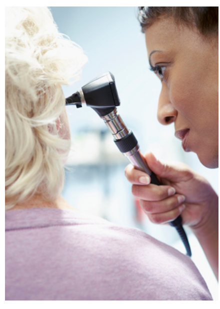
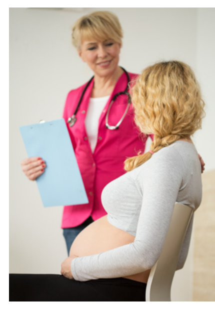




External Quality Review of Indiana's Care Programs: Hoosier Healthwise, Hoosier Care Connect and HIP 2.0 Review Year Calendar 2018

BURNS & ASSOCIATES, INC.
Health Policy Consultants

3030 North Third Street, Suite 200
Phoenix, AZ 85012
(602) 241-8520
www.burnshealthpolicy.com

FINAL REPORT
2019 External Quality Review of Indiana's Health Coverage Programs:
Hoosier Healthwise, Hoosier Care Connect and Healthy Indiana Plan

ACKNOWLEDGMENTS

The CY 2019 External Quality Review Team included the following individuals who served as reviewers and/or report contributors:

Burns & Associates Staff
Mark Podrazik, Project Director
Jesse Eng, SAS Programmer
Akhilesh Pasupulati, SAS Programmer
Ryan Sandhaus, SAS Programmer
Barry Smith, Analyst

Additional Principal Reviewer Staff
Linda Gunn, Ph.D., A.G.S. Consulting, Inc.
Kristy Lawrance, Lawrance Policy Consulting, LLC

Burns & Associates, Inc. would like to thank the staff at Anthem, CareSource, Managed Health Services and MDwise for their assistance in providing documentation and assistance in planning for the onsite portion of this review. We would also like to thank Susan Beecher and Meredith Edwards at the Office of Medicaid Policy and Planning for their assistance during the course of this study.

Inquiries may be sent to
mpodrazik@burnshealthpolicy.com

BURNS & ASSOCIATES, INC.
Health Policy Consultants

3030 NORTH THIRD STREET, SUITE 200
PHOENIX, AZ 85012
(602) 241-8520

TABLE OF CONTENTS

Abbreviations List
Executive Summary

Section I: Overview of Indiana's Medicaid Managed Care Programs
Introduction I-1
Enrollment at a Glance I-3
Indiana Medicaid's CY 2018 Quality Strategy Plan I-7

Section II: Approach to this Year's External Quality Review
Introduction II-1
EQR Activities in CY 2019 .... II-1
The EQR Review Team II-3

Section III: Validation of Performance Measures
Introduction III-1
Goals of the Reporting Manual Redesign Process III-2
Process Used to Redesign the Reporting Manuals III-4
Outcomes from the Continuous Quality Improvement Process III-5

Section IV: Validation of Performance Improvement Projects
Introduction IV-1
Methodology Related to the Validation Process IV-2
Quality Improvement Projects Reviewed IV-2
Summary of Findings IV-4
Individual MCE Profiles and Recommendations to Each MCE IV-7

Section V: Examination of Provider Network Adequacy
Introduction V-1
Methodology to Conduct the Review of Network Adequacy V-1
Findings from the Review of Access to Services by Provider Specialty V-3
Comparison to Previous EQRs V-10
Recommendations V-10

Section VI: Focus Study on Audit of Provider Directories
Introduction VI-1
Methodology for Conducting the Study VI-1
Findings VI-3
Comparison to Previous EQRs VI-7
Recommendations VI-7

Section VII: Focus Study on Potentially Preventable Emergency Department Visits
Introduction VII-1
Background on Potentially Preventable Emergency Department Visits VII-1
Methodology for Defining the Study Sample VII-2
Findings from the Review of the Study Sample VII-4
Comparison to Previous EQRs VII-11
Recommendations VII-11

Section VIII: Focus Study on Preventive Care for Adults and Well Visits for Children

Introduction VIII-1
Background VIII-2
Methodology for Defining the Study Sample VIII-4
Findings VIII-7
Comparison to Previous EQRs VIII-24
Recommendations VIII-15

Section IX: Focus Study on the Delivery of Prenatal Care Services

Introduction IX-1
Background IX-1
Methodology for Defining the Study Sample IX-3
Findings IX-4
Comparison to Previous EQRs IX-13
Recommendations IX-13

Section X: Focus Study on the Health Needs Screening Tool

Introduction X-1
Methodology X-1
Key Findings X-3
Recommendations X-10

Appendix A: Map of Indiana's 92 Counties to Eight Regions

Appendix B: 2018 External Quality Review Guide with Data Request Appendix

ABBREVIATIONS LIST

Abbrev	Meaning
AAP	Adult Access to Preventive/Ambulatory Health Svc
ACOG	American College of Obstetricians & Gynecologists
ACRG	Aggregated Clinical Risk Group
ADT	Admission/Discharge/Transfer
ADV	Annual Dental Visit
AIDS	Acquired immunodeficiency syndrome
AMB	Ambulatory Care
AMB-ED	Ambulatory Emergency Department Visit Rate
AOD	Alcohol or Other Drug Dependence
APR-DRG	All Patient Refined Diagnostic Related Grouping
B&A	Burns & Associates, Inc.
CFR	Code of Federal Regulations
CHAT	Comprehensive Health Assessment Tool
CHIP	Children's Health Insurance Program
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CR/CM	Care or Case Management
CRG	Clinical Risk Group
CY	Calendar Year
DRG	Diagnosis-Related Group
DXC	DXC Technology (OMPP's fiscal agent)
E&M	Evaluation and Management
EAPG	Enhanced Ambulatory Patient Groupings
ED	Emergency Department
EDW	Enterprise Data Warehouse
EPSDT	Early Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
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
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set

Abbrev	Meaning
HCC	Hoosier Care Connect
HHW	Hoosier Healthwise
HIP	Healthy Indiana Plan 2.0
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HNS	Health Needs Screening
IET	Initiation and Engagement of Alcohol & Drug Dependence Treatment
IHCP	Indiana Health Coverage Programs
LSC	Lead Screening in Children
MCE	Managed Care Entity
MCO	Managed Care Organization
MHIN	Michiana Health Information Network
MHS	Managed Health Services
N/A	Not Applicable
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
OB-GYN	Obstetrics and Gynecology
OMPP	Office of Medicaid Policy and Planning
P4O	Pay For Outcomes
PDF	Portable Document Format
PE	Presumptive Eligibility
PIPs	Performance Improvement Projects
PMP	Primary Medical Provider
POWER	Personal Wellness and Responsibility Account
PPC	Prenatal and Postpartum Care
PPR	Potentially Preventable Hospital Readmissions
PPV	Potentially Preventable Emergency Department Visits
PTSD	Post-Traumatic Stress Disorder
QIP	Quality Improvement Project
RCP	Right Choices Program
RID	Medicaid Recipient ID
RSV	Respiratory syncytial virus
SAS	Statistical Analysis System
SED/SMI	Serious Emotional Disturbance/Serious Mental Illness
SUD	Substance Use Disorder
UCC	Urgent Care Centers

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 uninsured custodial parents and caretakers of Medicaid and CHIP children as well as noncustodial 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. 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.

In CY 2018, 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, a McLaren company, has also been participating in HHW since its inception. 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.

---

[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.

Net enrollment in Indiana Medicaid's program decreased by almost 63,000, or 4.3 percent, from the end of CY 2017 to the end of CY 2018. Enrollment in the three managed care programs combined fell by almost 80,000 members, or 6.9 percent, during CY 2018. Enrollment in fee-for-service increased by almost 17,000 individuals, or 5.3 percent. Some of this is due to a change in the treatment of individuals who are deemed to be presumptively eligible for Medicaid (PE). Prior to CY 2018, individuals with PE status were automatically enrolled in managed care. Now, these individuals are enrolled in fee-for-service until their Medicaid eligibility status is confirmed.

At the end of CY 2018, the overall managed care enrollment for Indiana Medicaid was 76.3 percent of total 1.41 million enrollees.[3] Anthem has 40 percent of total managed care enrollment across the three programs; CareSource has 9 percent; MDwise has 28 percent; and MHS has 23 percent.

EQRO Activities in CY 2019

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. 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 2019 EQR is MCE activities that occurred in CY 2018. Topics included:

- Validation of Performance Measures through the Redesign of the MCE Reporting Manuals
- Validation of MCE Performance Improvement Projects (Quality Improvement Projects, QIPs)
- Examination of Provider Network Adequacy at Each MCE
- Optional EQR Activity: Focus Study on Validation of Provider Directories
- Optional EQR Activity: Focus Study on Potentially Preventable Emergency Department Visits
- Optional EQR Activity: Focus Study on Preventive Care for Adults and Well Visits for Children
- Optional EQR Activity: Focus Study on the Delivery of Prenatal Care Services
- Optional EQR Activity: Focus Study on the Health Needs Screening Tool

The redesign of the MCE Reporting Manuals substantially occurred during January through March, 2019. All of the other EQR tasks were conducted during April through September, 2019. For most activities in the EQR, a desk review was conducted first. With the exception of the Reporting Manual project in which meetings were held with the OMPP and all MCEs together, the onsite meetings for other tasks were conducted with each MCE individually. In total, six meetings were held on the Reporting Manual and 16 meetings were held with the MCEs (four meetings for each of the four MCEs). There were seven individuals on B&A's EQR Review Team this year.

Validation of Performance Measures

The OMPP developed report templates that were created in a Reporting Manual. There were three Reporting Manuals, one for each managed care program. Many of the reports were common to all three programs; however, over the years the elements on some reports or specifications changed in one manual and not another. Since the MCEs contract with more than one OMPP program, this added confusion in reporting. Further, B&A learned through previous EQRs in validating measures from these reports that instructions were being interpreted differently by the MCEs which impacted what was submitted on reports.

---

[3] Source: OMPP Enterprise Data Warehouse as of August 2019.

In an effort to streamline the maintenance of reports and the validation and review of reports by OMPP staff, the B&A Team compiled the templates from 75 reports in the HHW manual, 101 reports in the HIP manual, and 86 reports in the HCC manual. The reports were cross-walked across the three Reporting Manuals to determine which reports were common to more than one program and which were unique to a specific program. Every report was given a provisional assignment of eliminate, retain with changes, or retain with no changes.

For reports that were to be retained, B&A reviewed the data elements on each report and the instructions that accompanied the report. Items were tracked as questions to OMPP subject matter experts. The entire series of reports were divided into four working sessions. B&A first met internally with the OMPP team one week, then the all-MCE team the following week to go over reports in each section.

After these meetings concluded, the B&A team documented the changes that were agreed upon either for the report templates or the instructions that accompany it. B&A created new report templates that added automatic calculation fields and new validation fields. B&A also made substantial changes to the instructions from the previous Reporting Manuals.

A fifth meeting was held with the MCEs to review all changes. The MCEs used the new reporting templates and instructions to fill out required information for Q1 2019. Reports were delivered to the OMPP by May 31, 2019. The OMPP team and B&A collectively conducted a validation review of the data that was submitted.

After the Reporting Manual was released, B&A worked with the OMPP Quality Team in June 2019 to create 12 dashboard reports that dynamically link key measures submitted by the MCEs from the quarterly reports in the Reporting Manual. Each dashboard is formatted on one page in landscape format. The dashboard contains up to four measures and allows for up to four quarters of trend reporting. Results for a specific measure are displayed for each of OMPP's programs side-by-side for ease of comparison across programs. The dashboards will be reviewed with the MCEs and publicly released to stakeholders.

Validation of Performance Improvement Projects

The OMPP uses the term "Quality Improvement Project" (QIP) to describe the projects in this review. B&A reviewed 10 QIPs in this year's EQR as follows:

Inventory of the Quality Improvement Programs Reviewed in the 2019 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				X			
Annual Dental Visit	X									
Asthma Medication Management						X				
Behavioral Health Admissions								X	X	X
ED Utilization		X	X							
Follow-up from a Psychiatric Hospitalization	X	X	X				X			
Health Needs Screening	X	X	X	X	X		X	X	X	X
Job Connect Program				X	X					
Lead Screening						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.

In Section IV of this report, B&A offers its assessment of the measures selected by each MCE for its QIPs, the definition of interventions, and the effectiveness of results from the interventions conducted. A one-page summary is also offered that highlights information on the QIPs from each MCE. This includes specific recommendations from B&A to each of the MCEs about their own QIPs.

Examination of Provider Network Adequacy

B&A conducted an assessment of provider network adequacy in the EQR conducted in CY 2018. For that assessment, B&A examined 16 provider specialties. In particular, we examined not just where members from each MCE had access to providers (as self-reported by the MCE), but also where members utilized providers within the MCE's network. B&A used claims experience from CY 2017 to compute the driving distance between the member's home and the provider's location. The average driving distance was computed by provider specialty and by county for each provider specialty within each OMPP program. These values were compared to OMPP's contract requirements. Recognizing that members have the choice to seek care from providers that are further from their home than other providers that may be available to them, B&A nonetheless believes that the average driving distance is a truer representation of provider availability.

In the CY 2019 EQR, B&A conducted a similar study for nine provider specialty categories. B&A used utilization from the CY 2018 time period in this year's study. In total, over 3.8 million Medicaid member trips were used in the study. Many of the provider specialty categories are the same as the prior year since they represent the most common services utilized (e.g., primary care, dental). Other provider categories have been added at the request of the OMPP (e.g., splitting behavioral health providers into two groups for behavioral health and substance use disorder, or SUD). For acute care specialties, the average was also computed across eight regions of the state. Each of the state's 92 counties were mapped to one of eight regions. This was completed due to the lower sample size for these specialty services.

Key findings from this study include the following:

- Average driving distance, primary care: 12.8 to 16.8 miles was variation by MCE/program
- Average driving distance, dental services: 12.8 to 20.1 miles was variation by MCE/program
- MCE/program/county combinations with average > 30 miles: 148 (primary care), 158 (dental) [This is out of a potential 920 combinations.]
- 11 of 92 counties identified with member distances exceeding OMPP standards for primary care; for dental services, 12 counties

- Average driving distance, SUD services: 13.7 to 19.3 miles was variation by MCE/program
- Average driving distance statewide, behavioral health services: 14.1 to 19.0 miles variation MCE/program/county combinations with average > 30 miles: 202 (SUD), 208 (behav. health)
- 17 of 92 counties identified with member distances exceeding OMPP standards for SUD; for behavioral health, 19 counties

Focus Study on Audit of Provider Directories

B&A conducted a review of each of the MCE's online provider directories to review the ease in which members have to navigate information about providers when seeking care. Additionally, B&A sampled a total of 960 providers from directory databases provided to B&A by each MCE. This sample was used to conduct a telephonic audit by calling each provider office to validate the information displayed in the MCE's online directory about the provider. The sample of providers was a cross-section across the four MCEs; across the HHW, HIP and HCC programs; and across all 92 Indiana counties. The sample did focus, however, on primary care (including pediatricians), OB/GYN, behavioral health, and some physical health specialists.

B&A found that each MCE met the minimum OMPP contractual requirements for online provider directory content. Further, all of the MCEs have value-added items on their directories as well, but these vary by MCE. The directories are easy to navigate to conduct a query, but there could be confusion for members on the terms to filter on for specialties. B&A observed that there are 98 different descriptors for provider categories across the MCE's directories. For 37 categories, they are specific to just one MCE.

When the National Provider Identifiers (NPIs) in multiple MCE directories were matched side-by-side, it was found that the address never matched exactly across all four MCEs. It only matched 39.9 percent of the time among three MCEs and 49.0 percent of the time among two MCEs.

The results of the provider directory phone audit were disappointing. After the 960 calls that were initially conducted, B&A could only make live contact with 636 providers. Of these, the provider that was included in our sample was currently working at the office we had listed only 60 percent of the time. Among this 60 percent (385 live phone confirmations), the correct address was validated 72 percent of the time, the group name was validated 99 percent of the time, and the individual's provider specialty was validated 94 percent of the time.

When asked if they contracted with a specific OMPP program, 94 percent of the offices could confirm positively that they contracted with HHW; for HIP, 89 percent; and for HCC, 86 percent.

Focus Study on Potentially Preventable Emergency Department Visits (PPVs)

B&A utilized 3M's Core Grouping Software in its CY 2015 EQR to assist the OMPP and its MCEs assess the rate of PPVs within managed care. In the CY 2015 EQR, the rate of PPVs were examined using CY 2014 utilization. In this year's EQR, B&A used service data from CYs 2016 through 2018.

PPVs are ED visits that may result from a lack of adequate access to care or ambulatory care coordination. PPVs are ambulatory sensitive conditions (e.g., asthma) in which adequate patient monitoring and follow-up (e.g., medication management) should be able to reduce or eliminate. The 3M software assigns ED visits to an Enhanced Ambulatory Patient Grouping (EAPG). B&A analyzed not only the rate of PPVs by OMPP program and by MCE, but also by the EAPG categories to inform where member education could be most useful to avoid the ED.

The statewide PPV rate for HHW was steady near 70 percent in each of the three years. For HIP, the rate moved up and down between 69 and 74 percent. For HCC, the PPV rate went down slightly from 70 percent each year. Within each CY/OMPP program, the MCEs have PPV rates within three percentage points of each other. The one exception is CareSource in CY 2017. Actual ED visits, regardless of whether deemed a PPV or not, are also similar across the MCEs in each program.

Infants have the highest PPV rate among the age groups studied in both HHW and HCC for all MCEs. As the age of the child progresses, the PPV rates decline. The PPV rates for adults are higher in HIP than in HCC in CYs 2017 and 2018. The Actual PPV rates are similar across most regions in CY 2018. The top EAPG categories found for children included Infections of Upper Respiratory Tract, Otitis Media (ear infection), Bronchiolitis & Pneumonia, Gastroenteritis, and Nausea. For adults, the top EAPGs were Chest Pain, Abdominal Pain, and Musculoskeletal System and Connective Tissue Diagnoses.

B&A obtained a clinical risk score for each member in HHW, HIP and HCC in CY 2018. This was used to risk-adjust the PPV rates for each MCE. When applying this risk adjustment logic, it was found that Anthem performed better than expected for its membership in HHW and as expected for its membership in HIP and HCC. MHS also performed better than expected in HHW and HIP, but worse than expected in HCC. Both CareSource and MDwise performed worse than expected on a risk-adjusted basis in both HHW and HIP.

Focus Study on Preventive Care for Adults and Well Visits for Children

B&A examined the utilization of both well care visits (as defined by the HEDIS®[4] measures W15, W34 and AWC) as well as other primary care visits to the children and adolescents in the HHW and HCC programs. For the adult measure, B&A used the HEDIS measure for Adults' Access to Preventive/Ambulatory Health Services (AAP). Analyses were conducted to examine who delivers well care and primary care services to the members, the rate of numerator compliance for each measure statewide and by subpopulations, the differences in the rate of well care and primary care visit utilization for children and adolescents, and the rate of emergency department usage for members in the denominator of each measure examined. All results reported are for the anchor year ending December 31, 2018.

For the infant measure (W15), the sample was almost 35,000 members; for the young child measure (W34), 125,000 members; for the adolescent measure (AWC), 170,000 members; for the adult measure (AAP), 285,000 members.

Well care and primary care is delivered almost 50/50 between physician offices and clinics for Medicaid children statewide. Some MCEs have a higher proportion to physician offices (Anthem) while other MCEs are higher for clinics (MDwise). The proportion among adults was similar to what was seen for children.

The MCEs may report annual HEDIS results using a hybrid method (combination of provider claims and medical records). Sampling is also allowed. B&A only used claims in this study and used the total population (no sampling). Key findings on the rate of compliance for each HEDIS measure under this method in CY 2018 are summarized below.

- The statewide rate for six or more well visits for children in the first 15 months of life (HEDIS W15) was 47 percent for both female and male members in HHW. The rates were 55 percent and 54 percent, respectively, in HCC. The W15 rate varies by region in HHW from a low of 42 percent in the Northwest to 54 percent in the Southeast.
- There are disparities across race/ethnicities in HHW: Caucasians, 49 percent; African-American, 36 percent; Hispanic, 51 percent; other race/ethnicities, 60 percent.
- The statewide rate for children with an annual visit in the 3rd through 6th years of life (HEDIS W34) was 65 percent for the HHW population and 71 percent for the HCC population. There is

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

no difference by gender in either program. There is little variation in the W34 rates by region in either the HHW or HCC programs.

- In HHW, Caucasian and African-American children have a similar rate of 63 percent. This is much lower than Hispanic children and children of other race/ethnicities. A similar pattern was found in HCC.
- Most of the MCEs have HEDIS W34 rates that center around the statewide average. CareSource is the only MCE far below the statewide average.
- The statewide rate for adolescents age 12 to 21 with an annual visit (HEDIS AWC) was 51 percent for the HHW population and 44 percent for the HCC population. Females have a higher rate than males in both programs. There is little variation in the AWC rates by region in either the HHW or HCC programs.
- In both HHW and HCC, Caucasian and African-American children have a similar rate. This is lower than the rate for Hispanic children and children of other race/ethnicities in HHW and for Hispanic children in HCC.
- The rates are the same between Anthem and MHS in the HCC program. In HHW, MHS has a rate higher than its peers while CareSource has a rate lower than its peers.
- The statewide rate for adults' access to preventive care (HEDIS AAP) was 82 percent for the HIP population and 85 percent for the HCC population. Females have a higher rate than males in both programs. Adults in the higher age group of 45-64 have a higher rate of compliance than adults in the 19-44 age group.
- The rates are similar across the MCEs except that CareSource has a rate lower than its peers. There is little variation in the AAP rates by region in either HIP or HCC.
- In both HIP and HCC, Caucasian members have a higher rate of compliance than minority populations.

