relationships when making a PMP auto assignment.	6.2.2	1.00	2.00	2.00	2.00	2.00	2.00
83	The MCE shall have written policies and procedures for allowing members to select a new PMP, including PMP auto-assignment, and provide information on options for selecting a new PMP when a PMP terminates, is non-compliant with provider standards, or when the change is ordered due to a grievance proceeding.	4.2.2	1.00	2.00	2.00	2.00	2.00	2.00
84	The Health Needs Screening (HNS) must be conducted within 90 calendar days of the MCE's receipt of a new member's fully eligible file form the State.	4.2.3	3.00	6.00	0.00	0.00	6.00	0.00
85	The initial HNS shall be followed by a detailed Comprehensive Health Assessment Tool (CHAT) by a health care professional when a member is identified through the HNS as having a special health care need.	4.2.3	3.00	6.00	6.00	6.00	6.00	6.00
86	The MCE shall keep up-to-date records of all members found to have special health care needs based on the initial screening, including documentation of the follow-up detailed CHAT and member contacts.	4.2.3	1.00	2.00	2.00	2.00	2.00	2.00
87	The MCE must maintain a system for tracking and reporting the number and type of members' calls and inquiries it receives during business hours and non-business hours.	4.3.1	5.00	10.00	10.00	10.00	10.00	10.00
88	The MCE's member services helpline staff must be prepared to efficiently respond to member concerns or issues.	4.3.1	5.00	10.00	10.00	10.00	10.00	10.00
89	The MCE shall respond to questions and concerns submitted by members electronically within 24 hours. If the response cannot be delivered within 24 hours, the MCE shall notify the member but a final response shall be provided within 3 business days.	4.3.2	3.00	6.00	6.00	6.00	6.00	6.00
90	The MCE shall inform members that information is available upon request in alternative formats and how to obtain them (e.g. Braille, large font, audiotape, other languages).	4.4	1.00	2.00	2.00	2.00	2.00	2.00
91	The MCE shall provide notification to OMPP, the enrollment broker and its members of any covered service that the MCE or any of its subcontractors do not cover on the basis of moral or religious grounds and guidelines for how and where to obtain those services in accordance with 42 CFR 438.102.	4.4	1.00	2.00	2.00	2.00	2.00	2.00
92	The MCE shall have in place policies and procedures to ensure that materials are accurate in content, accurate in translation and do not defraud, mislead or confuse the member.	4.4	2.00	4.00	4.00	4.00	4.00	4.00
93	The Member Handbook must include:							
	93.1 Contractor's contact information (address, telephone number, TDD number, website address)	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
	93.2 MCE's services and benefits	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
	93.3 The procedures for obtaining benefits, including authorization requirements	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00

Appendix D
Detailed Scoring for MCE Compliance with OMPP Contract Provisions and Federal Regulations

Scoring: 0 = Not Met; 1 = Partially Met; 2 = Fully Met

Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
93.4	Contractor's office hours and days, including the availability of a 24-hour Nurse Call Line	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.5	Any restrictions on the member's freedom of choice among network providers, as well as the extent to which members may obtain benefits	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.6	The extent to which, and how, after-hours and emergency coverage are provided	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.7	The post-stabilization care services rules set forth in 42 CFR 422.113(c)	4.4.1	0.50	1.00	1.00	0.00	1.00	1.00
93.8	The extent to which, and how, urgent care services are provided	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.9	Applicable policy on referrals for specialty care and other benefits not provided by the member's PMP	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.10	HIP pregnancy policy (HIP only)	7.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.11	HIP co-payments for emergency room services (HIP only)	7.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.12	Information about the availability of pharmacy services and how to access pharmacy services	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.13	Member rights and protections, as enumerated in 42 CFR 438.100	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.14	Responsibilities of members	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.15	Special benefit provisions (for example, co-payments, deductibles, limits or rejections of claims) that may apply to services obtained outside of the network	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.16	Procedures for obtaining out-of-network services	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.17	Standards and expectations to receive preventive health services	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.18	Policy on referrals to specialty care	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.19	Procedures for notifying members affected by termination or change in any benefits, services or service delivery sites	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.20	Procedures for appealing decisions adversely affecting members' coverage, benefits or relationship with the MCE	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.21	Procedures for changing PMPs	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.22	Standard and procedures for changing MCEs	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.23	Process for submitting disenrollment requests	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.24	The process by which an American Indian/ Alaska Native member may elect to opt-out of managed care pursuant to 42 USC § 1396u–2(a)(2)(C) and transfer to fee-for-service benefits through the State	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.25	Procedures for making complaints, filing grievances and recommending changes in policies and	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.26	Grievance, appeal and fair hearing procedures as required at 42 CFR 438.10(g)(1)	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.27	For a State hearing describe (i) the right to a hearing, (ii) the method for obtaining a hearing, and (iii) the rules that govern representation at the hearing.	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.28	Information about advance directives	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.29	Process on how to report a change in income, change in family size, etc.	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.30	Information about the availability of the prior claims payment program for certain members and how to access the program administrator	4.4.1	0.25	0.50	0.50	0.50	0.50	0.50
93.31	Information on alternative methods or formats of communication for visually and hearing-impaired and non-English speaking members and how members can access those methods or formats.	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.32	Information on how to contact the Enrollment Broker	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00
93.33	Statement that MCE will provide information on the structure and operation of the health plan	4.4.1	0.25	0.50	0.50	0.50	0.50	0.50
93.34	In accordance with 42 CFR 438.6(h), that upon request of the member, information on the MCE's provider incentive plans will be provided.	4.4.1	0.50	1.00	1.00	1.00	1.00	1.00