Focus Study on the Delivery of Prenatal Care Services

B&A conducted a study in this EQR that focused on examining the prevalence of prenatal visits during the last four weeks of pregnancy. This was also the focus of a study we conducted in the CY 2016 EQR. In addition to understanding the overall trend in HIP and HHW, the study examines the prenatal visits in the last four weeks among cohort populations stratified by: the MCE she is enrolled with, the age of the mother, her race/ethnicity, the region where she lives, and the type of delivery (vaginal or Cesarean). The final sample in this year's study was 28,997 women, with 13,198 enrolled in HHW and 15,799 enrolled in HIP.

This study found that when enrolled with the MCE, prenatal care was generally being delivered according to standards set forth by the American College of Obstetricians and Gynecologists, namely, one prenatal visit per week in the four weeks prior to delivery. However, it was found that a large percentage of women are not enrolled with the MCE for their entire pregnancy. Although almost all members in HHW were enrolled with the MCE in weeks 37 through 40, in HIP, only 96 percent of members were enrolled during this time. When enrollment was tracked with the MCE further back in each member's pregnancy, in HHW only 84 percent of members were enrolled with the MCES between weeks 17 and 21. In HIP, only 73 percent were enrolled at this time in their pregnancy.

The rate of a women with a minimum of four visits in the last four weeks prior to delivery was examined across subpopulations within the study sample. There was actually little variation across the populations reviewed. In HHW overall, 86 percent of women had four or more visits; in HIP overall, 89 percent of women did. There was not a significant difference in these percentages when B&A stratified by the age of the mother. By race/ethnicity, African-American women have a higher rate of prenatal visits than other race/ethnicities in HHW. The findings are more similar in HIP across race/ethnicities.

There is a slight difference in the number of visits received based on the type of delivery recorded in HHW, but not in HIP. In HHW, the percentage was lowest (83%) for vaginal delivery with complications and highest (90%) for vaginal delivery with sterilization. In HIP, the range was from 90 to 92 for all delivery types.

There was some variation seen in the rates of women with four or more visits across regions within HHW. But the regional variation was unique to each MCE as to which regions had the highest and lowest compliance rates for prenatal visits. The variations across regions were also found in HIP.

Focus Study on the Health Needs Screening Tool

The OMPP requires that its MCEs utilize a common Health Needs Screening (HNS) tool. The MCEs are required to screen new members within 90 days of their enrollment with the MCE. The OMPP has set a target of 70 percent completion within this timeframe. Allowances are made for individuals who terminate during the first 90 days or individuals who had recently been screened by another MCE.

The MCEs are required to submit files to the OMPP's vendor that contain information about HNSs that are completed. The files submitted are in a format pre-established by the OMPP. In addition to enrollment-related information, the MCE submits the member responses to each of the questions on the HNS. The HNS tool used in CY 2018 by the MCEs contained 63 questions.

The OMPP's vendor intakes the files submitted by the MCEs and verifies the format and completeness of the file itself. The vendor also determines the denominator that is used to compute the MCE's completion rate within 90 days for new members. This is for use in the final determination of Pay for Outcomes money tied to this measure. No analysis is conducted on the responses to health questions, however.

The focus of the B&A in this study, therefore, is to analyze the actual responses to HNS that were completed in CY 2018. The results of this information were joined with data collected by B&A from each MCE of its members enrolled in complex case or care management in CY 2018. B&A assessed if there were connections between the responses given in the HNS and case/care management participation of new members. B&A examined the results from 102,336 unduplicated HNS completed in CY 2018.

B&A selected nine questions in the tool related to physical health questions and eight questions in the tool related to behavioral health for a concentrated review. B&A found challenges with the completeness and integrity of the responses to these HNS questions. There appears to be significant opportunity by all MCEs to validate the responses within each question.

Further, the results of the assessments appear to be little utilized by the MCEs with respect to complex case or care management activities. Although not every question on the instrument would yield potential eligibility for case or care management, many questions would, particularly if these are responses from new members for which there is no historic claims utilization. It is recognized that not every member who responds affirmatively to certain questions will ultimately be enrolled in case or care management, but B&A recommends that a process should be designed by the MCE to document why the member ultimately does not need this service (or they refused).

B&A learned that the OMPP was working with the MCEs to work on a "revamp" of the HNS tool in late 2019. B&A endorses this effort to curtail the number of questions to those most pertinent to obtain information on initial enrollment. With this reduction in questions, B&A encourages the OMPP to require that each MCE create a roadmap to determine the next step to work with their new member if there is an affirmative response to each question on the new HNS.

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.

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 Account was used in HIP 1.0 and continues 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

---

[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.

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 be eligible for the HIP State Plan package which offers additional benefits.

The HHW and HIP were aligned in Calendar Year (CY) 2011 under a family-focused model such that the programs 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.

The **Hoosier Care Connect (HCC)** program was implemented April 1, 2015 under 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.

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 2018, 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, a McLaren company, has also been participating in HHW since its inception. 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.

The latest contract between the OMPP and the MCEs began January 1, 2017 for the HHW and HIP programs. With this new contract, both pharmacy and dental were added as services under the MCEs' responsibility for HHW (these services were already in the HIP and HCC contracts). With the change in the HHW contract, the covered services under all three contracts are now almost identical. The current contract for HCC began April 1, 2015 and is in effect until March 31, 2020. Enrollment changes across programs occurred in early CY 2018. 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 decreased by almost 63,000, or 4.3 percent, from the end of CY 2017 to the end of CY 2018. Enrollment in the three managed care programs combined fell by almost 80,000 members, or 6.9 percent, during CY 2018. Enrollment in fee-for-service increased by almost 17,000 individuals, or 5.3 percent. Some of this is due to a change in the treatment of individuals who are deemed to be presumptively eligible for Medicaid (PE). Prior to CY 2018, individuals with PE status were automatically enrolled in managed care. Now, these individuals are enrolled in fee-for-service until their Medicaid eligibility status is confirmed.

Within each MCE programs, the enrollment in HCC remained constant in CY 2018. Enrollment decreased in HHW but this was due to moving adults into HIP. Notwithstanding this change, overall enrollment in HIP also decreased between the end of CY 2017 and CY 2018.

The overall managed care enrollment for Indiana Medicaid was 78.5 percent of total enrollment at the end of CY 2017. As of the end of CY 2018, it was 76.3 percent.

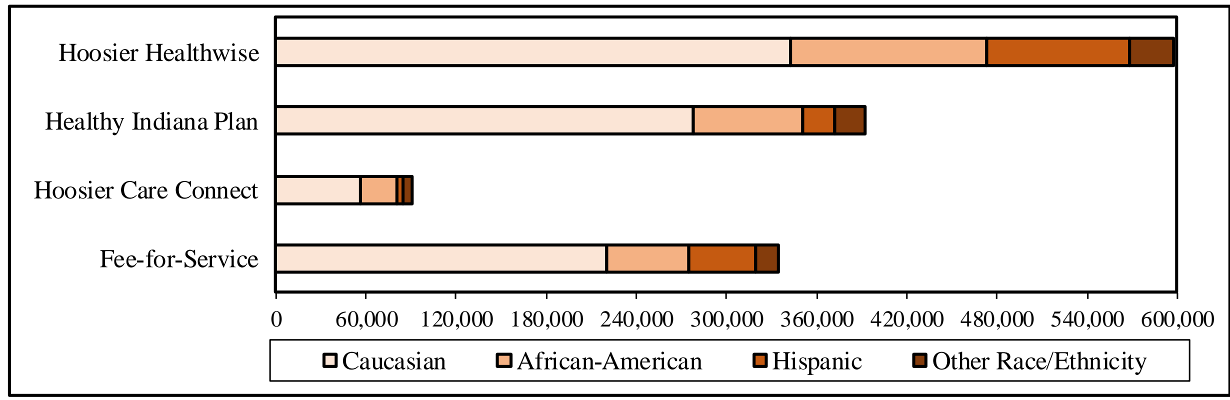
Exhibit I.1
Enrollment Across Indiana Medicaid's Programs, Year End 2015 - 2018

	Managed Care Programs				
	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect	Fee-for-Service	All Combined
December 2015	600,431	355,164	97,609	338,180	1,391,384
	43.2%	25.5%	7.0%	24.3%	100.0%
	75.7%			24.3%	100.0%
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%
December 2018	597,615	392,018	90,488	334,676	1,414,797
	42.2%	27.7%	6.4%	23.7%	100.0%
	76.3%			23.7%	100.0%

Source: OMPP Enterprise Data Warehouse as of August 2019.

The profile of Indiana Medicaid's total enrollment by race/ethnicity at the end of CY 2018 was 63.4 percent Caucasian, 20.0 percent African-American, 11.6 percent Hispanic, and 5.0 percent other race/ethnicities combined. As seen in Exhibit I.2, the HHW program has a higher proportion of minorities, particularly Hispanic, than the other managed care programs. The HCC program has a similar percentage of Caucasians compared to total Indiana Medicaid enrollment, but a higher proportion of African-Americans. The HIP program has a higher proportion of Caucasians.

Exhibit I.2
Enrollment in Indiana Medicaid's Programs by Race/Ethnicity
As of December 2018



Percent of Members	Caucasian	African-American	Hispanic	Other Race/Ethnicity	**Total**
Hoosier Healthwise	57.4%	21.8%	16.0%	4.9%	100.0%
Healthy Indiana Plan	71.0%	18.6%	5.4%	5.0%	100.0%
Hoosier Care Connect	62.1%	27.0%	4.6%	6.4%	100.0%
Fee-for-Service	65.7%	16.6%	13.1%	4.7%	100.0%

Source: OMPP Enterprise Data Warehouse as of August 2019.

Exhibit I.3 shows the enrollment distribution within managed care by MCE. Anthem and MDwise have a similar proportion (33%-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 2018 is 40 percent for Anthem (an increase from 38% in CY 2017), 28 percent for MDwise (a decrease from 30% in CY 2017), 23 percent for MHS (no change from CY 2017), and nine percent for CareSource (no change from CY 2017).

Exhibit I.3
Managed Care Program Enrollment by MCE
As of December 2018

	Hoosier Healthwise	**Healthy Indiana Plan**	**Hoosier Care Connect**	**All Combined**
Anthem	34%	44%	62%	40%
CareSource	9%	11%	0%	9%
MDwise	33%	27%	0%	28%
MHS	24%	18%	38%	23%

Source: OMPP Enterprise Data Warehouse as of August 2019.

Exhibit I.4 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.4
Managed Care Program Enrollment by Region and MCE
As of December 2018

Distribution of Enrollment by Program and Region on 12/31/18

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Hoosier Healthwise
Healthy Indiana Plan
Hoosier Care Connect

Northwest
North Central
Northeast
West Central
Central
East Central
Southwest
Southeast

Distribution of Enrollment by Program/MCE and Region on 12/31/18

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

HHW- Anthem
HHW- CareSource
HHW- MDwise
HHW- MHS
HIP- Anthem
HIP- CareSource
HIP- MDwise
HIP- MHS
HCC- Anthem
HCC- MHS

Northwest
North Central
Northeast
West Central
Central
East Central
Southwest
Southeast

Source: OMPP Enterprise Data Warehouse as of August 2019.

The display for Exhibit I.5 is similar to what was shown in Exhibit I.4, 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/brown colors represent different age groups among adults.

Exhibit I.5 illustrates the targeted populations of each of Indiana's managed care programs. As of December 2018, almost 99 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.5
Managed Care Program Enrollment by Age and MCE
As of December 2018

Distribution of Enrollment by Program and Age on 12/31/18

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Hoosier Healthwise
Healthy Indiana Plan
Hoosier Care Connect

Age <1
Age 1-5
Age 6-12
Age 13-18
Age 19-30
Age 31-40
Age 41-50
Age >50

Distribution of Enrollment by Program/MCE and Age on 12/31/18

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

HHW- Anthem
HHW- CareSource
HHW- MDwise
HHW- MHS
HIP- Anthem
HIP- CareSource
HIP- MDwise
HIP- MHS
HCC- Anthem
HCC- MHS

Age <1
Age 1-5
Age 6-12
Age 13-18
Age 19-30
Age 31-40
Age 41-50
Age >50

Source: OMPP Enterprise Data Warehouse as of August 2019.

Indiana Medicaid's CY 2018 Quality Strategy Plan

The OMPP, like other State Medicaid Agencies, develops a Quality Strategy Plan. In its 2018 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.6. Most of the initiatives carried forward from what was released prior Quality Strategy Plan. 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. 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 2018, page 5.
https://www.in.gov/fssa/ompp/5533.htm

Exhibit I.6
OMPP Quality Strategy Initiatives for 2018

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	Achieve at or above 80% participation rate in the EPSDT program.	✓		
Adult Preventive Care	Achieve at or above the 90th (HIP) or 75 (HCC) percentile for the percentage of adults that had a preventive care visit (HEDIS).		✓	✓
Improvement in Behavioral Health	Achieve at or above the 90th percentile (HHW, HIP) or 72.8% (HCC) for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders (HEDIS).	✓	✓	✓
Emergency Room Visits	Achieve at or below the 10th percentile of Ambulatory Emergency Department Care Visits (HEDIS).	✓		
	Achieve at or below 75 (HIP) or 80 (HCC) visits per 1,000 member months.		✓	✓
Freqency of Prenatal Care	Achieve at or above the 90th percentile for the frequency of prenatal care (HHW, HIP) and post-partum care (HIP only) (HEDIS).	✓	✓	
Pregnant Women Smoking Cessation	Achieve an increase in the percentage who are referred to and have one contact with the Indiana Tobacco Quitline.		✓	
Lead Screening in Children	Achieve at or above the 75th percentile for lead screening in children (HEDIS).	✓		
Medication Management for People with Asthma	Achieve at or above the 90th percentile for medication management for people with asthma (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.		✓	
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 care within a minimum of 30 miles of a member's residence and vision care within a maximum of 60 miles of a member's residence.		✓	
POWER Account Rollover	Achieve at or above 85% of the number of members who receive a preventive exam during the year.		✓	
Completion of Health Needs Screen (HNS)	Achieve completion of a HNS for >= 70% of all members within 90 days of enrollment.			✓
Completion of Comprehensive Health Assessment Tool (CHAT)	Achieve completion of a CHAT for >= 73% of all members within 150 days of enrollment.			✓

Source: Indiana Medicaid Managed Care Quality Strategy Plan 2018

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 2018 are listed in Exhibit I.7 below.

Exhibit I.7
OMPP Pay for Outcomes Program in Effect for CY 2018

HEDIS Code	Description	HHW	HIP	HCC
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			✓
LSC	Lead Screening for Children	✓		
MMA	Medication Management for People with Asthma	✓		
PPC	Timeliness of Prenatal Care and Postpartum Care 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 2018

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

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

Introduction

Burns & Associates (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 four 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
4) Validation of MCE network adequacy

All four of these activities were completed in the EQR conducted in Calendar Year (CY) 2018. For the EQR conducted in CY 2019, all but the first activity was completed.

In lieu of the review of MCE compliance with federal Medicaid managed care regulations completed last year, for the CY 2019 EQR, B&A worked with the OMPP to develop focus studies covering specific aspects of the HHW, HIP and HCC programs. Since 2013, B&A has completed 21 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.

EQRO Activities in CY 2019

B&A met with the OMPP in early 2019 and developed the following topics for this year's EQR:

- Validation of Performance Measures through the Redesign of the MCE Reporting Manuals
- Validation of MCE Performance Improvement Projects (Quality Improvement Projects, QIPs)
- Examination of Provider Network Adequacy at Each MCE
- Optional EQR Activity: Focus Study on Validation of Provider Directories
- Optional EQR Activity: Focus Study on Potentially Preventable Emergency Department Visits
- Optional EQR Activity: Focus Study on Preventive Care for Adults and Well Visits for Children
- Optional EQR Activity: Focus Study on the Delivery of Prenatal Care Services
- Optional EQR Activity: Focus Study on the Health Needs Screening Tool

The details pertaining to each aspect of this year's EQR were released to the MCEs in an EQR Guide on April 30, 2019. 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.

The activity related to Validation of Performance Measures was unique this year in that it included a comprehensive review of all reporting by the MCEs in the OMPP quarterly Reporting Manuals. This activity occurred in a concentrated time period in January through March 2019 with follow-up through September 2019. All of these meetings were held with all MCEs in attendance with OMPP. More details

related to this work is discussed in Section III. All of the remaining tasks in this year's EQR were conducted during April through September, 2019.

Exhibit II.1
EQR Focus Studies Conducted of MCE Operations in HHW, HIP and HCC, 2013 - 2018

Review Conducted	Review Year	HHW	HIP	HCC	Functional Area	Review Topic
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
CY 2018	CY 2017	x	x	x	Encounters	Study of MCE Encounters Validation
CY 2018	CY 2017	x	x	x	Pharmacy	Study of MCE Pharmacy Management

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. Beginning in 2018, B&A coordinated with Optum to receive refreshed enrollment, provider and claims/encounters files at the start of each month that includes up-to-date information from the prior month. Both fee-for-service claims and encounter data is delivered to B&A monthly for institutional services, professional services, dental services and pharmacy scripts.

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.

Sections III through X 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 2018. Throughout the report, where applicable, information is presented for each program individually. The focus studies that were conducted reviewed information on all four 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. Additionally, a webinar was held individually with each MCE. 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. The focus of all meetings was either to interview MCE staff appropriate to the study topic or to review preliminary findings related to the study topic. Most onsite meetings and the webinar were between two and three hours in length. A summary of the meeting schedule is shown below:

- July 9-10: In-person meetings held with each MCE to review results of the assessment of network adequacy and initial results from the focus study on potentially preventable ED visits.

- July 16-17: In-person interviews were held to interview MCE staff on how they manage and deliver preventive and well care services as well as prenatal care. An additional session covered the MCE's process to conduct health risk screenings of new members and how this data is tracked and reported to the OMPP.

- July 30-31: A webinar was held with each MCE to review results of the review of delivery of preventive care to adults, well care to children and adolescents, and prenatal care to pregnant women.

- August 26-27: 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 facilitated the meetings pertaining to the redesign of the Reporting Manual. 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 2007-2018.

- Dr. Linda Gunn, AGS Consulting, Inc. Dr. Gunn participated as a team member in the validation of provider directories. Dr. Gunn performed this function in the CY 2016 EQR as well. She has participated in B&A's EQRs for Indiana programs in CYs 2009-2018.

- Kristy Lawrance, Lawrance Policy Consulting, LLC. Ms. Lawrence participated as a team member in the redesign of the MCE Reporting Manual. She also shared responsibility with Mark Podrazik conducting the validation of QIPs. Ms. Lawrance also participated in B&A's EQRs for Indiana programs in CYs 2013-2018.

- Jesse Eng, SAS Programmer, Burns & Associates, Inc. Mr. Eng conducted analytical support in SAS for the focus studies related to preventive care for adults and well care for children. He also performed the analytics with Barry Smith to assess the adequacy of MCE provider networks. 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 studies on potentially preventable emergency department visits and prenatal care. He also assisted in the compilation of data from health needs screening records. In the 2018 EQR, he served as the lead programmer for B&A's focus study related to medication adherence.

- Barry Smith, Analyst, Burns & Associates, Inc. Mr. Smith conducted analytical support related to the assessment of network adequacy as well as detailed analysis of the responses from the health needs screening tools. He also developed the sampling for the validation of provider directories. He has previously worked on the Data Analysis Team for the EQRs conducted in CYs 2009-2018.

- Ryan Sandhaus, SAS Programmer, Burns & Associates, Inc. Mr. Sandhaus conducted analytical support in SAS for the intake and validation of the monthly files delivered to B&A from the State's EDW. In recent EQRs, he conducted analysis related to encounter validation and the validation of performance measures.

SECTION III: VALIDATION OF PERFORMANCE MEASURES

Introduction

In previous External Quality Reviews (EQRs), Burns & Associates (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 created an MCE Reporting Manual for each of the three managed care programs—Hoosier Healthwise (HHW), Healthy Indiana Plan (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.

When this form of validation has been conducted, 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

Findings from EQRs conducted in recent years showed that B&A was not always able to validate the results reported by MCEs in the Reporting Manual templates against encounter claims and enrollment information provided by the OMPP to B&A from the State's Enterprise Data Warehouse (EDW). Reasons why B&A could not match results reported by the MCEs were primarily due to the following:

1. An MCE interpreted the instructions provided by the OMPP on how to compute a measure differently from how the OMPP intended. In many cases, after detailed discussions with the MCE, B&A observed that the interpretation was legitimate, but the instructions themselves were not specific enough such that multiple interpretations could be made.

2. An MCE did not update its internal programming for specification changes in the computation of a specific measure.

3. Incomplete encounters in the EDW meant that B&A was not utilizing the same source database that was found internally at the MCE. Even if the computation methods were the same between the MCE and B&A, the results would differ due to different starting points.

4. Some measures that involve continuous enrollment criteria would differ between the MCE and B&A because the MCE was counting enrollment at a point-in-time during the year (e.g. at the end of a quarter when the report was due to the OMPP) whereas B&A had the benefit of an extended period since that point-in-time when retroactive eligibility could have occurred.

To further complicate this, the OMPP maintained three different reporting manuals—one for each program. Many of the reports that the MCEs were required to complete were common to all three programs (HHW, HIP and HCC). There were times, however, where there were subtle differences in the format or the data elements on the report across the three reporting manuals. The MCEs would use the specification from one reporting manual and apply it to all three even if the specifications were not exactly the same.

B&A had assisted the OMPP with a full redesign of its MCE Reporting Manual as part of the CY 2012 EQR. At that time, the Reporting Manual covered the HHW and HIP programs only. Since that time, the HCC has been implemented and additional reporting requirements are needed in the HIP with the design of HIP 2.0. For this year's EQR, in consultation with the OMPP, it was decided to undertake another redesign of each of the Reporting Manuals.

Goals of the Reporting Manual Redesign Process

B&A assisted the OMPP with defining goals for successful completion of the Reporting Manual redesign:

1. Streamline the report templates so that three Reporting Manuals will be unified into one. For example, instead of having three report templates for the same report, create one with columns for each OMPP program. This will ensure consistency across the programs.

2. Where not already present on reports, ensure that numerators and denominators of a specific measure are included in the report. By doing this, it is easier to track the root cause when an MCE's results vary significantly from its peers.

3. Build validation checks within each report. Since the MCEs are entering information into each report template by hand, the validation cells are useful to ensure that data validates against other data that has been reported.

4. Build automatic calculations in reports wherever possible. Protect the calculation fields. This saves on data entry and ensures further validity of the data reported.

5. Build automatic calculations that are used for informational purposes and quality control. For example, a claims report may show the number of claims adjudicated in 21 days, then the number adjudicated in 21 to 30 days, then the number adjudicated in greater than 30 days. One automatic calculation field will sum the three values together to obtain the total claims adjudicated. A second calculation field will display the percentage of claims adjudicated within 21 days (an OMPP contractual requirement). By displaying this value in real-time on the report, the MCE can perform face validity on the numbers entered.

6. Ensure that every report has detailed instructions that accompanies it. The format of the instructions will be consistent across reports. The instructions themselves are peer reviewed by the subject matter experts at each MCE before they are finalized.

7. Retire reports that no longer serve a specific purpose.

8. Add reports that are required for necessary contract oversight.

9. Keep reports, but change them as needed, to allow for the most useful data to be reported.

10. Upon implementation of the new Reporting Manual, the OMPP will provide specific feedback to each MCE every quarter on elements that it deems need further research or review by the MCE.

11. Build reporting dashboards that use the information populated in report templates. The dashboard reports are for OMPP leadership and for use in transparent reporting to external stakeholders.

Process Used to Redesign the Reporting Manuals

Desk Review

The B&A Team compiled the templates from 75 reports in the HHW manual, 101 reports in the HIP manual, and 86 reports in the HCC manual. The reports were cross-walked across the three Reporting Manuals to determine which reports were common to more than one program and which were unique to a specific program. Even when a report was common to all three programs, for example, the templates were reviewed to ensure that the data elements reported were the same across all three manuals. When they were not the same, differences were cited.

Once the universe of unique reports across the three Reporting Manuals was identified, each report was reviewed for its utility in ongoing reporting. Every report was given a provisional assignment of eliminate, retain with changes, or retain with no changes.

For reports that were to be retained, B&A reviewed the data elements on each report and the instructions that accompanied the report. Items were tracked as questions to the OMPP where the instructions were not clear or the intent of the data field was not known. Options were also identified on ways to add fields or design changes to reports that would be retained to make them clearer for the end user.

Once the total number of reports that needed review were determined, B&A divided the level of review effort into four meeting sessions that were two to three hours in length. Individual subject matter experts from within the OMPP were invited to attend meetings with the OMPP Quality Team to review potential needs within that functional unit and to gain feedback on ideas for report restructuring. Participants from within program integrity, utilization management, pharmacy, member services, provider relations, and federal waiver reporting were invited to attend one or more of these meetings.

In Person Meetings

A kickoff meeting was held with the OMPP Quality Team and representatives from all MCEs in December 2018 to orient them to the process that would be undertaken and the level of commitment required. After this meeting, meeting dates were scheduled in January and February 2019 for all-MCE meetings to be held on this topic.

The B&A team facilitated four in-person meetings at the OMPP's office to review sections of the Reporting Manual with members of the OMPP team. These meetings served as preparatory meetings for the four external meetings that were held with all MCEs. These eight meetings collectively were conducted in a concentrated time period with one meeting per week during the months of January and February 2019. For the external meetings, the MCE's Reporting Managers attended all four meetings. Then, similar to the internal format with the OMPP team, specific subject matter experts were invited from each MCE depending upon the topics covered in each meeting.

B&A prepared a facilitated outline of what would be discussed at each internal and external meeting. The questions and items to consider, along with copies of the current report templates, were sent to invitees in advance of each meeting.

During the internal OMPP sessions, some items were decided immediately and these decisions were communicated to the MCEs. Other items were deliberated but the OMPP wanted to allow for feedback from the MCEs before making a final decision. The items to be deliberated were the focus of the external meetings.

Development Work

After each external meeting, the B&A team documented the changes that were agreed upon either for the report templates or the instructions that accompany it. Also, from the feedback garnered, it was determined that some new reports were needed to either replace reports that would be retired or to complement the suite of reports that already existed. B&A created brand new report templates and also made substantial modifications to most of the existing reports. Even if the basic structure of a report did not change, B&A added the new features discussed previously such as adding automatic calculation fields, new validation fields, and adding columns to account for each of the three OMPP programs.

B&A also made substantial changes to the instructions from the previous Reporting Manuals. The changes were necessary to be made either to align with the current report structure and/or to include the feedback gained from the internal and external meetings. A draft instructions manual was created in PDF format. Because this manual exceeded 160 pages in length, bookmarks were added for ease of navigation to find the instructions for a specific report.

Feedback Process

A fifth meeting was held in person with B&A, the OMPP, and the MCEs in late March 2019. This meeting summarized all of the changes made to date in the revised Reporting Manual. Shortly after this meeting, the final report templates were delivered to the MCEs along with the new instructions. The MCEs were asked to use the new templates to report Quarter 1 2019 information. It was agreed that this first use of the reporting templates would be considered the testing period.

Testing

The MCEs used the new reporting templates and instructions to fill out required information for Q1 2019. Reports were delivered to the OMPP by May 31, 2019. In addition to the actual reports, the MCEs tracked additional feedback items such as fixes that were required in the templates or continued confusion on language in the instructions.

Based on feedback received from the MCEs during the testing process, B&A released a revised version of the Reporting Manual templates and instructions on May 10, 2019.

Once the Q1 2019 data was submitted by the MCEs, the OMPP team and B&A collectively conducted a validation review of the data that was submitted. Although few in number, specific items were brought to the attention of individual MCEs related to specific report submissions.

Building Dashboards

After the Reporting Manual was released, B&A worked with the OMPP Quality Team in June 2019 to decide on dashboards that would be useful for ongoing monitoring. Ultimately, 12 dashboards were developed. Each contains selected measures from the Reporting Manual and are based on themes. The dashboards are as follows:

1. Claims Adjudication
2. Encounters Submissions
3. Member Services
4. Provider Services
5. HEDIS Preventive Care

6. HEDIS Other Measures
7. AHRQ Measures
8. Inpatient and Emergency Department Utilization
9. Pharmacy Utilization
10. Case and Care Management
11. Service Authorizations
12. HIP Federal Reporting

Each dashboard is formatted on one page in landscape format. The dashboard contains up to four measures and allows for up to four quarters of trend reporting. Results for a specific measure are displayed for each of OMPP's programs side-by-side for ease of comparison across programs.

Results for each MCE are reported for every measure in every quarter. An all-MCE average is computed for the measure for each quarter. Then, each MCE is measured individually against the all-MCE average for the quarter. Color coding indicates if the MCE is above or below its peers.

For some measures, the OMPP has a specified target. Each MCE is also measured against this target. When a target has not been set, the four-quarter average trend is reported instead. This allows the reader to easily assess if the most recent quarter's results are above or below the target or four-quarter trend.

The first set of dashboard reports were introduced to the MCEs in July 2019. The final dashboards were delivered to the OMPP in September 2019 along with instructions that provided techniques to easily capture the data from the reports submitted by the MCEs in the Reporting Manual each quarter. B&A built internal shells in each dashboard so that the computations on each dashboard are computed automatically once the latest quarter of data submitted by the MCEs is uploaded into the dashboard shells.

Outcomes from the Continuous Quality Improvement Process

As a result of this process, the OMPP was able to more clearly articulate its priority areas on measure reporting that aligns with its own Quality Strategy document. This is illustrated in the new dashboard reports that were created from data submitted through the quarterly reports in the Reporting Manual.

The reports in the new Reporting Manual were aligned across the three programs so that reporting is consistent across programs. Further, data elements across reports were also aligned to allow for additional consistency. For example, the application of continuous enrollment requirements was made consistent across HEDIS measures that are reported using the administrative (claims-based) method. Allowances for claims submission lag were made more uniform (usually 90 days after the service period) for most utilization-oriented reports.

The administrative time both for the MCEs to complete the reporting templates and for the OMPP team to validate the results has been simplified through the use of pre-established calculation and validation fields embedded in each report template. As part of the final review before submission, the MCEs have a single report that encompasses all validation checks across all reports in the Reporting Manual. This serves as a quick reference for both the MCEs and the OMPP to ensure the integrity of the data submitted immediately upon receipt by the OMPP.

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 (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, was 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. 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.

A new QIP reporting tool was developed by B&A in cooperation with the Office of Medicaid Policy and Planning (OMPP) and the MCEs during the EQR conducted in CY 2014. This new format for the MCEs to submit their annual QIP reports 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 in November 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.

As part of the validation of QIPs conducted in the CY 2019 EQR, the B&A EQR team members reviewed the submissions on 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. Onsite interviews were held with each MCE and the subject matter experts related to each QIP in August 2019. The B&A team asked questions of the subject matter experts specific to each QIP.

Methodology Related to the Validation Process

1. B&A verified with each MCE the QIPs in place for CY 2018 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, 2019.

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 2018 QIPs.

6. One-on-one meetings were held with each MCE on August 26 or 27 to discuss their QIP reports.

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 ten QIPs shown Exhibit IV.1 on the next page. Anthem had five QIPs, CareSource had two QIPs, MDwise had five QIPs, and MHS had three QIPs. The middle section of the exhibit states if the MCE indicated if the QIP would continue in CY 2019 or not. If it is going to continue, the MCE cited any improvements that are being made to the QIP in CY 2019.

Exhibit IV.1
Inventory of the Quality Improvement Programs Reviewed in the 2019 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				X			
Annual Dental Visit	X									
Asthma Medication Management						X				
Behavioral Health Admissions								X	X	X
ED Utilization		X	X							
Follow-up Psychiatric Hospitalization	X	X	X				X			
Health Needs Screening	X	X	X	X	X		X	X	X	X
Job Connect Program				X	X					
Lead Screening						X				

Will the QIP Continue in 2019?

	Anthem HHW	Anthem HCC	Anthem HIP	Caresource HHW	Caresource HIP	MDwise HHW	MDwise HIP	MHS HHW	MHS HCC	MHS HIP
AOD Treatment								Yes	Yes	Yes
Adult Preventive Care Visit		Yes	Yes				No			
Annual Dental Visit	TBD									
Asthma Medication Management						Yes				
Behavioral Health Admissions								Yes	Yes	Yes
ED Utilization		Yes	Yes							
Follow-up Psychiatric Hospitalization	Yes	Yes	Yes				Yes			
Health Needs Screening	Yes	Yes	Yes	Yes	Yes		No	Yes	Yes	Yes
Job Connect Program				Yes	Yes					
Lead Screening						Yes				

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

	Anthem HHW	Anthem HCC	Anthem HIP	Caresource HHW	Caresource HIP	MDwise HHW	MDwise HIP	MHS HHW	MHS HCC	MHS HIP
AOD Treatment								No	No	No
Adult Preventive Care Visit		Yes	Yes				N/A			
Annual Dental Visit	TBD									
Asthma Medication Management						Yes				
Behavioral Health Admissions								Yes	Yes	Yes
ED Utilization		Yes	Yes							
Follow-up Psychiatric Hospitalization	Yes	Yes	Yes				Yes			
Health Needs Screening	No	No	No	Yes	Yes		N/A	Yes	Yes	Yes
Job Connect Program				Yes	Yes					
Lead Screening						Yes				

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.

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. In some cases, the measures defined in CY 2018 are an improvement over the measures defined in CY 2017 for the same QIP.

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, the MCEs that have this QIP showed results that were worse than the prior year. Many of the MCEs ran tests for statistical significance on the results of their measures from the prior year. An (*) indicates that the change in the measure result (whether yes or no if improvement was found in absolute terms) was not statistically significant.

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.

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. In the middle section of Exhibit IV.3, the total number of interventions completed (first number) are listed out of the total planned (second number).

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.

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		
	HHW	HCC	HIP	HHW	HIP	HHW	HIP	HHW	HCC	HIP
AOD Treatment								HEDIS	HEDIS	HEDIS
Adult Preventive Care Visit		HEDIS	HEDIS				HEDIS			
Annual Dental Visit	HEDIS									
Asthma Medication Management						HEDIS				
Behavioral Health Admissions								Yes	Yes	Yes
ED Utilization		HEDIS	HEDIS							
Follow-up Psychiatric Hospitalization	HEDIS	HEDIS	HEDIS				HEDIS			
Health Needs Screening	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Job Connect Program				Yes	Yes					
Lead Screening						HEDIS				

When the word 'HEDIS' is shown, it means yes, the measure is well defined and the MCE is using the HEDIS specification.

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

	Anthem			Caresource		MDwise		MHS		
	HHW	HCC	HIP	HHW	HIP	HHW	HIP	HHW	HCC	HIP
AOD Treatment								Mixed	Mixed	Mixed
Adult Preventive Care Visit		Yes*	Yes*				Yes*			
Annual Dental Visit	No*									
Asthma Medication Management						No*				
Behavioral Health Admissions								No*	Yes*	No*
ED Utilization		Yes	Yes							
Follow-up Psychiatric Hospitalization	No	No	No				No*			
Health Needs Screening	No	No	No	Yes	Yes		No*	Yes	Yes	Yes
Job Connect Program				No	Yes					
Lead Screening						Yes*				

*Indicated that the assessment of improvement was not statistically significant.

Exhibit IV.3
Summary of Findings Related to Validation of Interventions in Each MCE's Quality Improvement Program

	Anthem			Caresource		MDwise		MHS		
	HHW	HCC	HIP	HHW	HIP	HHW	HIP	HHW	HCC	HIP
Were the Intervention(s) Well Defined in the QIP?										
AOD Treatment								Yes	Yes	Yes
Adult Preventive Care Visit		Yes	Yes				Yes			
Annual Dental Visit	Yes									
Asthma Medication Management						Yes				
Behavioral Health Admissions								Yes	Yes	Yes
ED Utilization		No	No							
Follow-up Psychiatric Hospitalization	Yes	Yes	Yes				Yes			
Health Needs Screening	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Job Connect Program				Yes	Yes					
Lead Screening						Yes				
Were the Intervention(s) Completed as Planned?										
AOD Treatment								2 of 3	2 of 3	2 of 3
Adult Preventive Care Visit		2 of 2	2 of 2				1 of 1			
Annual Dental Visit	1 of 1									
Asthma Medication Management						2 of 2				
Behavioral Health Admissions								1 of 3	1 of 3	1 of 3
ED Utilization		0 of 3	0 of 3							
Follow-up Psychiatric Hospitalization	2 of 2	2 of 2	2 of 2				3 of 3			
Health Needs Screening	3 of 3	3 of 3	3 of 3	3 of 4	3 of 4		2 of 2	4 of 4	4 of 4	4 of 4
Job Connect Program				1 of 1	1 of 1					
Lead Screening						2 of 2				
Were the Results from the Intervention(s) Computed Effectively?										
AOD Treatment								No	No	Mixed
Adult Preventive Care Visit		Yes	Yes				Yes			
Annual Dental Visit	Yes									
Asthma Medication Management						Yes				
Behavioral Health Admissions								No	No	No
ED Utilization		N/A	N/A							
Follow-up Psychiatric Hospitalization	Yes	Yes	Yes				Yes			
Health Needs Screening	Yes	Yes	Yes	No	No		Yes	Yes	Yes	Yes
Job Connect Program				Yes	Yes					
Lead Screening						Yes				

Individual MCE Profiles and Recommendations to Each MCE

In this section, B&A offers a brief description of the interventions used by each of the MCEs in their 2018 QIPs. Based on our assessment of each QIP, B&A offers some recommendations to each MCE for continuous quality improvement on those QIPs that are continuing in future years.

Anthem

QIPs Reviewed

- AAP: Adult Access to Preventive Care (HCC, HIP)
- ADV: Annual Dental Visit (HHW)
- ED: ED Utilization (HCC, HIP)
- FUH: Follow-up After Psychiatric Hospitalization (HHW, HCC, HIP)
- HNS: Health Needs Screening (HHW, HCC, HIP)

Types of interventions used

- Text message joined with live voice calls (AAP, ADV)
- Referral to case management, referral to community health worker, texts (ED)
- Text at discharge, behavioral health facility provider incentive payment (FUH)
- Pursuant kiosks in Walmart, text campaign, dedicated member outreach team (HNS)

B&A's overall assessment of Anthem's QIPs

- Anthem has credible and usable data to show success or failure of most of its interventions, but this is not all communicated on the reports to the OMPP.

- The interventions for most QIPs have been in long-standing use and do not appear to be 'moving the needle' much if at all. There needs to be thought on how to target the interventions better or develop new ones.

- There is evidence that many of Anthem's QIPs have some type of internal dashboard that is maintained ongoing, but this is not shared with OMPP. This would be useful to show OMPP as evidence of ongoing tracking and trending.

CareSource

QIPs Reviewed

- JOB: Job Connect Program (HHW, HIP)
- HNS: Health Needs Screening (HHW, HCC, HIP)

Types of interventions used

- The Job Connect program itself (JOB)
- Pursuant kiosks in Walmart, member fairs, dedicated member outreach team (HNS)

B&A's overall assessment of CareSource's QIPs

- Although the Job Connect program itself is commendable, it is really more an intervention to other quality outcomes than a QIP itself. Further, the total population in this QIP is small. It would seem to be more effective for CareSource to focus on a QIP that would involve a larger portion of its total enrolled members.

- It is recognized that the OMPP required that the HNS be set up as a QIP for each MCE. It is also recognized that some plans for interventions were well-intended at the start of the year but did not come to fruition. There needs to be better thought through on how the QIP will be designed at the outset of the year.

- B&A saw some evidence of internal dashboards related to these QIPs, but they could be streamlined and enhanced for ongoing reporting to OMPP.

MDwise

QIPs Reviewed

- AAP: Adult Access to Preventive Care (HIP)
- AMM: Asthma Medication Management (HHW)
- LSC: Lead Testing (HHW)
- FUH: Follow-up After Psychiatric Hospitalization (HIP)
- HNS: Health Needs Screening (HIP)

Types of interventions used

- Live voice calls (AAP)
- Provider outreach on panel adherence (Asthma)
- Automated calls, targeted provider outreach (Lead)
- Targeted outreach to providers, member incentive, case management (FUH)
- Email campaign, phone campaign, follow-up research for alternative member phone numbers (HNS)

B&A's overall assessment of MDwise's QIPs

- B&A commends MDwise for its continued approach to testing new interventions and assessing their effectiveness for the FUH QIP.

- The assessment and lessons learned for lead testing and AAP interventions appeared credible and MDwise is taking action for improvement of these interventions in the future.

- MDwise continues to have effective processes for tracking and increasing HNS compliance.

- There appears to be opportunities to identify more effective interventions on the asthma QIP if it is to be continued.

- B&A saw evidence of internal dashboards related to some QIPs, but they could be streamlined and enhanced for ongoing reporting to OMPP.

MHS

QIPs Reviewed

- AOD: Alcohol and Other Drug Abuse Treatment (HHW, HCC, HIP)
- BH: Behavioral Health Admissions (HHW, HCC, HIP)
- HNS: Health Needs Screening (HHW, HCC, HIP)

Types of interventions used

- Field-based case management, Clean Slate program (AOD)
- Field-based case management, outbound calls for first-time prescription fills, member calls for medication adherence (BH)
- Internal process improvement, text campaign joined with live calls, email campaigns, digital advertising (HNS)

B&A's overall assessment of MHS's QIPs

- The materials shared with the EQR team on AOD and BH were very helpful, but these were not reported on the QIP reports to OMPP. The submissions to OMPP were disappointing and sometimes incomplete or incorrect.

- The interventions for the AOD and BH QIPs have been in long-standing use and do not appear to be 'moving the needle' much if at all. There needs to be thought on how to target the interventions better or develop new ones.

- There is evidence that for MHS's HNS QIP, there are internal dashboard(s) that are maintained ongoing, but this is not shared with OMPP. This would be useful to show OMPP as evidence of ongoing tracking and trending.

SECTION V: 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. In Calendar Year (CY) 2018, the OMPP required that each MCE submit maps that identify the locations of providers across multiple specialties to ensure that its members in each OMPP program have access to providers. Additional reports were submitted by the MCEs to identify the count of members by specific geographic location (e.g., by zip code) that lacked access to a provider in that specialty. The total percentage of members with access could, therefore, be computed.

Burns & Associates (B&A) conducted an assessment of provider network adequacy in the External Quality Review (EQR) conducted in CY 2018. For that assessment, B&A examined 16 provider specialties. In particular, we examined not just where members from each MCE had access to providers (as self-reported by the MCE), but also where members utilized providers within the MCE's network. B&A used claims experience from CY 2017 to compute the driving distance between the member's home and the provider's location. The average driving distance was computed by provider specialty and by county for each provider specialty within each OMPP program. These values were compared to OMPP's contract requirements. Recognizing that members have the choice to seek care from providers that are further from their home than other providers that may be available to them, B&A nonetheless believes that the average driving distance is a truer representation of provider availability.