Appendix D
Detailed Scoring for MCE Compliance with OMPP Contract Provisions and Federal Regulations

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Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
94	The MCE must provide information to members through a website that contains:							
	94.1 The MCE's provider network identifying each provider's specialty, service location(s), hours of operation, phone numbers, public transportation access, languages spoken by the provider or provider's office staff, lists of hospital providers, home care providers and all other network providers, and whether the provider is accepting new members.	4.4.2	1.00	2.00	2.00	2.00	2.00	2.00
	94.2 The MCE's contact information for member inquiries, member grievances and appeals.	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.3 The MCE's member services phone number, TDD number, hours of operation and after-hours access numbers, including the 24-hour Nurse Call Line	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.4 A member portal with access to electronic Explanation of Benefit (EOB) statements. Preventive care and wellness information.	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.5 For HIP members, the member portal shall also include up-to-date POWER Account balance information, including the required annual and monthly contribution amounts and payments made for HIP Plus or HIP State Plan Plus members.	7.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.6 For HHW, information about well child visits and prenatal services.	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.7 Information about the cost and quality of health care services.	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.8 A description of the MCE's disease management programs and care coordination services	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.9 The member's rights and responsibilities, as enumerated in 42 CFR 438.100.	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.10 The member handbook information.	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.11 MCE-distributed literature regarding all health or wellness promotion programs that the MCE offers.	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.12 MCE's marketing brochures and posters.	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.13 The HIPAA privacy statement.	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.14 Links to OMPP's website for general Medicaid, HHW or HIP information.	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.15 Information on pharmacy locations and preferred drug lists applicable to each program and benefit package	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.16 List of all prior authorization criteria for prescription drugs, including mental health drugs	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.17 Transportation access information.	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.18 Information about how to access dental services and how to access the MCE's dental network.	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.19 A list and brief description of each of the MCE's member outreach and education materials.	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.20 Information on behavioral health covered services and resources.	4.4.2	0.50	1.00	1.00	1.00	1.00	1.00
	94.21 A secure portal through which members may complete the health screening questionnaire.	4.4.2	1.00	2.00	2.00	2.00	2.00	2.00
95	POWER Account educational materials must include, at minimum, information about opportunities for employer participation, non-payment policies, requesting a POWER Account recalculation, and rollover policies.	7.4.4.2	1.00	2.00	2.00	2.00	2.00	2.00
96	Provider quality information must also be made available to members. The MCE must capture quality information about its network providers, and must make this information available to members.	4.4.5	1.00	2.00	2.00	2.00	2.00	2.00
97	The MCE shall comply with 42 CFR 438.102 which relates to provider-enrollee communications.	4.7	1.00	2.00	2.00	2.00	2.00	2.00
98	The MCE must have written policies in place regarding the rights protected under 42 CFR 438.100 to its members.	4.8	1.00	2.00	2.00	2.00	2.00	2.00

Appendix D
Detailed Scoring for MCE Compliance with OMPP Contract Provisions and Federal Regulations