In the CY 2019 EQR, B&A conducted a similar study for nine provider specialty categories. Many of the provider specialty categories are the same as the prior year since they represent the most common services utilized (e.g., primary care, dental). Other provider categories have been added at the request of the OMPP (e.g., splitting behavioral health providers into two groups for behavioral health and substance use disorder). B&A used utilization from the CY 2018 time period to update the average driving distance calculations.

Methodology to Conduct the Review of Network Adequacy

Exhibit V.1
Provider Specialties in the Study and OMPP Access Standard for Each Specialty

Access Standard	Specialty
1 provider within 30 miles	Primary Care
	General Dentist
1 provider within 45 miles	Behavioral Health
	Substance Use Disorder
2 providers within 60 miles	Prenatal/Postpartum
	General Surgeon
	Cardiologist
	Oncologist
	Ophthalmologist

B&A identified members enrolled in HHW, HIP and HCC in CY 2018 and compiled their utilization during this time period. The provider specialties examined in this year's study appear in Exhibit V.1.

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 nine specialty categories for the study period of CY 2018. 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 2018. 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.

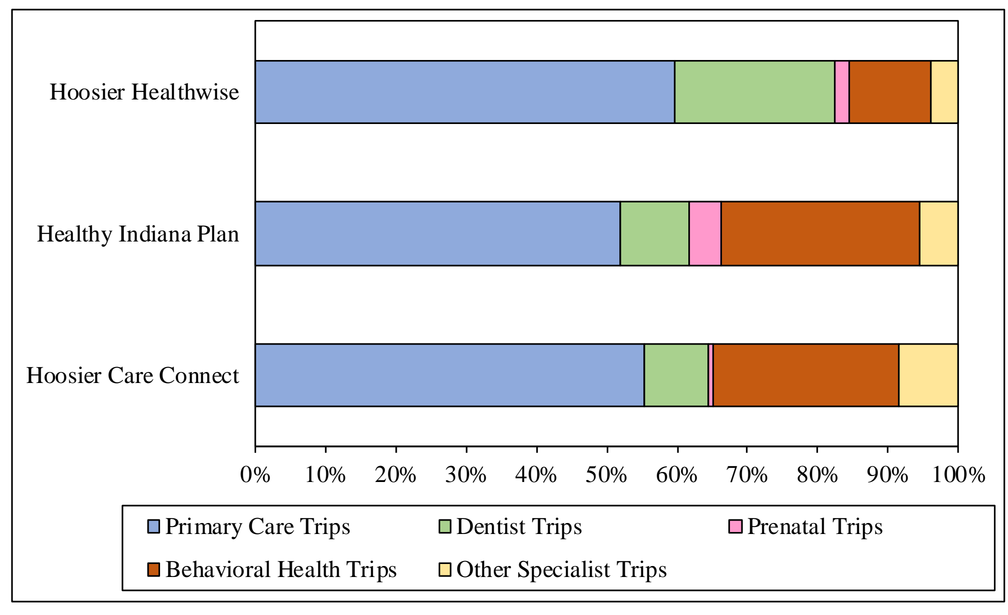
Geocoding software (either the Google Distance Matrix web service or BING Maps web service) was used to map the driving distance from the member's home to the provider's office[10]. Some exclusions were applied due to the fact that the latitude/longitude coordinates were missing or not valid for either 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 3,819,451 trips—for HHW, there were 1,693,784 trips; for HIP, there were 1,674,175 trips; and for HCC, there were 451,492 trips. A distribution of the trips studied within each program appears in Exhibit V.2 on the next page.

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. For acute care specialties, the average was also computed across eight regions of the state. Each of the state's 92 counties were mapped to one of eight regions. This was completed due to the lower sample size for these specialty services. Lastly, B&A computed the average driving distance for each provider specialty on a statewide basis for each MCE/program combination.

For all except for the acute care specialties, B&A created a three-scale range to count the number of counties that had average driving distance of 20 miles or less, between 20 and 30 miles, and greater than 30 miles. Although this scale range is stricter than OMPP's contractual requirements, it was used to assess the relative variation in the average distance travelled by members across the 92 counties in the state.

[10] Note that B&A computes the driving distance (turn by turn) as opposed to a crow flies' distance.

Exhibit V.2
Proportion of Trips in the Network Adequacy Study
by Program and Major Provider Type



	Primary Care Trips	Dentist Trips	Prenatal Trips	Behavioral Health Trips	Other Specialist Trips	Total
Hoosier Healthwise	1,010,307	386,185	33,078	199,596	64,618	1,693,784
Healthy Indiana Plan	868,845	163,651	76,515	471,086	94,078	1,674,175
Hoosier Care Connect	249,493	40,999	3,199	119,654	38,147	451,492

Findings from the Review of Access to Services by Provider Specialty

Exhibits V.3 through V.5 that appear on the following pages examine the average distance travelled by members for each provider specialty and the count of counties that have an average value within each of B&A's defined distance ranges. The provider specialties displayed are primary care, dental, substance use disorder (SUD), serious emotional disturbance/serious mental illness (SED/SMI), and prenatal/postpartum care.

The exhibits are displayed in a similar manner. The average distance statewide for each MCE/program is shown in the top box to allow for side-by-side comparison. In the lower box, the count of counties (out of a total of 92) is depicted for each distance range used by B&A. In some cases, a count of counties for 'sample too low' appears. This means that the individual county had less than 10 trips within the MCE/program reviewed, so the average distance was not reportable.

Exhibits V.6 and V.7 appear after these exhibits. These two exhibits are oriented in the same manner and show results for the four acute care specialty providers reviewed. Because the sample is smaller for these specialties (the four specialties combined represented 5.1% of all trips reviewed in the study), the average distance is shown at the region level. Exhibit V.6 shows results for general surgery and cardiology. Exhibit V.7 shows results for oncology and ophthalmology.

Key findings from each of these exhibits appears below. For Exhibits V.3 through V.5, counts are shown out of 920 MCE/program/county combinations (92 counties * 10 MCE/program combinations).

Exhibit V.3 (Primary Care and Dental Providers):

- Average driving distance statewide, primary care, all MCEs/programs: 12.8 to 16.8 miles.
- MCE/program/county combinations with average > 30 miles: 148.
- Counties with challenges for most MCEs include the following:
  - In the North regions: Jasper, Newton, LaGrange, Wabash
  - In the Central regions: Benton, Fountain, Warren
  - In the South regions: Crawford, Lawrence, Orange, Washington
- Average driving distance statewide, dental, all MCEs/programs: 12.8 to 20.1 miles.
- MCE/program/county combinations with average > 30 miles: 158.
- Counties with challenges for most MCEs include the following:
  - In the North regions: Newton, Pulaski, Starke
  - In the Central regions: Fountain, Union, White
  - In the South regions: Franklin, Greene, Jefferson, Ripley, Scott, Switzerland

Exhibit V.4 (SUD and SED/SMI Providers):

- Average driving distance statewide, SUD services, all MCEs/programs: 13.7 to 19.3 miles.
- MCE/program/county combinations with average > 30 miles: 202.
- Counties with challenges for most MCEs include the following:
  - In the North regions: Jasper, LaGrange, Newton, Pulaski, Steuben, Wabash
  - In the Central regions: Benton, Fountain, Rush
  - In the South regions: Crawford, Decatur, Greene, Martin, Jefferson, Jennings, Ripley, Switzerland
- Average driving distance statewide, SED/SMI services, all MCEs/programs: 14.1 to 19.0 miles.
- MCE/program/county combinations with average > 30 miles: 208.
- Counties with challenges for most MCEs include all listed for SUD plus Jackson and Scott

Exhibit V.5 (Prenatal/Postpartum Providers):

- The overall average driving distance to seek prenatal and postpartum services statewide was between 14.1 and 19.0 miles across MCEs/programs.
- MCE/program/county combinations with average > 30 miles: 246.
- Counties with challenges for most MCEs include the following:
  - In the North regions: Jasper, Kosciusko, LaGrange, Newton, Wabash
  - In the Central regions: Benton, Fountain, Howard, White
  - In the South regions: Crawford, Lawrence, Washington

Exhibit V.6 (General Surgery and Cardiology Providers):

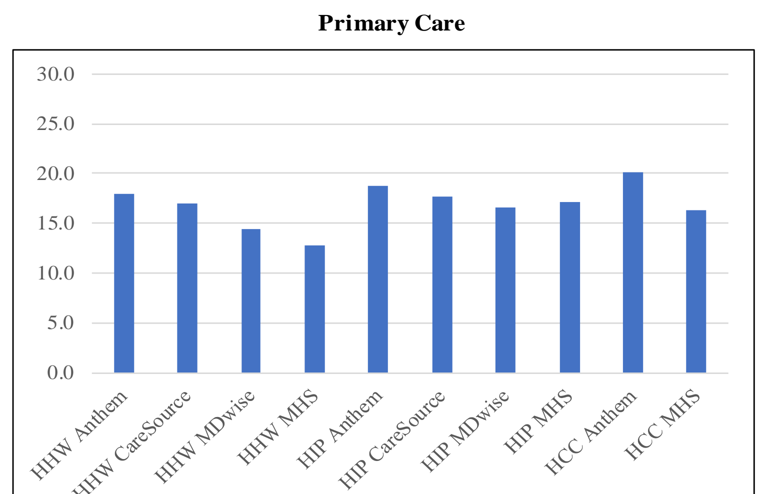
- All MCEs meet the OMPP target of 60 miles at the region level for general surgery and cardiology.
- With the exception of West Central (surgery, cardiology) and Southeast (cardiology), the average distance is under 30 miles in each region.

Exhibit V.7 (Oncology and Ophthalmology Providers):

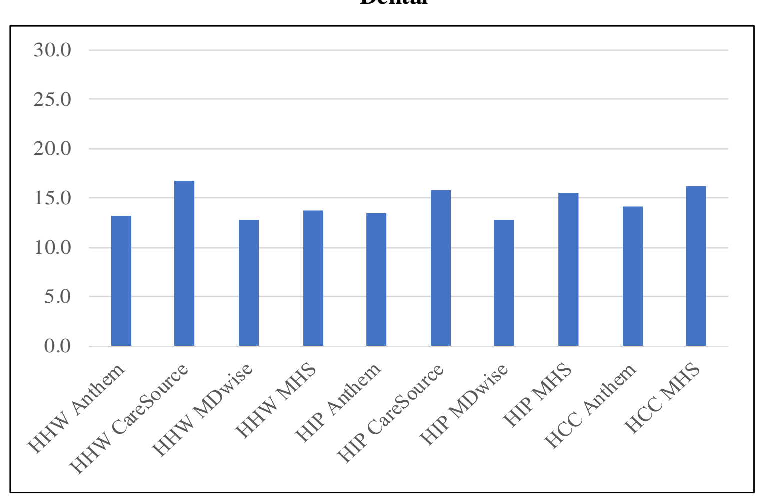
- All MCEs meet the 60-mile target for ophthalmology. For oncology, 69 out of 73 MCE/program/region combinations meet this target (7 regions are excluded due to low volume).
- With the exception of West Central (oncology, ophthalmology) and East Central (oncology), the average distance is under 30 miles in each region.

Exhibit V.3
Average Driving Distance for Members Using Each Service in CY2018, by MCE/Program

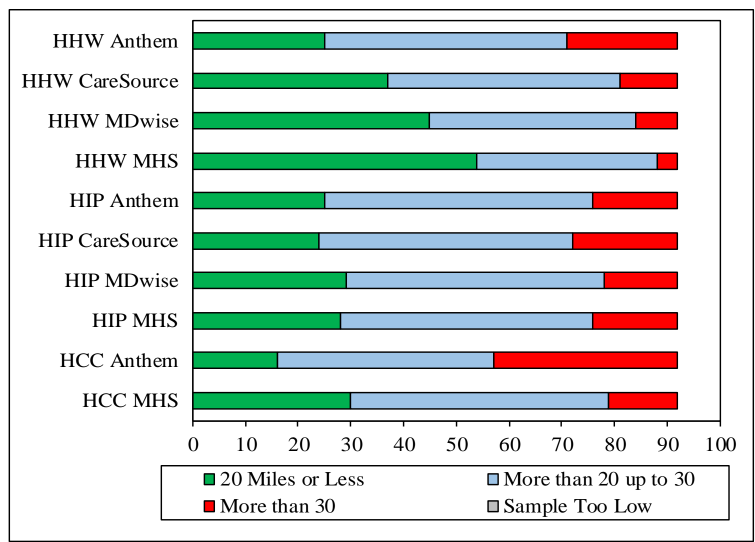
Primary Care



Dental



Colored Bars Plot # Counties (out of 92) in Each Distance Range



Colored Bars Plot # Counties (out of 92) in Each Distance Range

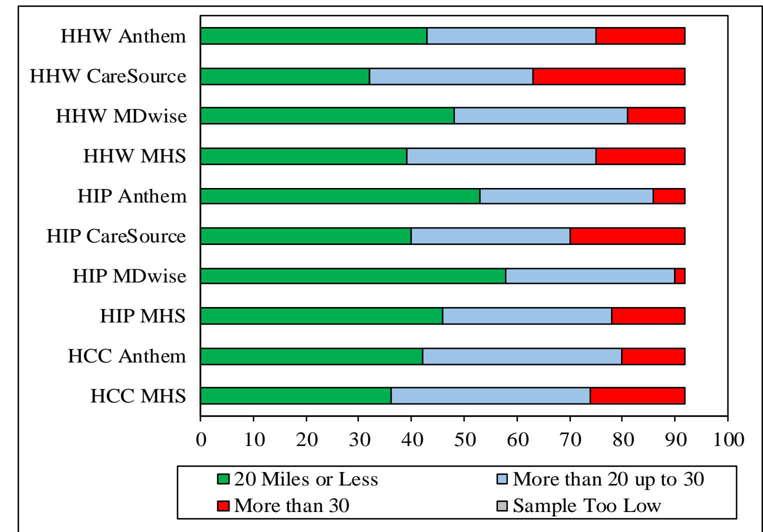
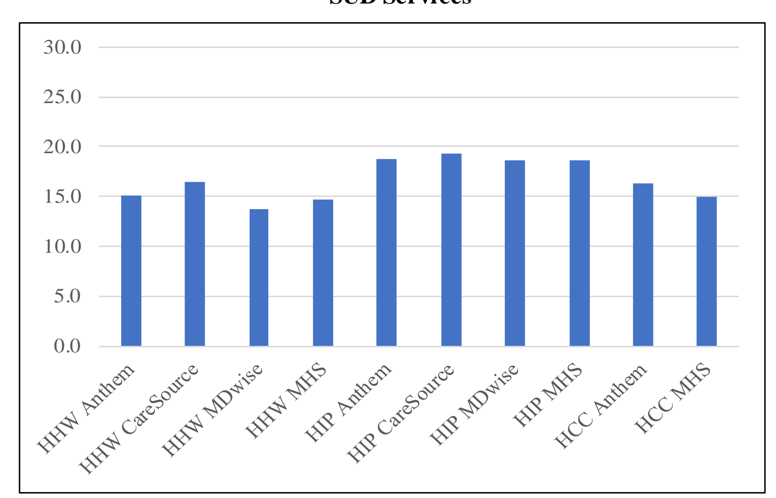
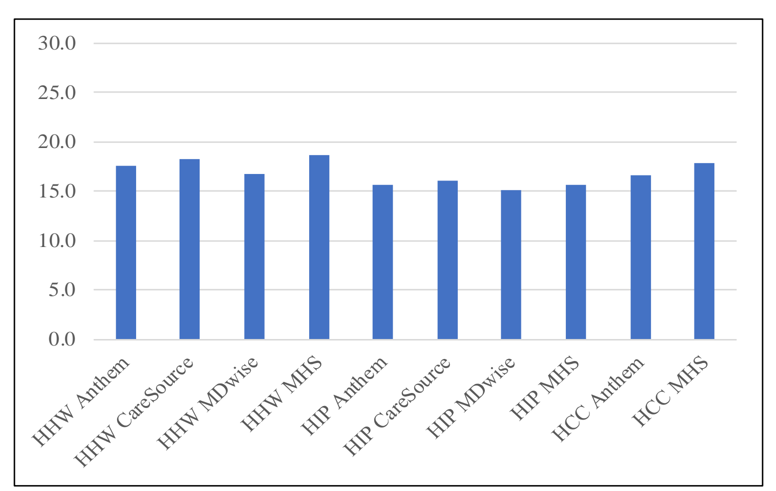


Exhibit V.4
Average Driving Distance for Members Using Each Service in CY2018, by MCE/Program

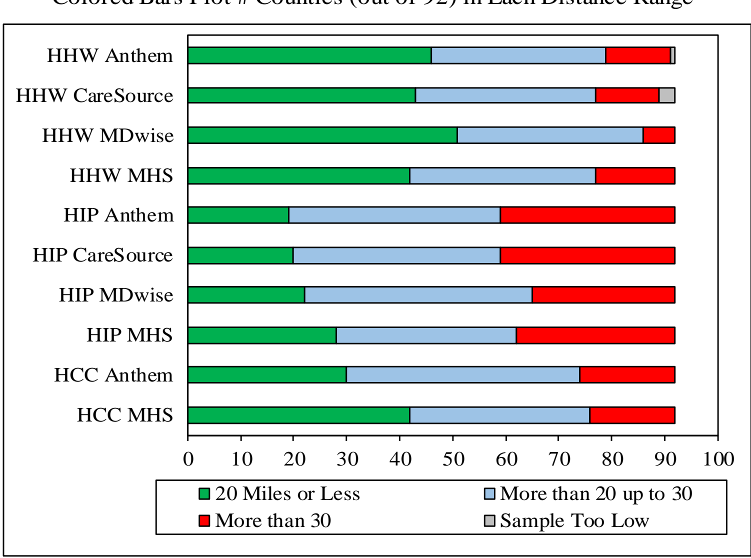
SUD Services



SED/SMI Services



Colored Bars Plot # Counties (out of 92) in Each Distance Range



Colored Bars Plot # Counties (out of 92) in Each Distance Range

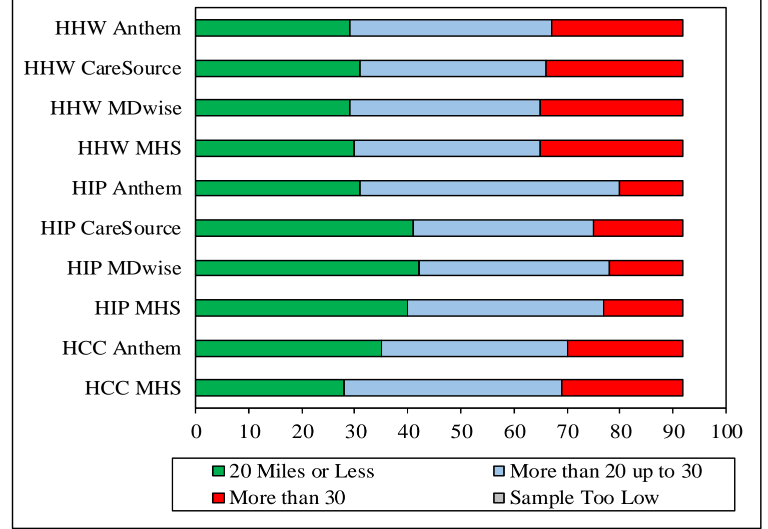
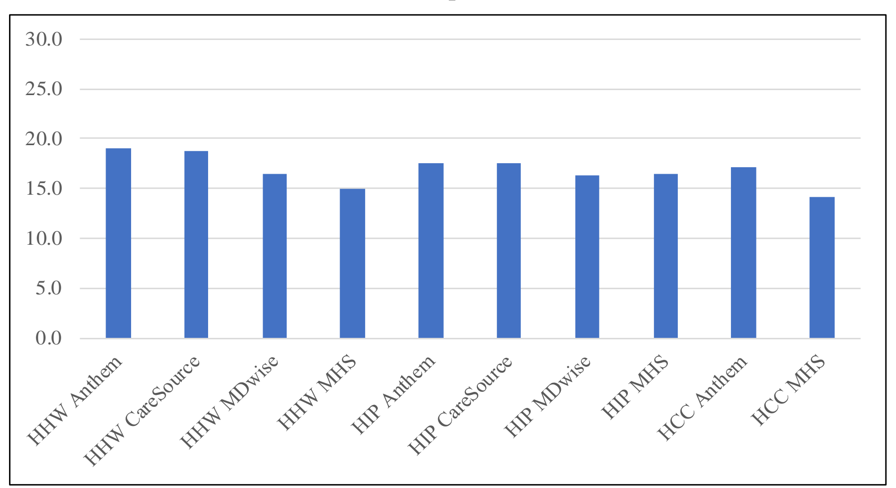


Exhibit V.5
Average Driving Distance for Members Using Each Service in CY2018, by MCE/Program

Prenatal/Postpartum Services



Colored Bars Plot # Counties (out of 92) in Each Distance Range

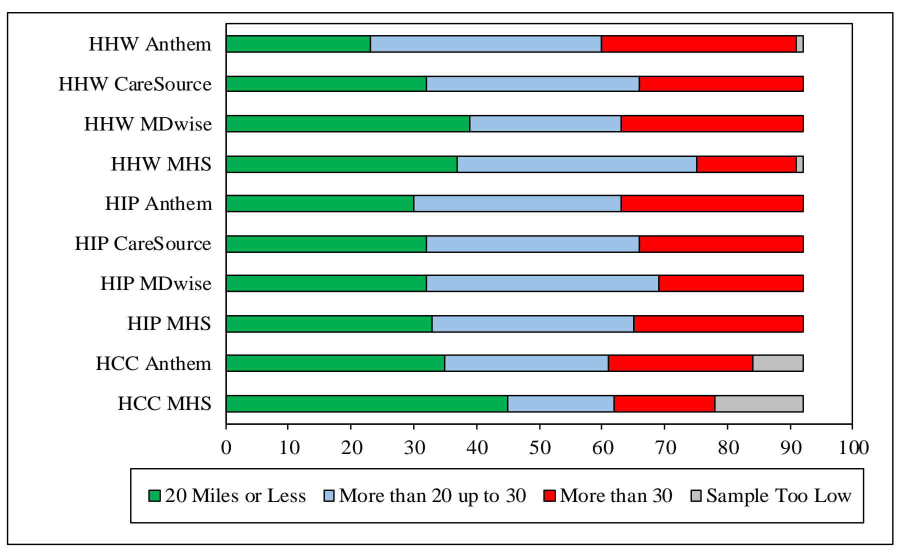


Exhibit V.6
Average Driving Distance Report for Selected Acute Specialty Services
Representing Trips from Indiana Medicaid Members in Managed Care that Took Place in Calendar Year 2018

Legend	
Green	Average driving distance was 30 miles or less (most favorable)
Blue	Average driving distance was > 30 but < 60 miles (still within OMPP target)
Red	Average driving distance was more than 60 miles (outside of OMPP target)

General Surgery	HHW Anthem	HHW CareSource	HHW MDwise	HHW MHS	HIP Anthem	HIP CareSource	HIP MDwise	HIP MHS	HCC Anthem	HCC MHS
Northwest	32.4	13.3	12.0	10.9	19.1	11.7	12.6	13.9	19.7	9.8
North Central	30.2	38.8	31.1	19.3	21.9	25.4	23.8	21.2	22.8	18.4
Northeast	24.4	22.5	22.7	21.8	29.3	29.5	29.4	22.2	30.0	22.1
West Central	30.9	39.7	45.8	45.2	30.5	31.1	29.4	36.5	30.5	27.4
Central	15.7	14.2	22.3	12.5	18.8	16.8	12.7	16.9	12.1	11.4
East Central	22.1	21.5	25.5	13.4	15.1	14.0	18.7	10.1	22.7	18.3
Southwest	12.8	13.5	33.0	26.7	19.7	23.7	25.3	24.7	16.0	24.1
Southeast	22.8	23.0	32.5	26.0	19.4	33.9	21.1	18.4	20.5	18.5

Cardiology	HHW Anthem	HHW CareSource	HHW MDwise	HHW MHS	HIP Anthem	HIP CareSource	HIP MDwise	HIP MHS	HCC Anthem	HCC MHS
Northwest	12.9	14.2	14.7	14.7	10.6	11.0	11.2	10.1	10.4	10.7
North Central	8.1	8.3	9.5	7.1	9.4	8.2	17.5	7.9	11.9	9.7
Northeast	18.9	17.8	14.9	15.5	27.5	25.6	27.9	25.1	24.3	19.0
West Central	61.6	59.1	53.7	46.6	50.4	26.7	27.8	29.3	52.6	27.1
Central	33.0	20.2	18.8	19.6	25.7	19.1	14.0	14.9	20.7	12.4
East Central	28.2	22.3	16.2	25.8	25.9	17.7	16.2	20.4	30.1	21.9
Southwest	36.7	21.6	19.1	16.8	20.4	16.9	16.4	19.8	28.3	18.4
Southeast	52.1	30.8	28.5	34.0	52.8	53.4	41.6	47.3	48.1	27.0

Exhibit V.7
Average Driving Distance Report for Selected Acute Specialty Services
Representing Trips from Indiana Medicaid Members in Managed Care that Took Place in Calendar Year 2018

Legend
Green: Average driving distance was 30 miles or less (most favorable)
Blue: Average driving distance was > 30 but < 60 miles (still within OMPP target)
Red: Average driving distance was more than 60 miles (outside of OMPP target)

Oncology	HHW Anthem	HHW CareSource	HHW MDwise	HHW MHS	HIP Anthem	HIP CareSource	HIP MDwise	HIP MHS	HCC Anthem	HCC MHS
Northwest	20.0	sample <10	49.5	22.8	21.9	22.3	24.8	19.7	16.4	14.0
North Central	3.9	no data	sample <10	sample <10	18.2	20.2	17.5	14.0	17.5	14.4
Northeast	11.5	58.5	55.3	sample <10	22.3	20.8	23.1	20.8	25.1	16.6
West Central	34.7	58.4	66.7	52.9	38.0	50.9	48.0	33.6	34.8	39.2
Central	9.1	18.1	15.1	21.0	18.2	16.0	13.9	20.6	16.8	17.7
East Central	30.6	58.2	58.8	60.6	58.3	56.3	60.6	55.4	48.0	33.4
Southwest	50.7	sample <10	sample <10	61.5	21.3	26.7	30.7	32.9	22.3	29.8
Southeast	19.5	28.0	42.2	32.8	22.2	26.8	24.1	21.5	22.2	17.3

Ophthalmology	HHW Anthem	HHW CareSource	HHW MDwise	HHW MHS	HIP Anthem	HIP CareSource	HIP MDwise	HIP MHS	HCC Anthem	HCC MHS
Northwest	16.6	15.7	17.3	13.4	15.1	11.8	14.3	12.0	16.3	17.1
North Central	16.4	21.0	20.7	13.2	18.0	14.7	18.8	13.2	17.9	14.2
Northeast	13.9	18.4	14.1	17.4	16.0	36.9	15.2	20.7	19.2	18.9
West Central	49.6	55.4	37.7	50.3	31.2	35.4	26.1	28.0	43.5	39.1
Central	18.6	17.3	16.3	19.6	15.0	15.2	14.5	17.5	18.0	16.8
East Central	37.7	54.2	30.7	39.4	22.5	27.9	20.4	22.2	34.6	27.7
Southwest	33.3	33.4	27.1	33.3	19.3	21.6	18.6	21.4	23.0	32.7
Southeast	19.2	30.2	28.3	25.7	26.5	28.4	28.8	23.7	20.2	27.6

Comparison to Previous EQRs

B&A compared the count of unique counties with average distance above 30 miles in this study with the study conducted in the CY 2018 EQR for selected services. The results are shown below.

For primary care, total counties for all MCEs combined with average greater than 30 miles:

- For HHW: CY 2019 study, 44; CY 2018 study, 106
- For HIP: CY 2019 study, 66; CY 2018 study, 117
- For HCC: CY 2019 study, 48; CY 2018 study, 52

For dental care, total counties for all MCEs combined with average greater than 30 miles:

- For HHW: CY 2019 study, 74; CY 2018 study, 78
- For HIP: CY 2019 study, 44; CY 2018 study, 41
- For HCC: CY 2019 study, 30; CY 2018 study, 37

For behavioral health, total counties for all MCEs combined with average greater than 30 miles:

- For HHW: CY 2019 study, 45 for SUD, 105 for SED; CY 2018 study, 136 SUD/SED combined
- For HIP: CY 2019 study, 123 for SUD, 58 for SMI; CY 2018 study, 170 SUD/SMI combined
- For HCC: CY 2019 study, 34 for SUD, 45 for SED/SMI; CY 2018 study, 73 SUD/SED/SMI combined

Recommendations

Based on the findings presented above and the trends found with the study conducted in the CY 2018 EQR, B&A offers some recommendations to all MCEs as a whole and others to specific MCEs.

1. For All MCEs: Primary care average distances improved between the CY 2018 and CY 2019 studies, but dental and behavioral health distances remained steady. For all services reviewed, 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 should investigate if this is occurring.
    b. The MCEs are encouraged to drill into the observations specific to the members with miles above the standard to determine if this may member choice or a true access issue.

2. For All MCEs: There are more counties with an average distance above 30 miles for SUD among HIP members than HHW or HCC and this is where most SUD services are delivered. The State continues to expand its SUD network of providers. Each MCE is encouraged to build relationships and incentives to contract with all of the SUD providers in the IHCP.

3. For All MCEs: Although the statewide average distance is under 30 miles for prenatal and post-partum services, there are also opportunities to improve distances at the individual county level.

4. Specific areas for Anthem to review:

    a. Access to dental services continues to be a challenge for some members in the network.
    b. Although meeting the <60 mile threshold for the specialty services reviewed, Anthem is higher than other MCEs for cardiology in the West Central region.

5. Specific areas for CareSource to review:

    a. Access to dental services continues to be a challenge for some members in the network. CareSource has more individual counties above the 30-mile average threshold than its peers.
    b. Although meeting the <60 mile threshold for the specialty services reviewed, CareSource is higher than other MCEs for ophthalmology in the Northeast region (HIP) and East Central region (HHW).

6. Specific areas for MDwise to review:

    a. Although meeting the <60 mile threshold for the specialty services reviewed in most regions, MDwise is higher than other MCEs for oncology in the West Central region (HHW) and East Central region (HIP).

7. Specific areas for MHS to review:

    a. Although meeting the <60 mile threshold for the specialty services reviewed in most regions, MHS is higher than other MCEs for oncology in the Southwest region (HHW).

SECTION VI: FOCUS STUDY ON AUDIT OF PROVIDER DIRECTORIES

Introduction

The managed care entities (MCEs) under contract to deliver services in the Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC) programs are authorized to contract with any provider who first enrolls in Indiana's Health Coverage Program (IHCP). The enrollment process in the IHCP is administered for the OMPP by its fiscal agent, DXC. The MCEs receive file notifications of additions, deletions and changes to the IHCP from DXC. Providers have the option to contract with some, all or none of the MCEs. Providers also have the option to contract with just the HHW, HIP or HCC program or any combination of programs.

In previous External Quality Reviews (EQRs), Burns & Associates (B&A) found that providers were often selective as to which MCE or which program they contracted with. Part of this was due to a difference in the rate of provider reimbursement between the HIP and HHW/HCC programs. In HIP, state legislation requires that the MCEs pay providers the prevailing Medicare rate for a service or 130 percent of the Medicaid rate when no Medicare rate is available. This caused a historic differential between the providers who contracted in HIP versus the other programs.

This variation appears to have shifted in more recent years. Although there is still some distinction between HIP and the other programs, if a provider chooses to contract with an MCE, it often contracts with all OMPP programs that the MCE serves. Further, B&A has found that there is a higher proportion of providers that contract with all four or at least three of the MCEs. This is a shift even from five years ago.

In the Calendar Year (CY) 2016 EQR, B&A reviewed the information available to managed care members in the online provider directories published by the MCEs. A sample of 720 providers was selected for telephonic verification of the information about their practice that was listed in the online directories. In this year's EQR, B&A once again conducted a review of the MCE's online directories. This time, a total of 960 providers were selected for the telephonic audit of information. The section provides a summary of our review of the online directory tools and the results of the phone audit.

Methodology for Conducting the Study

B&A conducted an initial review of each MCE's online provider directory to inventory the potential data elements available to members. These data elements were matched against the OMPP's contract requirements for the minimum standards of information required in the directory.

As part of the EQR Guide released to the MCEs in April 2019, B&A requested that each MCE deliver information that is presented in the directory in tabular format. The data request made was common to all MCEs. The tables were due back to B&A in mid-June.

Upon receipt of each MCE's database, B&A conducted validation tests to ensure that the database contained the relevant information needed for this study. A check was made for duplicate, or potential duplicate, records. B&A also ensured that there was an indicator that showed if the provider was contracted under HHW, HIP, and/or HCC. Another variable indicated if the provider listed was an individual practitioner, a group practice, or a hospital. As needed, B&A conducted follow-up calls with each MCE about their database to ensure that we understood the contents and to verify the completeness

of what was delivered. The provider's IHCP ID, their tax ID, and their national provider identifier (NPI) were all collected in order to cross-reference across MCE files.

B&A mapped the IHCP ID for the providers on each MCE roster to a provider demographic file provided to B&A by the OMPP from the State's Enterprise Data Warehouse (EDW). The county location where the provider delivers services was captured as well as provider specialty assigned by DXC. B&A compared the DXC-assigned provider specialty designation to the designation provided by the MCE in its submission to B&A. A comparison was made with meaningful differences between the two assignments noted to the MCE. Each MCE was given the opportunity to validate B&A's comparison and offer updates to its directory submission or clarification of why there may be differences between the DXC-assigned specialty and the MCE-assigned specialty category. The sampling for the telephone audit and the desk review of each MCE's directory was not completed until final sign-off was given by each MCE.

Desk Review of Database Information

The NPIs that were found in more than one MCE directory were placed in a separate Microsoft Excel file for comparison (n= 26,514). Street addresses that appeared in each MCE's directory were aligned side-by-side to compare them across MCEs for each NPI. No sampling was done here (the full list of 26,514 was reviewed). A function was used in Excel to identify exact matches on street addresses. An exact match was tagged "yes" and a non-match was tagged "no". All "no" records were passed on to a second level review.

The second level review was the visual inspection of the addresses across the MCEs. Examples where there was a close match were converted from "no" to "yes". An example of this could be the following: MCE #1 showed 123 Main Street, MCE #2 showed 123 Main St., and MCE #3 showed 123 Main Street, Suite 101.

Sampling for the Telephone Audit

B&A mapped the dozens of provider specialty categories into one of five higher-level groups:

- Primary Medical Provider (PMP), excluding OB/GYNs and Pediatricians
- Pediatricians
- OB/GYNs (includes those contracted as PMPs and those who are not)
- Behavioral Health providers
- Other Acute Care specialties

A sample of 960 unique providers was constructed that was used to outreach to providers telephonically to verify information. Some features of the sample include the following:

- By MCE: 240 providers were selected from each of the four MCEs.
- By major category: Primary Medical Provider (n=240), Pediatrician (n=240), OB-GYN (n=240), Various Other Acute (n=120), Various Behavioral Health (n=120).
- By geography: The sample included providers in every county of the state.
- MCE contracting: 38.0 percent of the providers selected were contracted with all four MCEs. Another 38.3 percent were contracted with three of the four MCEs.
- By program: Although providers could contract with more than one OMPP program, at least 41 percent of providers were identified as HHW providers, 39 percent as HIP providers, and 20 percent at HCC providers.

Telephonic Audit of Database Information

During the months of July through September, calls were made to the sample of 960 providers. Calls were made during standard business hours on weekdays. The B&A representative identified themselves to provider offices when the phone was answered and indicated the reason for the call. The information that was being validated was stored in a Microsoft Access database. An online data entry screen was created where the team member could read the information to the provider office staff member and then check online on the screen if the information matched or not. The specific information that was validated against the provider directories included:

- Office phone number (as evident if the office answered)
- Office address
- Provider group name (when a group practice)
- If the individual provider that was being referenced on the call was still at the practice
- The provider's specialty
- If the provider accepts members in the OMPP program (HHW, HIP, and/or HCC depending on the information given to us by the MCE)
- If the provider contracted with the MCE(s)
- If the provider is accepting new members in the program(s)

The EQR team member had the opportunity to enter in correct information when the provider's office confirmed that a piece of information was incorrect.

Three attempts were made to each office if unsuccessful on the first call. The auditor stayed on hold for up to three minutes if initially put on hold by the office. The team member gave each call a completion status. The options included "complete", "incomplete" and "provider office refused to participate". When the status was designated incomplete, a reason was given for the incomplete status.

Findings

Navigation of the MCE's Online Directories

B&A found that each MCE met the minimum OMPP contractual requirements for online provider directory content. Further, all of the MCEs have value-added items on their directories as well, but these vary by MCE. An inventory of features of each MCE's online directory appear in Exhibit VI.1 on the next page.

The directories are easy to navigate to conduct a query, but there could be confusion for members on the terms to filter on for specialties. B&A observed that there are 98 different descriptors for provider categories in the MCE's directories:

- Anthem has 51; CareSource has 74; MDwise has 43; and MHS has 45
- There are only 18 descriptors of provider categories common to all four MCEs (e.g., dental, chiropractic).
    - Another 18 categories are common to three MCEs (e.g., audiologist, endocrinology).
    - Another 25 categories are common to two MCEs (e.g., family/general practice).
    - There are 37 categories used by only one MCE.

Exhibit VI.1
Features of Each MCE's Online Provider Directory Search Functionality for Members

Starting search criteria:	Anthem	Care Source	MHS	MDwise
Specialty Type - General	✓	✓	✓	✓
By Name	✓	✓	✓	✓
Distance criteria	✓	✓	✓	✓
Accepting New Patients?	✓	✓	✓	✓
Able to serve as PCP filter	✓	✓	✓	✓

After search is conducted, information shown:	Anthem	Care Source	MHS	MDwise
Provider's name	✓	✓	✓	✓
Provider's gender	✓	✓	✓	✓
Provider's specialty	✓	✓	✓	✓
Provider's address	✓	✓	✓	✓
Provider's phone number	✓	✓	✓	✓
Hospital affiliation, if any	✓	✓	✓	
Medical group affiliation	✓	✓	✓	
Board certification	✓		✓	✓
Status as a PCP	✓	✓	✓	✓
Language(s) spoken	✓	✓	✓	✓
Office ADA accessibility	✓	✓	✓	
Provider's office hours	✓	✓	✓	✓
Office access to public transportation	sometimes	✓	✓	✓
Provider's status in network	✓	✓	✓	✓
Exact distance to provider	✓	✓	✓	✓
Open after 5pm	✓	✓	✓	✓
Open weekends		✓	✓	✓
Driving distance and directions to provider	✓	✓	✓	

Ability to refine initial search:	Anthem	Care Source	MHS	MDwise
Sort by distance	✓		✓	✓
Sort by name	✓	✓	✓	
Sort by specialty	✓	✓	✓	
Increase or decrease distance	✓		✓	
Filter by language spoken	✓		✓	✓
More refined subspecialties	✓	✓	✓	
Open after 5pm / weekends			✓	
ADA accessibility to office	✓		✓	
Accepts Medicaid	✓		✓	
Recognitions by health plan	✓		✓	

Other features:	Anthem	Care Source	MHS	MDwise
Ability to create PDF report	✓	✓	✓	✓
Ability to email results	✓			✓
Ability to print	✓	✓	✓	✓
Ability to compare providers side-by-side	✓			✓

Desk Review of Office Addresses

There are 3,673 NPIs present in all four MCE directories. Another 8,783 are present in three directories and 14,058 in two directories.

When the NPIs in multiple directories were matched side-by-side, it was found that the address never matched exactly across all four MCEs. It only matched 39.9 percent of the time among three MCEs and 49.0 percent of the time among two MCEs. When the NPI appeared in three of the four MCE directories,

a match on the address was found in all three directories 16.2 percent of the time and in two of the directories 58.3 percent of the time. Details are found in Exhibit VI.2 below.

Exhibit VI.2
Findings on Provider Address Matches When Listed in Multiple MCE Directories

Count of Unique NPIs in Multiple MCE Directories	26,514	
	Count	**Pct**
with 2 MCEs	14,058	53.0%
with 3 MCEs	8,783	33.1%
with 4 MCEs	3,673	13.9%

Count NPIs in Multiple Directories Where Addresses Same Across MCEs

# of MCEs	No Match	2 Match	3 Match	4 Match	Total
2 MCEs	5,148	8,910	0	0	**14,058**
3 MCEs	2,236	5,123	1,424	0	**8,783**
4 MCEs	403	1,800	1,466	4	**3,673**
Total	**7,787**	**15,833**	**2,890**	**4**	**26,514**

% NPIs in Multiple Directories Where Addresses Same Across MCEs

# of MCEs	No Match	2 Match	3 Match	4 Match	Total
2 MCEs	36.6%	63.4%			**100.0%**
3 MCEs	25.5%	58.3%	16.2%		**100.0%**
4 MCEs	11.0%	49.0%	39.9%	0.1%	**100.0%**
Total	**29.4%**	**59.7%**	**10.9%**	**0.0%**	**100.0%**

Telephone Audit

The results of the provider directory phone audit were disappointing. After the 960 calls that were initially conducted, B&A achieved a status of 66 percent complete (n= 636), 32 percent incomplete (n= 306) and two percent refused (n= 18). Among the reasons cited for incomplete calls, 190 were for when messages had to be left multiple times (62% of incomplete), 51 calls were disconnected (17% of incomplete), and 65 were for various other reasons (21% of incomplete) such as busy signal, extended wait time, or no answer.

Among the 636 that B&A could reach by live voice, the provider that was included in our sample was currently working at the office we had listed 60 percent of the time. Because our audit was to validate information on this provider specifically, that meant that our sample to audit was further reduced to 385 providers (60% of 636 reached).

A summary of the results from the phone audit appears in Exhibit VI.3 on the next page. In the upper left box, it was found that among the 385 live phone confirmations, the correct address was validated 72 percent of the time, the group name was validated 99 percent of the time, and the individual's provider specialty was validated 94 percent of the time.

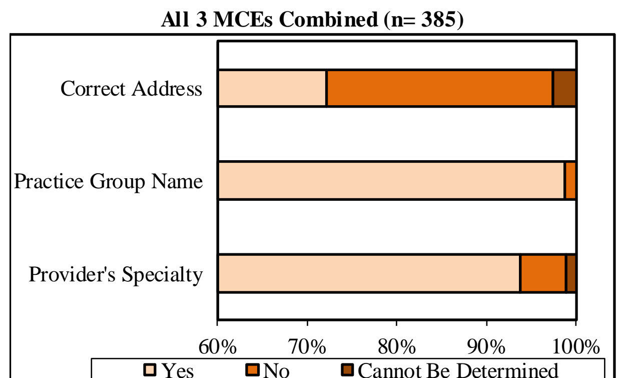
When asked if the provider or group practice contracted with a specific MCE, 94 percent of the offices could confirm positively that they contracted with Anthem; for CareSource, 90 percent; for MDwise, 91 percent; and for MHS, 94 percent.