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Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
99	The MCE shall arrange for free oral interpretation services to its members for the services it provides in accordance with 42 CFR 438.1c(4).	4.10	1.00	2.00	2.00	2.00	2.00	2.00
100	The MCE shall incorporate the Office of Minority Health's CLAS standards into the provision of health care services to its members.	4.11	2.00	4.00	4.00	4.00	4.00	4.00
101	The MCE shall comply with 42 CFR 422.128 which relates to maintaining written policies and procedures for advance directives.	4.12	1.00	2.00	2.00	2.00	2.00	2.00
	Module 5, Part II: Grievances and Appeals							
102	The MCE shall establish written policies and procedures governing the resolution of grievances and appeals in accordance with 42 CFR 438.10(g)(1).	4.9	5.00	10.00	10.00	10.00	10.00	10.00
103	The MCE's policies for recordkeeping and reporting of grievances and appeals, must comply with 42 CFR 438, Subpart F and the Managed Care Policies and Procedures Manual.	4.9	4.00	8.00	8.00	8.00	8.00	8.00
104	The MCE must notify members of the disposition of grievances and appeals pursuant to IC 27-13-10-7 or IC 27-8-28-16, where applicable.	4.9.1	3.00	6.00	6.00	6.00	6.00	6.00
105	The Contractor shall provide members any reasonable assistance in completing forms and taking other procedural steps, including but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	4.9.1	2.00	4.00	4.00	4.00	4.00	4.00
106	The MCE must ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making and are health care professionals with appropriate clinical expertise in treating the member's condition or disease if the decision will be in regard to any of the following: (i) an appeal of a denial based on lack of medical necessity; (ii) a grievance regarding denial of expedited resolution of an appeal; and (iii) any grievance or appeal involving clinical issues.	4.9.1	2.00	4.00	4.00	4.00	4.00	4.00

Appendix D
Detailed Scoring for MCE Compliance with OMPP Contract Provisions and Federal Regulations

Scoring: 0 = Not Met; 1 = Partially Met; 2 = Fully Met

Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
107	The MCE's P&P governing appeals shall include provisions which address:							
	107.1 The MCE shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member.	4.9.1	1.00	2.00	2.00	2.00	2.00	2.00
	107.2 A provider, acting on behalf of the member and with the member's written consent, may file an appeal.	4.9.1	1.00	2.00	2.00	2.00	2.00	2.00
	107.3 The MCE must not take punitive action against a provider who requests or supports an expedited appeal on behalf of a member.	4.9.1	1.00	2.00	2.00	2.00	2.00	2.00
	107.4 Throughout the appeals process, the MCE must consider the member or representative as parties to the appeal.	4.9.1	1.00	2.00	2.00	2.00	2.00	2.00
	107.5 Allow the member and member representative an opportunity to examine the member's case file, including medical records.	4.9.1	1.00	2.00	2.00	2.00	2.00	2.00
	107.6 Allow the member and member representative to present evidence, and allegations of fact or law, in person or in writing.	4.9.1	1.00	2.00	2.00	2.00	2.00	2.00
	107.7 Upon determination of the appeal, ensure there is no delay in notification or mailing to the member.	4.9.1	1.00	2.00	2.00	2.00	2.00	2.00
108	The MCE must acknowledge receipt of each standard appeal within three business days.	4.9.3	3.00	6.00	6.00	6.00	6.00	6.00
109	The MCE shall make a decision on standard, non-expedited appeals within 30 calendar days of receipt of the appeal.	4.9.3	3.00	6.00	6.00	6.00	6.00	6.00
110	The MCE shall make a decision on expedited appeals within 48 hours of receipt of the appeal.	4.9.3	3.00	6.00	6.00	6.00	6.00	6.00
111	The MCE's appeals process must do the following:							
	111.1 Allow members, or providers acting on the member's behalf, 33 calendar days from the date of action notice within which to file an appeal.	4.9.3	1.00	2.00	2.00	2.00	2.00	2.00
	111.2 Ensure that oral requests seeking to appeal an action are treated as appeals.	4.9.3	1.00	2.00	2.00	2.00	2.00	2.00
	111.3 Maintain an expedited review process (within 48 hours) for appeals when the MCE or the member's provider determines its necessity.	4.9.3	1.00	2.00	2.00	2.00	2.00	2.00
	111.4 If the MCE denies the request for an expedited resolution of an appeal, the MCE transfers the appeal to the standard 30 business day timeframe and gives the member written notice of the denial within 2 days of the expedited appeal request.	4.9.3	1.00	2.00	2.00	2.00	2.00	2.00
112	Within thirty-three (33) calendar days from the date of the Contractor's decision, a member, or a member's representative may file a written request for a review of the Contractor's decision by an independent review organization (IRO).	4.9.4	2.00	4.00	4.00	4.00	4.00	4.00
113	Within 33 calendar days of exhausting the MCE's internal processes, the member may request an FSSA fair hearing.	4.9.5	2.00	4.00	4.00	4.00	4.00	4.00