When asked if they contracted with a specific OMPP program, 94 percent of the offices could confirm positively that they contracted with HHW; for HIP, 89 percent; and for HCC, 86 percent.

When asked if they were accepting new patients, B&A could not determine 40 percent of the time with HHW and HIP providers. For HCC, 91 percent confirmed that they were accepting new patients.

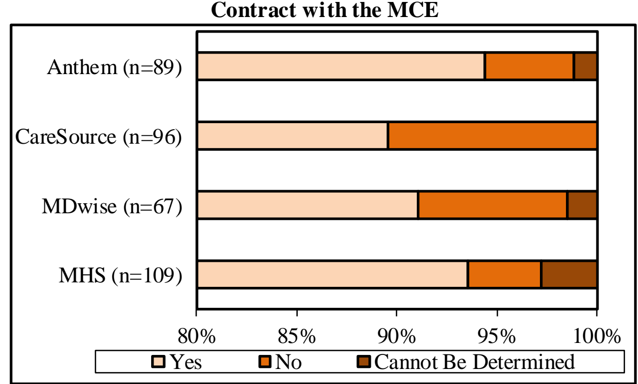
Exhibit VI.3
Summary Results of Provider Information in Phone Audit

All 3 MCEs Combined (n= 385)



	Can be Verified?		
	Yes	No	Cannot Be Determined
Correct Address	278	97	10
Practice Group Name	380	5	0
Provider's Specialty	361	20	4

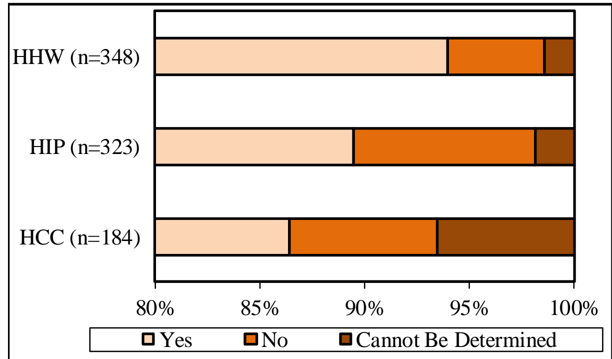
Contract with the MCE



	Can be Verified?		
	Yes	No	Cannot Be Determined
Anthem (n=89)	84	4	1
CareSource (n=96)	86	10	0
MDwise (n=67)	61	5	1
MHS (n=109)	102	4	3

Contract Under the OMPP Program

Provider may be counted more than once across MCEs



	Can be Verified?		
	Yes	No	Cannot Be Determined
HHW (n=348)	327	16	5
HIP (n=323)	289	28	6
HCC (n=184)	159	13	12

Confirm Accepting New Patients (when Yes on MCE Directory)

Count of Providers (provider may be counted with multiple MCEs)

HHW (n=551)
HIP (n=517)
HCC (n=250)
0% 20% 40% 60% 80% 100%
Yes No Cannot Be Determined

	Can be Verified?		
Contracted with	Yes	No	Cannot Be Determined
HHW (n=551)	271	59	221
HIP (n=517)	241	68	208
HCC (n=250)	61	5	1

Comparison to Previous EQRs

B&A compared the results of the telephone audit conducted this year against the results from the CY 2016 audit. In CY 2019, only 60 percent of providers sampled were still working at the office listed in the MCE's directory. In CY 2016, this was 63 percent. The results below reflect the percentages among providers who were working at the office listed in the directory and confirmations were gained by live voice. All percentages represent affirmative confirmation.

- For confirmation of address: CY 2019, 72%; CY 2016, 83%
- For confirmation of group practice name: CY 2019, 99%; CY 2016, 83%
- For confirmation of individual provider specialty: CY 2019, 94%; CY 2016, 79%

With respect to confirmation that the provider's office contracts with individual MCEs:

- For Anthem: CY 2019, 94%; CY 2016, 75%
- For MDwise: CY 2019, 91%; CY 2016, 71%
- For MHS: CY 2019, 94%; CY 2016, 79%

With respect to confirmation that the provider's office contracts with OMPP programs:

- For HHW: CY 2019, 94%; CY 2016, 72%
- For HIP: CY 2019, 89%; CY 2016, 71%
- For HCC: CY 2019, 86%; CY 2016, 70%

Recommendations

Although the navigation options for members in HHW, HIP and HCC in search of providers in the MCEs' online directories have greatly improved over the years, the validity of the data shown online could be greatly improved. As a result of this study, B&A offers the following recommendations to the OMPP and to the MCEs.

<u>Recommendations to the OMPP</u>

1. To ensure compliance with network adequacy standards, the OMPP should require the MCEs to report on average distance travelled by members and not just distance to the closest provider in the MCE's directory.

2. In addition to reviewing a statewide average distance travelled, for high-volume services (e.g., primary care, dental, OB-GYN), the OMPP may want to consider imposing standards at the county or regional level.

3. B&A suggests that the OMPP may clarify and strengthen access requirements to specialties within behavioral health (e.g. mental health compared to substance use disorder) in its contract with the MCEs.

4. The OMPP may consider requiring common terminology of at least some specialties listed in the MCE's provider directory to improve the member's online experience.

5. To ensure compliance with accurate provider directory information, the OMPP should require the MCEs to report on an annual audit of the information in its directory on a sample of providers.

Recommendations to the MCEs

1. Each MCE needs to enhance its education with providers to contact the IHCP when information about their practice changes, particularly when practitioners leave.

2. Each MCE should demonstrate to the OMPP its ongoing audit practice of the information in its own online provider directory

SECTION VII: FOCUS STUDY ON POTENTIALLY PREVENTABLE EMERGENCY DEPARTMENT VISITS

Introduction

Burns & Associates (B&A) has utilized 3M's Core Grouping Software in prior External Quality Reviews (EQRs) to assist the Office of Medicaid Policy and Planning (OMPP) and its managed care entities (MCEs) to assess the rates of potentially preventable hospital readmissions (PPRs) and potentially preventable emergency department visits (PPVs) within the managed care programs. In the CY 2015 EQR, B&A assessed inpatient utilization that occurred in CYs 2013 and 2014 to examine PPR rates. The rate of PPVs was also examined using CY 2014 utilization. In the CY 2017 EQR, PPR rates were once again reviewed using service data from CYs 2014 through 2016. In this CY 2019 EQR, the PPV rates are once again reviewed using service data from CYs 2016 through 2018.

The same methodology was used by B&A in CY 2019 as was used in CY 2015 to compute actual PPV rates so that longitudinal trends could be examined. The method used to compute risk-adjusted actual-to-expected rates, however, has been updated. Risk-adjusted PPV rates were computed for CY 2018 only. For this EQR, B&A computed PPV rates for each of the OMPP programs separately—Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP), and Hoosier Care Connect (HCC).

Background on Potentially Preventable Emergency Department Visits (PPVs)

It is important to note upfront the distinction between what may be classified as a non-emergent ED visit and a PPV. Although many ED visits may meet the criteria under both definitions, the two terms are not necessarily synonymous.

PPVs are ED visits that may result from a lack of adequate access to care or ambulatory care coordination. PPVs are ambulatory sensitive conditions (e.g., asthma) in which adequate patient monitoring and follow-up (e.g., medication management) should be able to reduce or eliminate.

The basis upon which ED visits are assessed to determine if they are PPVs are 3M's Enhanced Ambulatory Patient Groupings (EAPGs). The EAPGs are the classification system used in 3M's proprietary outpatient payment classification system. It should be noted that although there are over 500 different EAPGs, not all of them are considered for testing as a PPV. Since the EAPGs include everything from outpatient surgeries to lab and x-rays to chemotherapies to medical equipment, only those EAPGs which are related to ambulatory sensitive conditions are tested for PPVs. When submitted to the PPV software, these cases are given a flag that is called a medical visit indicator. For purposes of testing for PPV, a claim may have both a medical visit indicator and another significant procedure (e.g., an outpatient surgery code) on the claim. Only those cases that solely have the medical visit indicator with no other significant procedure are considered for the PPV test.

The term used to flag cases in the software is *potentially* preventable visit. There may be other information not submitted on the claim (e.g., the medical record) that would disqualify the visit from being classified as preventable. The software is limited to standard information submitted on a claim, so the assessment made is that the case was potentially preventable given the limited information provided to make the determination.

Methodology for Defining the Study Sample

An extract of encounters and enrollment information was provided to B&A by OMPP's data warehouse vendor in August 2019 for information received from the MCEs through June 2019 to use to conduct the analytics for this study. The computation of the Actual PPV rate itself is straightforward as described below. The risk adjustment process is more involved since it requires obtaining a risk score for every member enrolled with the MCE during the study period, regardless of whether or not the member had an ED visit. By doing this, B&A can compute not only the proportion of members in Indiana's managed care programs that had an ED visit, but also the percentage that had a PPV. B&A worked with technical advisors at 3M to develop this risk adjustment approach.

Step 1: Submit outpatient claims from the defined time period to the grouper and obtain the EAPG assignment.

ED visits with dates of service in CY 2016, CY 2017 and CY 2018 were submitted separately. Further, the data for each OMPP program—HHW, HIP and HCC—was submitted separately to the 3M grouper.

Step 2: Identify medical visits to include in the PPV test.

All ED visits (defined as CPT codes 99281-99285 or the presence of revenue code 450-459) were considered for the PPV test. If a claim has both a medical visit indicator and a significant procedure, then these are excluded from the PPV test.

The total number of EV visits considered were:

- For HHW: CY 2016- 338,897; CY 2017- 373,424; CY 2018- 318,009
- For HIP: CY 2016- 438,877; CY 2017- 400,950; CY 2018- 372,542
- For HCC: CY 2016- 122,478; CY 2017- 88,247; CY 2018- 103,917

Step 3: The PPV software determines the PPV status of each visit on a case-by-case basis.

A flag of PPV = Yes or No is given to each visit uniquely.

Step 4: Compute the hospital's or MCE's PPV Rate

The final PPV rate is simply the formula of:

$$\frac{\text{Total Number of ED Visits Considered with a PPV Flag = Yes}}{\text{Total Number of ED Visits Considered (Yes and No PPV Flag)}}$$

Step 5: Compute PPV rates at the MCE, age group and EAPG level to understand variations

Step 6: Apply risk adjustment logic to compute an Expected PPV Rate

Part of 3M's Core Grouping Software includes software to classify individuals into clinical risk groups (CRGs). 3M's CRGs are a categorical clinical model which assigns each member of a population to a single mutually exclusive risk category. CRG assignment is based on age, gender, interaction of diseases, persistence and recurrence. To obtain a CRG assignment for each individual, claims experience from a baseline period are submitted. Since B&A used CY 2018 as the study period for PPVs in the risk adjustment process, the baseline period of CY 2017 was used to obtain the CRG assignment for each

individual. All institutional, professional and pharmacy claims are submitted from the historical period in order to obtain the person's CRG assignment. 3M focuses on all services before and after a health care event, but time limited acute care diseases are given less significance. Additionally, the recency of a person's experience (such as the latest six months) is given more weight in the assignment.
The CRG software first assigns the patient to one of nine high-level statuses:

1. Healthy
2. Significant Acute
3. Single Minor Chronic
4. Multiple Minor Chronic
5. Single Dominant or Moderate Chronic
6. Multiple Significant Chronic
7. Three Dominant Chronic
8. Dominant, Metastatic and Complicated Malignancies
9. Catastrophic

Although there are more than 1,000 potential CRG categories in 3M's algorithm, 3M has developed Aggregated Clinical Risk Groups (ACRGs) into larger classification groups. For this project, B&A is using one of these options into 38 ACRG classifications. In addition, 3M recommends that any patient that is classified in high level status 8 or 9 listed above should be excluded from PPV calculations for risk adjustment. This means, in essence, that the 38 ACRGs are further reduced to 27. B&A followed this suggestion, so 27 PPV rates were computed for each ACRG. These are the risk adjustment factors that are used in the calculation of the Expected PPV rate.

The complete risk adjustment process can be summarized in the steps below.

1. Obtain the CRG assignment for each individual in the dataset.
2. Assign a CRG category to each member whether or not they had an ED visit. In this case, every member enrolled in HHW, HIP or HCC in CY 2018.
3. Further define the subset within each ACRG of members that had a PPV. So, within each ACRG, total member months of members with a PPV divided by total member months is the Expected PPV rate for that ACRG for the entire program. This was done for HHW, HIP and HCC members separately (but all MCEs combined).
4. Identify just the members in each MCE/program. Distribute the MCE's member months in CY 2018 by ACRG category.
5. Separate out the member months for those members in the MCE with a PPV. The sum of PPV member months for the MCE divided the MCE's total member months is the MCE's Actual PPV rate.
6. Multiply the total member months for the MCE in each ACRG by the Expected PPV rate determined statewide in Step 3. This gives a total Expected Value for the ACRG for this MCE.
7. Sum the Expected Values computed for all 27 ACRGs for the MCE.
8. Divide the summed Expected Values by the MCE's total member months. This is the MCE's Expected PPV rate.

<u>Step 7: Compute Actual-to-Expected Ratios</u>

The Actual-to-Expected Ratio for a given MCE, therefore, is

$$\frac{\text{The Actual PPV rate for the MCE/program (Step 6, Part 5 above)}}{\text{The Expected PPV rate for the MCE/program (Step 6, Part 8 above)}}$$

An Actual-to-Expected Ratio of 1.0 means that the MCE had PPVs as expected against the statewide benchmark that year. A ratio that is less than 1.0 means that the MCE did better than expected on PPV visits for its membership. A ratio that is greater than 1.0 means that the MCE did worse than the expected for its membership.

Findings from the Review of the Study Sample

Exhibit VII.1 shows the Actual PPV rates for CYs 2016 through 2018 by program and by MCE. The statewide PPV rate for HHW was steady near 70 percent in each of the three years. For HIP, the rate moved up and down between 69 and 74 percent. For HCC, the PPV rate went down slightly each year.

The Actual PPV rates across MCEs within each OMPP program and CY are within three percentage points of each other. The one exception is CareSource in CY 2017. It should be noted that the actual ED visit rate per 1,000 members, regardless of PPV status, is tight within the MCEs in CY 2018. In HHW, the rate per 1,000 is between 41 and 46 visits; in HIP, the rate is between 65 and 84 visits; in HCC, the rate is between 92 and 98 visits per 1,000 members.

Exhibit VII.1
PPV Rates by Program, by MCE and by Calendar Year

		HHW	HIP	HCC
CY 2016	**Combined**	**71.7%**	**69.1%**	**70.1%**
	Anthem	71.3%	67.4%	70.1%
	MDwise	72.1%	70.4%	70.7%
	MHS	71.4%	70.6%	68.5%
CY 2017	**Combined**	**69.7%**	**74.2%**	**69.6%**
	Anthem	69.4%	73.3%	69.1%
	CareSource	62.9%	76.3%	
	MDwise	71.5%	75.3%	
	MHS	69.1%	74.3%	70.1%
CY 2018	**Combined**	**70.2%**	**72.1%**	**68.2%**
	Anthem	70.1%	72.3%	68.5%
	CareSource	70.5%	72.1%	
	MDwise	71.2%	72.3%	
	MHS	68.7%	71.1%	67.8%

PPV rates vary to some degree within specific age groups in HHW. Infants have the highest PPV rate among the age groups studied in both HHW and HCC for all MCEs. As the age of the child progresses, the PPV rates decline. The PPV rates for adults are higher in HIP than in HCC in CYs 2017 and 2018. The PPV rates for adults remaining in HHW are much lower than their peers in HIP and HCC, but this population is very small.

Exhibit VII.2
PPV Rates by Program, by Age and by Calendar Year

		HHW	HIP	HCC
CY 2016	**Combined**	**71.7%**	**69.1%**	**70.1%**
	Age <1	85.8%		87.1%
	Age 1 to 5	77.5%		78.5%
	Age 6 to 18	66.8%		69.3%
	Age 19 +	38.9%	69.1%	69.8%
CY 2017	**Combined**	**69.7%**	**75.0%**	**69.6%**
	Age <1	84.8%		87.2%
	Age 1 to 5	75.7%		77.0%
	Age 6 to 18	65.7%		67.9%
	Age 19 +	52.6%	75.0%	69.4%
CY 2018	**Combined**	**70.2%**	**72.1%**	**68.2%**
	Age <1	83.7%		82.3%
	Age 1 to 5	74.4%		74.7%
	Age 6 to 18	64.3%		65.9%
	Age 19 +	52.2%	72.1%	68.2%

Exhibit VII.3
PPV Rates in CY2018 by Program and by Region

	Region	HHW	HIP	HCC
	ALL Regions	**70.2%**	**72.1%**	**68.2%**
1	Northwest	70.5%	71.4%	66.9%
2	North Central	67.8%	69.2%	65.7%
3	Northeast	72.2%	72.3%	69.9%
4	West Central	67.9%	70.1%	66.1%
5	Central	72.6%	73.0%	69.3%
6	East Central	67.9%	72.6%	68.8%
7	Southwest	67.2%	72.2%	69.1%
8	Southeast	68.2%	72.3%	66.7%

The Actual PPV rates are similar across most regions in CY 2018. The spread across regions is 4.4 percentage points in HHW; in HIP, 3.8 percentage points; in HCC, 4.2 percentage points. Although the differences in rates are modest, the only region that is consistently lower in all three programs is the North Central Region.

B&A cross-tabulated the list provided by each MCE of the urgent care centers that it contracted with in CY 2018. B&A identified each MCE's members with a home address within five miles of one of the MCE's contracted urgent care centers.

B&A ran the PPV rates for just these members in close proximity to an urgent care center and compared this to the MCE's Actual PPV rate in CY 2018 for all of its members. As the data in Exhibit VII.4 shows, the members in close proximity to an urgent care center actually have a slightly higher PPV rate for each MCE in HHW. For the HIP and HCC programs, the PPV rates are almost identical for each study group for every MCE.

In addition to examining PPV rates by age group, B&A also analyzed to see if there was a relationship between the PPV rate and the ED Visit CPT code that was billed on the claim. The five CPT codes 99281 through 99285 are intended to indicate the level of emergency department care required. These CPT codes are self-reported by the hospital.

Exhibit VII.4
PPV Rates in CY 2018 by Program and MCE
Assessing Members within 5 miles of a Contracted Urgent Care Center

All Members			
	HHW	**HIP**	**HCC**
# ED visits	318,009	372,542	103,917
Combined	**70.2%**	**72.1%**	**68.2%**
Anthem	70.1%	72.3%	68.5%
CareSource	70.5%	72.1%	
MDwise	71.2%	72.3%	
MHS	68.7%	71.1%	67.8%

Members within 5 Miles of Urgent Care			
	HHW	**HIP**	**HCC**
# ED visits	215,798	255,809	72,909
Combined	**71.1%**	**72.3%**	**68.5%**
Anthem	70.8%	72.4%	68.8%
CareSource	71.5%	72.1%	
MDwise	72.3%	72.7%	
MHS	69.5%	71.1%	68.0%

Exhibit VII.5
PPV Rate Based on Emergency Visit CPT Code Used
For All ED Visits Billed in CY 2018

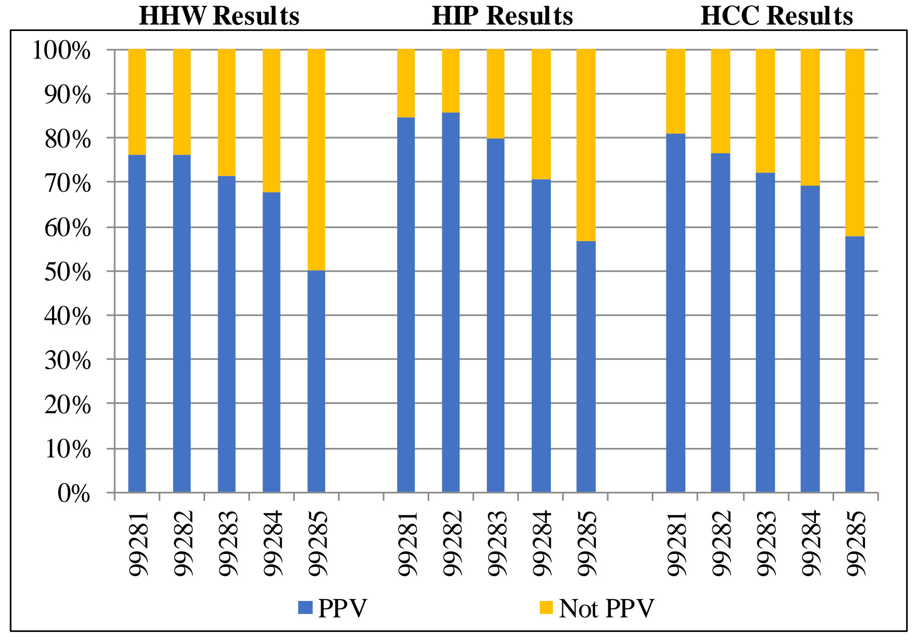


Exhibit VII.5 does show that the PPV rates follow a logical trend in that the highest PPV rate for each program is in CPTs 99281 and 99282 which are defined as low-intensity level ED visits. The higher the CPT code (and therefore the likely the greater the resource intensity), the lower the PPV rate which indicates that higher-level coded ED claims (such as in CPT 99285) are less potentially preventable. This trend was found in all three of OMPP's programs.

PPVs were examined at the EAPG level to determine if certain types of ED visits were more likely to be identified as PPVs than others. Exhibit VII.6 on the next page displays the top 10 EAPGs (based on the volume of PPVs) within age groups. Four age groups are shown: under age one, age 1 to 5, age 6 to 18, and age 19 and over.

The top row in each column shows what percentage that the top 10 EAPG categories represent of all PPVs. For the infants, 74 percent of all PPVs are within the top 10 EAPG categories. This percentage decreases as the age range increases. This indicates that there are more reasons for individuals presenting to the ED with PPVs the older the patient may be.

Just below this top row, the percentage is shown that the top 10 EAPGs comprise within each MCE/program. Within HHW, there is general uniformity across the MCEs with respect to how much the top 10 EAPGs contribute within each MCE's membership. In other words, the MCE's top 10 percentage is similar to the percentage at the top of the column. The same is true for each MCE when reviewing the top PPV EAPG categories for adults in HIP (far right column). For HCC, there is some more variation only because this program has the smallest enrollment of the three programs.

The top 10 EAPGs for PPVs within each age group are then ranked in the lower section of the exhibit. This shows that some EAPGs are actually common across the age groups, while other top PPV EAPGs are age-dependent. The * in a column means that the EAPG is not in the top 10 for that age group.

EAPG 562, Infections of Upper Respiratory Tract & Otitis Media, is the top EAPG reason for all three child age groups reviewed, but it is ranked 4th highest for adults. In fact, more than 20 percent of all PPVs for the youngest age groups are for this reason. Some top EAPGs are specific to infants, such as EAPG 572, Bronchiolitis & RSV Pneumonia, and EAPG 627, Non-Bacterial Gastroenteritis, Nausea & Vomiting.

Conversely, EAPG 604, Chest Pain, is the 2nd highest PPV EAPG for the adult age group. It is not in the top 10 for children. EAPG 661, Level II Other Musculoskeletal System and Connective Tissue Diagnoses, is ranked 3rd highest among adults. It is ranked 2nd highest for older children but not ranked high at all for younger children.

Exhibit VII.6

Distribution of CY 2018 PPVs by EAPG Category by Age Group

EAPG	EAPG Description	Age <1 Rank by Volume	Age <1 Pct of All ED Visits	Age 1-5 Rank by Volume	Age 1-5 Pct of All ED Visits	Age 6-18 Rank by Volume	Age 6-18 Pct of All ED Visits	Age 19+ Rank by Volume	Age 19+ Pct of All ED Visits
	The Top 10 PPV EAPG categories represent [x]% of all PPVs		**73.6**		**67.1**		**58.5**		**46.2**
	What % are the Statewide Top 10 EAPGs of the MCE's PPVs?								
	Anthem HHW		73.2		66.4		58.6		n/a
	Anthem HCC		68.8		56.9		49.6		42.2
	Anthem HIP		n/a		n/a		n/a		47.3
	CareSource HHW		73.9		68.5		59.1		n/a
	CareSource HIP		n/a		n/a		n/a		45.7
	MDwise HHW		74.5		68.6		60.7		n/a
	MDwise HIP		n/a		n/a		n/a		47.5
	MHS HHW		73.0		66.7		58.5		n/a
	MHS HCC		65.5		57.0		48.4		42.0
	MHS HIP		n/a		n/a		n/a		47.2
0510	Major Signs, Symptoms and Findings	*	*	9	2.5	*	*	*	*
0562	Infections of Upper Respiratory Tract & Otitis Media	1	21.6	1	20.7	1	11.7	4	4.4
0564	Level I Ear/Nose/Mouth/Throat & Cranial/Facial Diagnoses	5	6.3	4	6.8	4	6.1	*	*
0572	Bronchiolitis & RSV Pneumonia	2	8.1	10	2.3	*	*	*	*
0573	Community-Acquired Pneumonia	10	2.4	*	*	*	*	*	*
0576	Level I Other Respiratory Diagnoses	8	5.3	8	3.3	10	2.4	6	3.8
0604	Chest Pain	*	*	*	*	*	*	2	6.8
0627	Non-Bacterial Gastroenteritis, Nausea & Vomiting	3	7.5	6	6.0	7	3.6	8	3.3
0628	Abdominal Pain	*	*	*	*	5	5.5	1	7.8
0652	Fractures & Disclocations exc Femur, Pelvis & Back	*	*	*	*	8	3.3	*	*
0656	Back & Neck Diagnoses exc Lumbar Disc Diagnoses	*	*	*	*	*	*	7	3.8
0661	Level II Other Musculoskeletal System & Connective Tissue Diagnoses	*	*	*	*	2	9.2	3	6.1
0673	Cellulitis & Other Bacterial Skin Infections	*	*	*	*	*	*	9	3.1
0674	Contusion, Open Wound & Other Trauma to Skin & Subcutaneous Tissue	*	*	2	7.4	3	9.2	*	*
0675	Other Skin, Subcutaneous Tissue & Breast Diagnoses	6	6.0	5	6.7	6	4.9	*	*
0727	Acute Lower Urinary Tract Infections	*	*	*	*	*	*	10	3.0
0765	Other Antepartum Diagnoses	*	*	*	*	*	*	5	4.3
0807	Fever	7	5.8	7	4.6	*	*	*	*
0808	Viral Illness	4	6.3	3	6.8	9	2.6	*	*
0871	Signs, Symptoms & Other Factors Influencing Health Status	9	4.3	*	*	*	*	*	*

* means the EAPG is not in the Top 10 among PPV categories in that age group

After risk adjustment was completed, B&A computed the Actual-to-Expected ratios across multiple cohort populations. These results are shown in Exhibits VII.7 and VII.8. Each cohort population is compared to the statewide average Actual-to-Expected ratio of 1.0 in CY 2018 for each OMPP program separately.

It was found that Anthem performed better than expected for its membership in HHW and as expected for its membership in HIP and HCC. (B&A generally defines "as expected" as a ratio between 0.980 and 1.020). MHS also performed better than expected in HHW and HIP, but worse than expected in HCC. Both CareSource and MDwise performed worse than expected on a risk-adjusted basis in both HHW and HIP. The further the MCE's ratio is from 1.0, this indicates the degree to which the MCE did better or worse than expected.

Exhibit VII.7
PPV Actual-to-Expected Ratios in CY 2018, by Program / MCE

	Anthem	Care Source	MDwise	MHS
HHW	0.978	1.064	1.037	0.955
HIP	0.983	1.063	1.025	0.978
HCC	0.988			1.023

Red indicates worse than expected (value greater than 1.020)

Blue indicates as expected (value between 0.980 and 1.020)

Green indicates better than expected (value below 0.980)

The information presented in the previous exhibit was for the MCE's enrollment overall in each program. B&A also examined results at the regional level. These are shown in Exhibit VII.8 on the next page. In this more nuanced review, even if an MCE did worse than expected overall, there may be regions where it did as expected or better than expected. The opposite is also true.

For example, although MDwise did worse than expected overall in both HHW and HIP, it did as expected in three of the eight regions in HHW and better than expected in two of the regions. For its HIP members, it did as expected in three regions and better than expected in one region. The overall ranking, therefore, is indicative that a higher proportion of its members' ED visits were in regions where the MCE did worse than expected. CareSource also did worse than expected overall in both HHW and HIP, but it did as expected in one region in HHW and two regions in HIP.

Anthem did better than expected in HHW overall, but it did do worse than expected in one region. Anthem performed as expected in the HIP and HCC programs. It also performed as expected or better than expected in every region of the state.

MHS did better than expected in both the HHW and HIP programs, but in HHW it did have three regions where it did worse than expected. In HIP, two regions fell into this category. MHS did worse than expected overall in HCC and this was generally consistent across regions as well.

When examining each region, there is no clear pattern across MCEs and programs. The closest alignment is in the Central Region where most MCEs performed as expected or better than expected.

Exhibit VII.8
Actual-to-Expected Ratios Related to PPVs in CY 2018, by Region

	Hoosier Healthwise				Healthy Indiana Plan				Hoosier Care Connect	
Region	**Anthem**	**Care Source**	**MDwise**	**MHS**	**Anthem**	**Care Source**	**MDwise**	**MHS**	**Anthem**	**MHS**
All Regions	**0.972**	**1.064**	**1.037**	**0.955**	**0.983**	**1.063**	**1.025**	**0.978**	**0.988**	**1.023**
Northwest	0.992	1.089	1.007	0.973	0.960	1.003	1.055	1.027	0.981	1.041
North Central	1.000	1.139	1.063	0.961	0.904	1.117	1.038	1.059	0.970	1.033
Northeast	0.921	1.079	1.057	0.963	0.901	1.126	1.087	0.976	0.982	1.031
West Central	1.016	0.986	0.966	1.092	1.000	1.069	0.985	1.014	0.973	1.051
Central	0.967	1.032	1.052	0.959	1.003	1.007	1.017	0.957	0.991	1.018
East Central	1.058	1.081	0.962	0.991	0.980	1.095	0.999	1.007	0.979	1.029
Southwest	0.981	1.023	1.014	1.027	1.019	1.107	0.922	0.974	1.000	1.001
Southeast	1.006	1.122	1.016	0.944	0.980	1.083	1.038	0.962	0.988	1.022

Red indicates worse than expected (value greater than 1.020)

Blue indicates as expected (value between 0.980 and 1.020)

Green indicates better than expected (value below 0.980)

Comparison to Previous EQRs

When B&A last examined PPVs in the CY 2015 EQR reviewing CY 2014 data, only data for the HHW and HIP were examined because the HCC program just began in CY 2015.

In the CY 2015 review, the HHW program had an Actual PPV rate of 69 percent and the HIP program had an Actual PPV rate of 81 percent. Contrasting these results with what was reported in Exhibit VII.1, there has been little change in the PPV rate in HHW (most recent data near 70%), but there has been considerable improvement in HIP (most recent data near 72%).

Although the Actual PPV rate is unchanged in HHW, the rate of PPV visits per 1,000 member months has decreased in HHW. In the study of CY 2014 utilization in HHW, the rate of PPV claims was 38 per 1,000 member months; in CY 2018, it was down to 30 per 1,000. Conversely, although the Actual PPV rate went down in HIP, the rate of PPVs is fairly constant. The rate of PPV claims per 1,000 member months for HIP in CY 2014 was 51 per 1,000; in CY 2018, it was 56 per 1,000.

The trend found in this study that the youngest members had the highest PPV rates was also true in the prior study. The fact that certain conditions (i.e., the top EAPGs) make up the majority of PPVs was also found in the CY 2015 study. In particular, EAPG 562, Infections of Upper Respiratory Tract & Otitis Media, was ranked as the highest PPV EAPG for all three child age groups in the CY 2015 study just as it was in this study. EAPG 661, Level II Other Musculoskeletal System & Connective Tissue Disease, and EAPG 628, Abdominal Pain, were ranked the highest PPV EAGPs for adults in this study and the previous study.

Recommendations

Although there was little variation seen in the PPV rates among the three MCEs, there are opportunities to reduce this PPV rate for all populations. There was variation seen in the Actual-to-Expected ratios at the regional level. B&A offers the following recommendations to explore how to use the PPV data to inform ways to reduce unnecessary ED use.

1. With the finding that the highest PPV rate was for infants, the MCEs are encouraged to review the conditions where infants presented with PPVs to identify opportunities for targeted education.

2. With the finding that the Actual PPV rate was no different for members in close proximity to urgent care centers to those not near one, the MCEs are encouraged to enhance education and intervention efforts to members to use urgent care centers in lieu of hospital emergency rooms where available.

3. With the finding that some regions of the state had higher PPV rates than others, the MCEs are encouraged to conduct more detailed review of the specific locations within each region for greatest opportunity to reduce PPVs.

4. With this baseline information now available for a three-year period, the OMPP may want to consider either a P4O or other target for the reduction of PPVs, particularly in the HIP program.

SECTION VIII: FOCUS STUDY ON PREVENTIVE CARE FOR ADULTS AND WELL VISITS FOR CHILDREN

Introduction

As in previous years, preventive health was one of the high-priority areas of focus for the Office of Medicaid Policy and Planning's (OMPP's) quality strategy for Calendar Year (CY) 2018.

The OMPP has a Pay for Outcomes (P4O) program in its contracts with the managed care entities (MCEs). Three of the P4O measures are Healthcare Effectiveness Data and Information Set (HEDIS) measures related to preventive health:

- Well-Child Visits in the First 15 Months of Life, 6 or more Visits (HEDIS W15)
- Well -Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (HEDIS W34)
- Adolescent Well Care Visits (HEDIS AWC)

The P4O for the Hoosier Healthwise (HHW) program include the measures for W15, W34 and AWC since the population in HHW is predominantly children and adolescents. The P4O for the Healthy Indiana Plan (HIP) and the Hoosier Care Connect (HCC) programs include a measure for adult access to ambulatory care.

MCEs are paid annual performance bonuses based on the results of these measures. The bonus is stair-stepped in a manner based on the MCE's percentile ranking compared to other Medicaid health plans nationally. The P4O money starts to be paid if the MCE exceeds the HEDIS 50th percentile rate among Medicaid health plans nationally. Full P4O allocation dollars are awarded if an MCE exceeds the HEDIS rate above the 90th percentile for the child measures.

For the CY 2018 performance year, the OMPP paid out the following P4O related to the HHW measures[11]:

- For HEDIS W15, two MCEs exceeded the HEDIS 90th percentile, one increased to the 75th percentile, and a fourth was at the 25th percentile.
- For HEDIS W34, one MCE achieved the 75th percentile, a second was above the 50th percentile, while two were below the 25th percentile.
- For HEDIS AWC, one MCE exceeded the HEDIS 90th percentile, two were above the 75th percentile, and a fourth was below the 25th percentile.

The study in this EQR focused on examining the utilization of both well care visits (as defined by the HEDIS measures) as well as other primary care visits to the children and adolescents in the HHW and HCC programs. For the adult measure, Burns & Associates (B&A) used the HEDIS measure for Adults' Access to Preventive/Ambulatory Health Services (AAP). Utilization of the measure was examined for adults in the HCC and HIP programs in CY 2018. Analyses were conducted to examine who delivers well care and primary care services to the members, the rate of numerator compliance for each measure statewide and by subpopulations, the differences in the rate of well care and primary care visit utilization for children and adolescents, and the rate of emergency department usage for members in the denominator of each measure examined. All results reported are for the anchor year ending December 31, 2018.

---

[11] 2019 Quality Strategy Plan, Office of Medicaid Policy and Planning, Appendix VI
https://www.in.gov/fssa/ompp/5533.htm

Background

For both ongoing monitoring as well as establishing verifiable results for its P4O program, the OMPP requires the MCEs to hire an external certified HEDIS auditor to annually collect results on dozens of HEDIS measures and to assess whether or not each measure is reportable to the National Committee on Quality Assurance (NCQA). Among these measures is the three child measures and one adult measure that are a part of this study. Exhibit VIII.1 on the next page shows the results reported by the HEDIS auditors in each of the last three reporting years for the W15, W34 and AWC measures in the HHW and HCC programs. Exhibit VIII.2 on page VIII-4 shows the results reported by the HEDIS auditors for the AAP measure in the last three reporting years.

The reporting years are HEDIS 2017, HEDIS 2018 and HEDIS 2019. This means that the results are based on utilization and enrollment from the previous calendar year (CYs 2016, 2017 and 2018). For the three child measures, the hybrid method was used by the MCEs in all but one instance every year[12]. This means that compliance with the measure could be determined either by claims experience or by medical record abstraction. For the results shown for the AAP measure in Exhibit VIII.2, the administrative (claims-based) method was also used by the MCEs.

In the HHW program, the HEDIS results in the W15 measure have decreased over the three-year period (refer to upper left box in Exhibit VIII.1) for the three MCEs with results in all years[13]. The rate was 72-73 percent for Anthem and MDwise, 64 percent for MHS, and 57 percent for CareSource in HEDIS 2019. In the HCC program, the results are volatile year-to-year because the sample is much smaller.

The HEDIS results in the W34 measure in HHW were mixed. Both Anthem and MDwise saw a decline from HEDIS 2017 to 2019, while MHS was mostly steady. MDwise, however, has the highest rate in 2019 at 82 percent while Anthem and MHS are closer to 70 percent. CareSource results came in lower than the other three MCEs. Within the HCC population, Anthem's results improved from HEDIS 2017 to 2019 up to 78 percent. MHS's rate was steady (and also near their equivalent rate in HHW).

Both Anthem and MHS saw improvement in the AWC measure among the HHW population in the last three HEDIS reporting years. MDwise improved greatly from HEDIS 2017 to 2018 but held steady in 2019. Anthem and MDwise share a rate near 69 percent in HEDIS 2019 while MHS is at 63 percent. CareSource results came in lower than the other three MCEs. In the HCC program, results improved for both Anthem and MHS over time, but the actual results are lower (both 53%) than the same population in HHW.

In Exhibit VIII.2, three of the four MCEs have similar rates for age 20-44 among the HIP population near 80 percent. CareSource' rate is lower than its peers. A similar finding occurred among the 45-64 age group. Anthem, MDwise and MHS have similar rates (86-88%) in HEDIS 2019 while CareSource was at 79 percent. All MCEs saw improvement in the rate for age 20-44 over the three years. The rates were steadier among the age 45-64 population for all MCEs except MHS which saw some improvement.

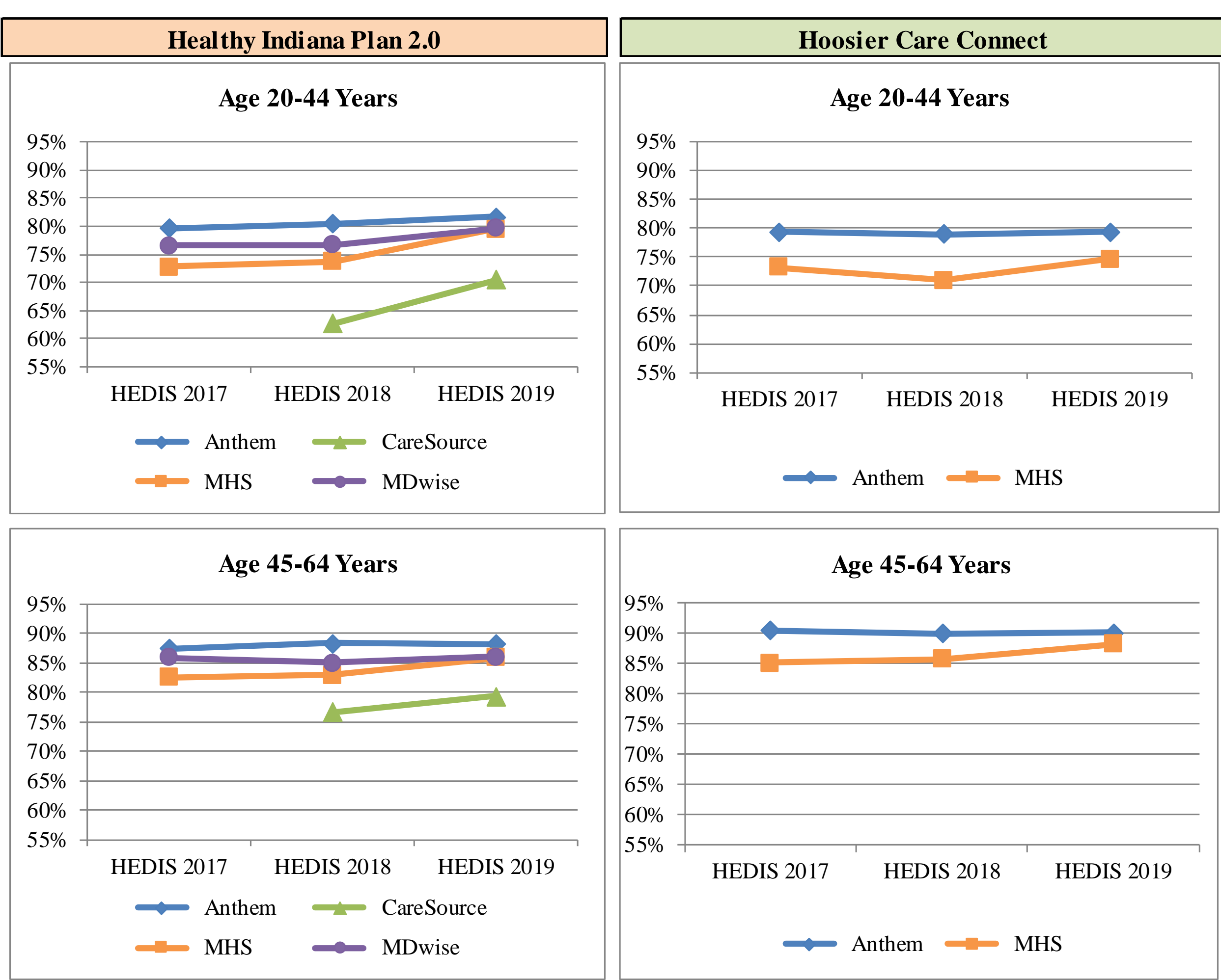
For the HCC population, the rates were steady across the three years for Anthem and MHS among both AAP age groups. As seen in HIP, the results are higher for age 45-64 than age 20-44.

---

[12] In HEDIS 2018, MHS used the administrative (claims-based) method to report the results of its W34 measure.
[13] Because CareSource began its contract with the OMPP in January 2017, for some HEDIS 2018 results there was reportable data but others the auditors deemed it not reportable. CareSource's full set of HEDIS reporting began with HEDIS 2019.

Exhibit VIII.1
Summary of Results from HEDIS Well Care Measures: W15, W34 and AWC
(Percentage of Total)

Exhibit VIII.2
Summary of Results from HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP)
(Percentage of Total)



Methodology for Defining the Study Sample

For this study, Burns & Associates (B&A) started by considering all eligible members in HHW, HCC or HIP for each of the HEDIS measures by using the HEDIS parameters to define the population. To do this, B&A used the enrollment file from the state's Enterprise Data Warehouse to determine (a) eligibility of a member within a program (HHW, HCC and/or HIP) and for what duration and (b) eligibility within an MCE. Members could meet the continuous enrollment requirement either by:

- Being enrolled continuously within the same program and MCE (e.g., a four-year-old was enrolled with Anthem in HHW during the entire year) or
- Being enrolled continuously within the same MCE but across programs (e.g., An Anthem member turned age 19 during the year. Although he was continuously enrolled with Anthem throughout CY 2018, he transitioned from the HHW program to the HIP program.)