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Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
	Module 6: Provider Network Management, Contracting and Relations							
114	The MCE shall ensure that its provider network is supported by written provider agreements, is available and geographically accessible and provides adequate numbers of facilities, physicians, pharmacies, ancillary providers, service locations and personnel for the provision of high-quality covered services for its members.	5.0	5.00	10.00	10.00	10.00	10.00	10.00
115	The Contractor shall also ensure that all of its contracted providers can respond to the cultural, racial and linguistic needs of its member populations.	5.0	2.00	4.00	4.00	4.00	4.00	4.00
116	The network must be able to handle the unique needs of its members, particularly those with special health care needs (i.e., direct access to specialists).	5.0	2.00	4.00	4.00	4.00	4.00	4.00
117	The MCE must ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members, if the MCE also serves commercial members.	5.2	2.00	4.00	4.00	4.00	4.00	4.00
118	As required under 42 CFR 438.206, the MCE must also make covered services available 24 hours-a-day, 7 days-a-week, when medically necessary. In meeting these requirements, the MCE must establish mechanisms to ensure compliance by providers.	5.2.2	2.00	4.00	4.00	4.00	4.00	4.00
119	The MCE must monitor providers regularly to determine compliance with the 24/7 availability provision and take corrective action if there is a failure to comply.	5.2.2	3.00	6.00	6.00	6.00	6.00	6.00
120	The MCE must monitor medical care standards to evaluate access to care and quality of services provided to members and to evaluate providers regarding their practice patterns.	5.2.2	2.00	4.00	4.00	4.00	4.00	4.00
121	The MCE must develop and maintain a comprehensive network of specialty providers (the MCE must have two providers within 60 miles of the member's residence for 21 specialties and within 90 miles for 10 other specialties).	5.2.3	5.00	10.00	10.00	10.00	10.00	10.00
122	The MCE must maintain two durable medical equipment providers and two home health providers to the MCE's members in each county or contiguous county.	5.2.3	2.00	4.00	4.00	4.00	4.00	4.00
123	In urban areas, the MCE must provide at least one behavioral health provider within 30 minutes or 30 miles; in rural areas, one within 45 minutes or 45 miles.	5.2.5	5.00	10.00	10.00	10.00	10.00	10.00
124	The MCE shall ensure the availability of general or family dentistry within 30 miles of each member's residence; for specialty dental services, within 60 miles.	5.2.7	2.00	4.00	4.00	2.00	4.00	4.00
125	MCEs must plan for, develop and/or enhance relationships with school-based health centers (SBHCs) with the goal of providing accessible quality preventive and primary health care services to school-aged Hoosier Healthwise members.	5.2.10	1.00	2.00	2.00	1.00	2.00	2.00
126	The MCE shall affiliate or contract with urgent care clinics and strongly encourages affiliating or contracting with non-traditional urgent care (retail) clinics.	5.2.13	1.00	2.00	2.00	2.00	2.00	2.00
127	The MCE must have written credentialing and re-credentialing policies and procedures for ensuring quality of care is maintained or improved and assuring that all contracted providers hold current state licensure and enrollment in the IHCP.	5.5	2.00	4.00	4.00	4.00	4.00	4.00

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Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
128	The MCE shall educate its contracted providers, including BH providers, regarding provider requirements and responsibilities, PA policies and procedures, clinical protocols, member rights, claims submission process, claims dispute process, program integrity, fraud and abuse, and P4P.	5.7	3.00	6.00	6.00	6.00	6.00	6.00
129	The MCE shall give providers at least 45 calendar days notice of any material changes that may affect providers' procedures.	5.8	1.00	2.00	1.00	1.00	2.00	1.00
130	The MCE must maintain a system for tracking and reporting the number and type of provider' calls and inquiries.	5.8.2	3.00	6.00	6.00	6.00	6.00	6.00
131	The MCE shall develop policies and procedures to prohibit the payment of charges for certain hospital acquired conditions and "never events".	5.9	1.00	2.00	2.00	2.00	2.00	2.00
132	The provider agreements must meet the following requirements:							
	132.1 Describe a written provider claim dispute resolution process.	5.4	0.50	1.00	1.00	1.00	1.00	1.00
	132.2 Require each provider to maintain a current IHCP provider agreement and to be duly licensed in accordance with the appropriate state licensing board and in good standing.	5.4	0.50	1.00	1.00	1.00	1.00	1.00
	132.3 Require each provider to submit all claims that do not involve a third party payer for services within 90 calendar days from the date of service.	5.4	0.50	1.00	1.00	1.00	1.00	1.00
	132.4 Require each provider to utilize the Indiana Health Coverage Program Prior Authorization Request Form available on the Indiana Medicaid website for submission of prior authorization requests to the MCE.	5.4	0.50	1.00	1.00	1.00	1.00	1.00
	132.5 Include a termination clause stipulating that the MCE must terminate its contractual relationship with the provider as soon as the MCE has knowledge that the provider's license or IHCP provider agreement has been terminated.	5.4	0.50	1.00	1.00	1.00	1.00	1.00
	132.6 Terminate the provider's agreement to serve the MCE's members at the end of the Contract with the State.	5.4	0.50	1.00	1.00	1.00	1.00	1.00
	132.7 Monitor providers and apply corrective actions for those who are out of compliance with FSSA's or MCE standards.	5.4	0.50	1.00	1.00	1.00	1.00	1.00
	132.8 Obligate the terminating provider to submit all encounter claims for services rendered.	5.4	0.50	1.00	1.00	1.00	1.00	1.00
	132.9 Not obligate the provider to participate under exclusivity agreements that prohibit the provider from contracting with other state MCEs.	5.4	0.50	1.00	1.00	1.00	1.00	1.00
	132.10 Provide the PMP with the option to terminate the agreement without cause with advance notice. Said advance notice shall not have to be more that ninety (90) calendar days.	5.4	0.50	1.00	1.00	1.00	1.00	1.00
	132.11 Provide a copy of a member's medical record at no charge upon reasonable request by the member.	5.4	0.50	1.00	1.00	1.00	1.00	1.00
	132.12 Require each provider to agree that it shall not seek payment from the State for any service rendered to a member.	5.4	0.25	0.50	0.50	0.50	0.50	0.50
	132.13 For behavioral health providers, require that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within seven (7) calendar days from the date of the member's discharge.	5.4	0.25	0.50	0.50	0.50	0.50	0.50

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Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
	132.14 Require each provider to agree to use best commercial efforts to collect required copayments for services rendered Package C members	5.4	0.25	0.50	0.50	0.50	0.50	0.50
133	The provider Policies & Procedures Manual must include the following information:							
	133.1 Benefits and limitations	5.7.2	0.50	1.00	1.00	1.00	1.00	1.00
	133.2 Claims filing instructions	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
	133.3 Criteria and process to use when requesting prior authorization	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
	133.4 Definition and requirements related to urgent and emergent care	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
	133.5 Participants' rights	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
	133.6 Provider' rights for advising or advocating on behalf of his or her patient	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
	133.7 Provider non-discrimination information	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
	133.8 Policies and procedures for grievances and appeals in accordance with 42 CFR 438.414	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
	133.9 Frequently asked questions and answers	5.8.1	0.25	0.50	0.50	0.50	0.50	0.50
	133.1 MCE, FSSA and OMPP contract information	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
134	The provider website must have the following information available:							
	134.1 MCE's contact information	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
	134.2 Provider Policy and Procedure Manual and forms	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
	134.3 All of MCE's provider communication materials, organized online in a user-friendly, searchable format by communication type and topic	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
	134.4 A link to the State's preferred drug list	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
	134.5 Claim submission information	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
	134.6 Provider claims dispute resolution procedures for contracted and out-of-network providers	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
	134.7 Prior authorization procedures, including a complete list of services which require prior authorization	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
	134.8 Appeal procedures	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
	134.9 Entire network provider listings	5.8.1	0.50	1.00	1.00	1.00	1.00	1.00
	134.10 Links to FSAA and OMPP's website for general Medicaid, HHW or HIP information	5.8.1	0.25	0.50	0.50	0.50	0.50	0.50
	134.11 HIPAA and 42 CFR Part 2 Privacy Policy and Procedures	5.8.1	0.25	0.50	0.50	0.50	0.50	0.50

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Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
	Module 7: Disease, Case and Care Management							
135	The MCE shall employ or contract with case managers with training, expertise and experience in providing case management services for members receiving behavioral health services.	3.7.3	5.00	10.00	10.00	10.00	10.00	10.00
136	At a minimum, the MCE shall provide case management services for members discharged from an inpatient psychiatric or substance abuse hospitalization for no fewer than 90 days following hospitalization.	3.7.3	3.00	6.00	6.00	6.00	6.00	6.00
137	With the appropriate consent, case managers shall notify both PMPs and behavioral health providers when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. This notice must be provided within 5 calendar days of the inpatient admission or emergency treatment.	3.7.4	2.00	4.00	4.00	4.00	4.00	4.00
138	The MCEs shall, on at least a quarterly basis, send a behavioral health profile to the respective PMP. The profile lists the physical and behavioral health treatment received by that member during the previous reporting period.	3.7.4	2.00	4.00	4.00	4.00	4.00	4.00
139	The MCE will contractually mandate that its behavioral health care network providers notify a member's MCE within five (5) calendar days of the member's visit, and submit information about the treatment plan, the member's diagnosis, medications, and other pertinent information.	3.7.4	2.00	4.00	4.00	4.00	4.00	4.00
140	MCEs shall, at a minimum, establish referral agreements and liaisons with both contracted and non-contracted CMHCs, and shall provide physical health and other medical information to the appropriate CMHC for every member.	3.7.4	2.00	4.00	4.00	4.00	4.00	4.00
141	MCEs shall offer, at a minimum, the following disease management programs:							
	141.1 Asthma	3.8	1.00	2.00	2.00	2.00	2.00	2.00
	141.2 Depression	3.8	1.00	2.00	2.00	2.00	2.00	2.00
	141.3 Pregnancy	3.8	1.00	2.00	2.00	2.00	2.00	2.00
	141.4 ADHD	3.8	1.00	2.00	2.00	2.00	2.00	2.00
	141.5 Autism/pervasive developmental disorder	3.8	1.00	2.00	2.00	2.00	2.00	2.00
	141.6 COPD	3.8	1.00	2.00	2.00	2.00	2.00	2.00
	141.7 Coronary artery disease	3.8	1.00	2.00	2.00	2.00	2.00	2.00
	141.8 Chronic kidney disease	3.8	1.00	2.00	2.00	2.00	2.00	2.00
	141.9 Congestive heart failure	3.8	1.00	2.00	2.00	2.00	2.00	2.00
	141.10 HIV	3.8	1.00	2.00	2.00	2.00	2.00	2.00
	141.11 Hepatitis C	3.8	1.00	2.00	2.00	2.00	2.00	2.00
142	All members identified with the conditions of interest in the MCE's disease management program shall receive materials no less than bi-annually. May be delivered by postal mail, IVR, web-based, email.	3.8.1	3.00	6.00	6.00	6.00	6.00	6.00
143	The MCE shall document the number of persons with each condition of interest in disease management, the number of mailings and the number of website hits.	3.8.1	2.00	4.00	4.00	2.00	4.00	4.00

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Review Item #	Review Item	HIP Contract Reference	Weight for Item	Max Score	Score Assigned to Each MCE			
					Anthem	Care Source	MDwise	MHS
144	All members identified with the conditions of interest in the MCE's care management program shall receive materials no less than bi-annually. May be delivered by postal mail, IVR, web-based, email; however, the MCE shall make every effort to contact members telephonically.	3.8.2	3.00	6.00	6.00	6.00	6.00	6.00
145	The MCE shall document the number of persons with each condition of interest in care management, the number of telephone contacts, category of intervention, intervention delivered, mailings and website hits.	3.8.2	4.00	8.00	8.00	8.00	8.00	8.00
146	Persons with clinical medical training shall be required to develop the member's complex case management plan. The Medical Director shall be available for consultation, as needed.	3.8.3	2.00	4.00	4.00	4.00	4.00	4.00
147	Care plans for individuals in complex case management shall include							
	147.1 clearly stated health care goals,	3.8.3	1.00	2.00	2.00	2.00	2.00	2.00
	147.2 defined milestones to document progress,	3.8.3	1.00	2.00	2.00	2.00	2.00	2.00
	147.3 clearly defined accountability and responsibility, and	3.8.3	1.00	2.00	2.00	2.00	2.00	2.00
	147.4 thorough review with appropriate corrections as indicated.	3.8.3	1.00	2.00	2.00	2.00	2.00	2.00
148	The MCE's case management services shall involve the active management of the member and his/her group of health care providers.	3.8.3	1.00	2.00	2.00	2.00	2.00	2.00
149	The member's health care providers shall be included in the development and execution of member care plans.	3.8.3	1.00	2.00	2.00	2.00	2.00	2.00
150	The MCE shall contact members enrolled in complex case management telephonically and in-person as indicated by their need.	3.8.3	2.00	4.00	4.00	4.00	4.00	4.00
151	The MCE shall document the number of persons with each condition of interest in complex case management, the number of outbound telephone contacts to providers and members, category of intervention, intervention delivered, mailings and website hits.	3.8.3	4.00	8.00	8.00	8.00	8.00	8.00
152	Case managers shall regularly and routinely consult with both the member’s physical and behavioral health providers to facilitate the sharing of clinical information, and the development and maintenance of a coordinated physical health and behavioral health treatment plan for the member.	3.7.3	2.00	4.00	4.00	4.00	4.00	4.00
153	Case managers shall notify both PMPs and behavioral health providers when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. Case managers must provide this notification within five (5) calendar days of the hospital admission or emergency treatment.	3.7.3	2.00	4.00	4.00	4.00	4.00	4.00
154	Utilization statistics on hospitalizations, emergency services, primary care and specialty care shall be documented and trended from baseline for individuals enrolled in complex case management.	3.8.3	2.00	4.00	4.00	2.00	4.00	4.00
155	The MCE must have mechanisms in place to ensure the continuity of care and coordination of medically necessary health care services for its members.	3.13	1.00	2.00	2.00	2.00	2.00	2.00

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					Anthem	Care Source	MDwise	MHS
	Module 8: Quality Management							
156	The MCE must meet the requirements of 42 CFR 438 subpart D and the NCQA, including the requirements listed below, in developing its Quality Management and Improvement Program and the Quality Management and Improvement Work Plan.							
	156.1 Include developing and maintaining an annual Quality Management and Improvement Work Plan	6.1	5.00	10.00	10.00	10.00	10.00	10.00
	156.2 Have in effect mechanisms to detect both underutilization and overutilization of services which are documented.	6.1	3.00	6.00	6.00	6.00	6.00	6.00
	156.3 Have written policies and procedures for quality improvement. Policies and procedures must include methods, timelines and individuals responsible for completing each task.	6.1	3.00	6.00	6.00	6.00	6.00	6.00
	156.4 Incorporate an internal system for monitoring services.	6.1	3.00	6.00	6.00	6.00	6.00	6.00
	156.5 Use HEDIS rate data and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members.	6.1	2.00	4.00	4.00	4.00	4.00	4.00
	156.6 Collect measurement indicator data related to areas of clinical priority and quality of care.	6.1	2.00	4.00	4.00	4.00	4.00	4.00
	156.7 Have procedures for collecting and assuring accuracy, validity and reliability of performance outcome rates that are consistent with protocols developed in the public or private sector.	6.1	3.00	6.00	6.00	6.00	6.00	6.00
	156.8 Develop and maintain a physician incentive program.	6.1	2.00	4.00	4.00	0.00	4.00	4.00
	156.9 Develop and maintain a member incentive program.	6.1	2.00	4.00	4.00	4.00	4.00	4.00
	156.10 Contract for an NCQA-accredited HEDIS audit and report audited HEDIS rates.	6.1	5.00	10.00	10.00	10.00	10.00	10.00
	156.11 Conduct a CAHPS survey and report survey results, one for HHW and another for HIP.	6.1	3.00	6.00	6.00	6.00	6.00	6.00
	156.12 Include a provider relations project annually.	6.1	2.00	4.00	4.00	4.00	4.00	0.00
157	The MCE shall establish an internal Quality Management and Improvement Committee to develop, approve, monitor and evaluate the Quality Management and Improvement Program and Work Plan.	6.1.1	5.00	10.00	10.00	10.00	10.00	10.00
158	The MCE's Medical Director and Pharmacy Director shall be an active participant in the MCE's Quality Management and Improvement Committee.	6.1.1	5.00	10.00	10.00	10.00	0.00	10.00
159	The MCE must have a structure in place that is incorporated into, and formally supports, the MCE's internal Quality Management and Improvement Committee and Quality Management and Improvement Work Plan.	6.1.1	5.00	10.00	10.00	10.00	10.00	10.00