Members who transitioned to a new program were assigned to the program that they were enrolled with on December 31, 2018. Members could only be assigned to one program and one MCE in the study. Exhibit VIII.3 outlines the requirements for member eligibility in the study.

Exhibit VIII.3
Enrollment Criteria Used for Member Inclusion in the Study

	W15	W34	AWC	AAP
Age	15 months old during measurement period	3 to 6 Years as of end of measurement period	12 to 21 Years as of end of measurement period	19 to 64 Years as of end of measurement period
Measurement Period	Analyzed claims from 10/1/17 – 12/31/18 *	Analyzed claims from 1/1/18 – 12/31/18	Analyzed claims from 1/1/18 – 12/31/18	Analyzed claims from 1/1/18 – 12/31/18
Continuous Enrollment	From 31 days after birth to 15 months of age	Entire measurement year	Entire measurement year	Entire measurement year
Allowable Gap	No more than one month within the MCE	No more than one month within the MCE	No more than one month within the MCE	No more than one month within the MCE
Anchor Date	The day the child turns 15 months old	December 31, 2018	December 31, 2018	December 31, 2018

*Conditional based on the date the member turned 15 months old during the measurement period.

The enrollees that met the criteria in Exhibit VIII.3 were divided by program and by MCE. The final study includes the count of members shown in Exhibit VIII.4.

Exhibit VIII.4
Count of Populations Defined in the Study

	W15 Denominators	W34 Denominators	AWC Denominators	AAP Denominators
	Hoosier Healthwise			
All MCEs	**34,222**	**120,829**	**157,493**	
Anthem	12,510	40,998	49,501	
CareSource	2,885	9,462	11,608	
MDwise	11,245	42,073	56,873	
MHS	7,582	28,296	39,511	
	Healthy Indiana Plan 2.0			
All MCEs				**236,232**
Anthem				103,562
CareSource				21,485
MDwise				67,763
MHS				43,422
	Hoosier Care Connect			
All MCEs	**427**	**4,821**	**12,868**	**48,818**
Anthem	275	2,671	7,277	32,050
MHS	152	2,150	5,591	16,768

Once the members were identified, B&A extracted all paid claims for the claim types for professional services or outpatient hospital services for each member during the study time period. There were no limitations placed on provider type or provider specialty who delivered services. The one limitation made for outpatient hospital claims is that claims with place of service in the emergency room were excluded from the study.

It is also important to define the terms well care and primary care for children and adolescents as used in this study. *Well care visits* as used in this study are visits as defined by the HEDIS Well Care Visit measures. These include procedure (CPT/HCPCS) codes (specifically, 99381-99385, 99391-99395, 99461, G0438 and G0439) or specific diagnosis codes that were reported on the claim. As per HEDIS, a well care visit is identified either through the presence of a CPT code or a diagnosis code.

For members in the study who were found not to be numerator compliant (that is, a well care visit was not found), B&A also looked in the same study period for any primary care visits that the member received. B&A defined primary care visits only by CPT codes and not by diagnosis codes. This is because a primary care visit could have been a well visit or a sick visit. The CPT codes used to define primary care visits were evaluation and management (E&M) codes 99201 through 99499 but excluding:

- Observation care (99217-99226)
- Inpatient hospital care (99221-99239, 99251-99255)
- Emergency department visits (99281-99285)
- Well care visits (defined above as 99381-99385, 99391-99395, 99461, G0438 and G0439)

After identifying members who had no well care visit but did have a primary care visit, B&A further identified members who had neither a well care visit nor a primary care visit. Additionally, specific to the HEDIS W15 measure, B&A analyzed members that had a combination of well care and primary care visits because the standard for numerator compliance in the W15 measure is six or more visits within 15 months as opposed to a single well care visit in the W34 and AWC measures.

A similar process was completed for the adults in the AAP HEDIS measure. For this measure, the value sets defined by the NCQA also include CPT codes and diagnosis codes; however, the list is broader than what is included for the well-child visit measures.

It should be noted that although the time period of study is the same, the rate of well care visits and adult preventive visits reported by B&A will differ from those reported by the HEDIS auditors in Exhibits VIII.1 and VIII.2 because: (a) B&A considered the entire eligible population in each population cohort rather than a sample and (b) B&A used the administrative (claims-based) method only whereas the HEDIS auditors used the hybrid (claims and medical records combined) method to obtain their results for well care visit rates.

B&A reviewed numerator compliance for each HEDIS measure for both the overall population as well as sub-populations within each measure that were distributed by MCE, by gender, by age and by region in the state. This was to assess if there was variation in numerator compliance among any of the sub-populations.

In addition to computing the rates for the HEDIS measures, B&A also considered the denominator population for each measure and analyzed its utilization of emergency department visits. In particular, B&A used the methodology described in Section VII to assess the prevalence of potentially preventable emergency department visits (PPVs) within each of the HEDIS measure populations.

Findings

Who Delivers Well Care and Primary Care Services to HHW, HCC and HIP Members

B&A analyzed the providers that are delivering well care and primary care services to members to determine if there are differences either in:

- the proportion among provider types delivering the service;
- the cohort of members served (W15, W34, AWC or AAP); or
- the MCE that the member is enrolled with.

Exhibits VIII.5 and VIII.6 that appear on the next two pages show the results of these comparisons. Exhibit VIII.5 shows results for the three child HEDIS measure while Exhibit VIII.6 shows the results for the one adult measure.

In Exhibit VIII.5 compares the proportion of visits delivered by physician offices and clinics for the W15 population (top boxes with blue bars), W34 population (middle boxes with green bars) and AWC population (bottom boxes with orange bars). For all MCEs combined, the ratio of well care and primary visits between the two provider categories is the same. The percentage of visits delivered by physician offices is 52 to 53 percent for each measure whereas the percentage of visits delivered by clinics is 47 to 48 percent.

There is some variation in this proportion across the MCEs. However, similar to the statewide results, the percentage split for each MCE is consistent across the W15, W34 and AWC populations. Anthem has the largest proportion of visits delivered by physician offices (60% for each measure) whereas MDwise has the smallest proportion (45% for each measure).

There are some differences within a HEDIS measure population between the HHW and HCC programs. Anthem has more visits delivered by clinics in HCC than in HHW. MHS has more visits delivered by clinics in HCC than in HHW.

Exhibit VIII.6 on page VIII-9 examines similar trends for the adults in HEDIS AAP denominator. The percentage of visits delivered by physician offices was the same for adults as was seen for children (53%). There are fewer clinic visits, however, because the HEDIS specification allows for preventive adult visits delivered in a hospital setting as well. For all MCEs combined, the percentage of visits delivered by clinics was 39 percent; by hospitals was 8 percent.

There is little difference in the percentage of visits delivered by hospitals across the MCEs, but the split between physician offices and clinics was shown for adults as was seen for children. Anthem has the highest percentage of visits delivered by physician offices (55%) whereas MDwise has the smallest proportion (47%).

Anthem and MHS have almost the same proportion of visits delivered by clinics in the HCC program. MHS has a slightly higher percentage delivered by a hospital than Anthem does.

Exhibit VIII.5
Who Delivers Well Care and Primary Care Visits to Children

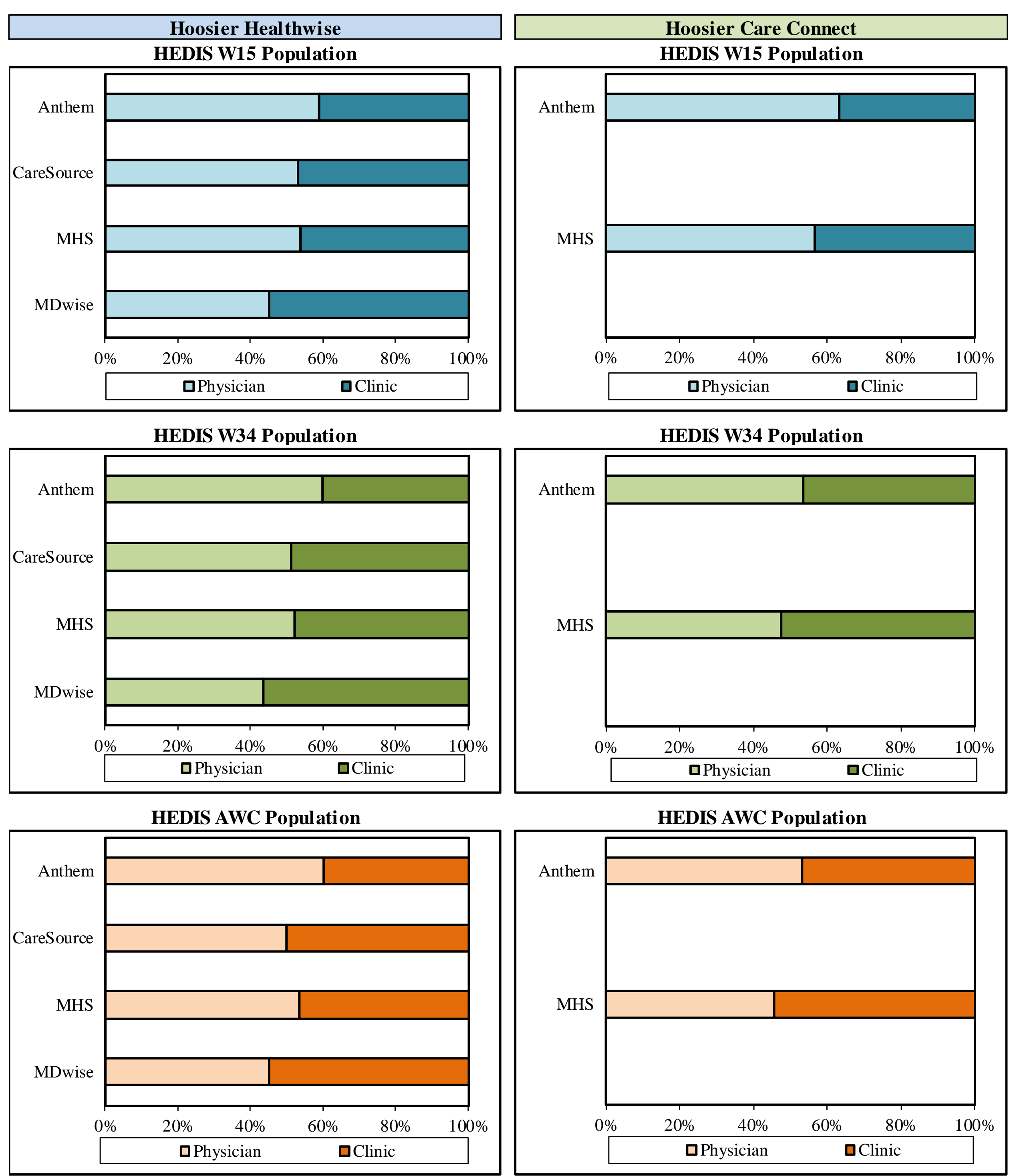
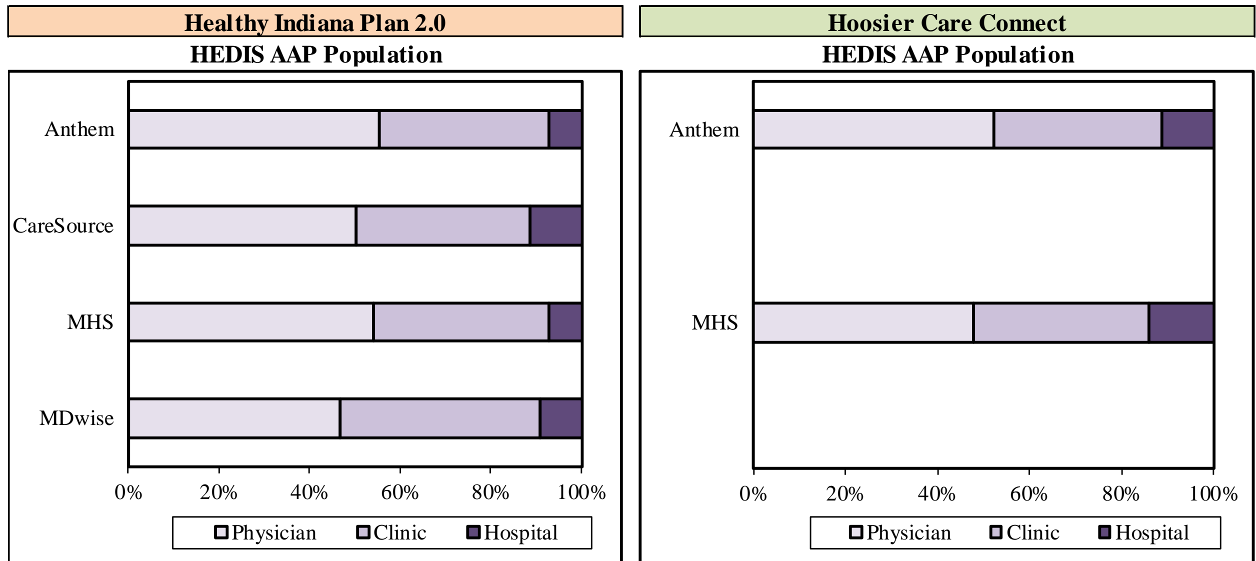


Exhibit VIII.6
Who Delivers Preventive and Ambulatory Health Services to Adults



<u>Members with a Well Care Visit</u>

Whereas Exhibits VIII.5 and VIII.6 examined the total number of visits received by members, Exhibits VIII.7 through VIII.9 examine the percent of eligible members in each child/adolescent population group who received a well care visit. In Exhibit VIII.10, the same analysis was completed for adults but measuring the percent of eligible members receiving a preventive or ambulatory health service.

The exhibits are constructed so that variations in the percent of members receiving a well care visit can be easily discerned when examined by gender, by region, by race/ethnicity, by MCE or by age (for all except the W15 population).

The columns in each exhibit represent one of the OMPP programs (HHW, HCC or HIP). The percentage that each sub-population represents of the total denominator population shown in the header is displayed. Next to it, the rate that represents numerator compliance is displayed.

For example, In Exhibit VIII.7, in the first set of columns, the information for the eligible W15 population within HHW is shown. There are 34,222 total children that met the HEDIS criteria to be in the denominator. When reviewing by region, the Northwest region has 12 percent of all eligible. The numerator compliance rate for W15 statewide in HHW is 47 percent. In the Northwest, it is 42 percent.

In the rate columns, the cells shaded in pink means that the cohort rate is more than three percentage points below the statewide rate at the top of the column. Cells shaded in green mean that the cohort rate is more than three percentage points above the statewide rate.

Keeping in mind that all of these results are based on the administrative method only, the following are the key findings from the review of Exhibits VIII.7 through VIII.10:

For the W15 measure (Exhibit VIII.7):

- The statewide rate for six or more well visits was 47 percent for both female and male members in HHW. The rates were 55 percent and 54 percent, respectively, in HCC.
- The W15 rate varies by region in HHW from a low of 42 percent in the Northwest to 54 percent in the Southeast. Besides Southeast, the only other region above 50 percent is Northeast.
- There are disparities across race/ethnicities in HHW: Caucasians, 49 percent; African-American, 36 percent; Hispanic, 51 percent; other race/ethnicities, 60 percent.
- Anthem and MHS have similar rates for this measure in HHW just above 50 percent. CareSource and MDwise are similar to each other but much lower than Anthem and MHS.
- There is much greater variation in the rates found in HCC because the W15 sample is very small.

For the W34 measure (Exhibit VIII.8):

- The statewide rate was 65 percent for the HHW population and 71 percent for the HCC population. There is no difference by gender in either program.
- There is little variation in the W34 rates by region in either the HHW or HCC programs. The one exception is that children in the Northeast have a higher rate in HCC than other regions.
- In HHW, Caucasian and African-American children have a similar rate of 63 percent. This is much lower than Hispanic children and children of other race/ethnicities. A similar pattern was found in HCC with the exception of other race/ethnicities (only 6% of the total population).
- Most of the MCEs have rates that center around the statewide average. CareSource is the only MCE far below the statewide average.
- Children at age six have the lowest rates compared to children ages three, four or five.

For the AWC measure (Exhibit VIII.9):

- The statewide rate was 51 percent for the HHW population and 44 percent for the HCC population. Females have a higher rate than males in both programs.
- There is little variation in the AWC rates by region in either the HHW or HCC programs. The exception is that children in the East Central region have a lower rate in both programs.
- In both HHW and HCC, Caucasian and African-American children have a similar rate. This is lower than the rate for Hispanic children and children of other race/ethnicities in HHW and for Hispanic children in HCC.
- The rates are the same between Anthem and MHS in the HCC program. In HHW, MHS has a rate higher than its peers while CareSource has a rate lower than its peers.
- From age 12 up to age 21, in both programs, the younger the age means the higher the rate of compliance.

For the AAP measure (Exhibit VIII.10):

- The statewide rate was 82 percent for the HIP population and 85 percent for the HCC population. Females have a higher rate than males in both programs.
- There is little variation in the AAP rates by region in either program.
- In both HIP and HCC, Caucasian members have a higher rate of compliance than minority populations.
- The rates are similar across the MCEs except that CareSource has a rate lower than its peers.
- Adults in the higher age group of 45-64 have a higher rate of compliance than adults in the 19-44 age group. The rates for each age group are similar between HIP and HCC.

Exhibit VIII.7
Rates for Well Child Visits in First 15 Months of Life (6 or more visits)
By Cohort Population

Legend to compare to statewide average result:
(green) rate more than 3% above statewide average
(red) rate more than 3% below statewide average

	Hoosier Healthwise Denominator = 34,222		Hoosier Care Connect Denominator = 427	
	% Population	Rate	% Population	Rate
Total Population	**100%**	**47%**	**100%**	**55%**
Gender				
Female	49%	47%	47%	55%
Male	51%	47%	53%	54%
Region				
Northwest	12%	42% (red)	8%	43% (red)
North Central	10%	45%	10%	36% (red)
Northeast	12%	50%	13%	59% (green)
West Central	7%	47%	6%	52%
Central	33%	46%	34%	57%
East Central	9%	48%	7%	62% (green)
Southwest	9%	46%	12%	57%
Southeast	8%	54% (green)	9%	65% (green)
Race/Ethnicity				
Caucasian	59%	49%	65%	57%
African-American	22%	36% (red)	27%	49% (red)
Hispanic	14%	51% (green)	3%	62% (green)
All Other	5%	60% (green)	5%	55%
Managed Care Entity				
Anthem	37%	50%	64%	53%
CareSource	8%	42% (red)		
MDwise	33%	41% (red)		
MHS	22%	51% (green)	36%	57%

Exhibit VIII.8
Rates for Well Child Visits in Third through Sixth Years of Life
By Cohort Population

Legend to compare to statewide average result:
- (green) rate more than 3% above statewide average
- (red) rate more than 3% below statewide average

	Hoosier Healthwise Denominator = 120,829		Hoosier Care Connect Denominator = 4,821	
	% Population	Rate	% Population	Rate
Total Population	**100%**	**65%**	**100%**	**71%**
Gender				
Female	49%	65%	39%	71%
Male	51%	65%	61%	70%
Region				
Northwest	13%	63%	13%	69%
North Central	10%	66%	8%	74%
Northeast	11%	65%	12%	75% (green)
West Central	7%	63%	9%	73%
Central	33%	67%	31%	70%
East Central	8%	62%	9%	71%
Southwest	9%	67%	10%	69%
Southeast	8%	65%	9%	68%
Race/Ethnicity				
Caucasian	57%	63%	59%	71%
African-American	22%	63%	29%	72%
Hispanic	16%	72% (green)	7%	76% (green)
All Other	5%	75% (green)	6%	59% (red)
Managed Care Entity				
Anthem	34%	67%	55%	71%
CareSource	8%	57% (red)		
MDwise	35%	64%		
MHS	23%	67%	45%	70%
Age				
Age 3	28%	67%	24%	76% (green)
Age 4	25%	65%	24%	74%
Age 5	24%	68%	25%	69%
Age 6	23%	61% (red)	27%	65% (red)

Exhibit VIII.9
Rates for Adolescent Well Care
By Cohort Population

Legend to compare to statewide average result:
- (green) rate more than 3% above statewide average
- (red) rate more than 3% below statewide average

	Hoosier Healthwise Denominator = 157,493		Hoosier Care Connect Denominator = 12,868	
	% Population	Rate	% Population	Rate
Total Population	**100%**	**51%**	**100%**	**44%**
Gender				
Female	50%	52%	36%	48%
Male	50%	50%	64%	42%
Region				
Northwest	14%	50%	14%	42%
North Central	9%	55%	9%	44%
Northeast	11%	52%	11%	46%
West Central	7%	50%	7%	42%
Central	32%	52%	33%	44%
East Central	9%	46%	10%	40%
Southwest	9%	51%	9%	47%
Southeast	8%	49%	7%	46%
Race/Ethnicity				
Caucasian	58%	48%	55%	43%
African-American	21%	51%	35%	46%
Hispanic	17%	60%	6%	48%
All Other	4%	57%	4%	30%
Managed Care Entity				
Anthem	31%	50%	57%	44%
CareSource	7%	40%		
MDwise	36%	51%		
MHS	25%	55%	43%	44%
Age				
Age 12	17%	60%	12%	62%
Age 13	16%	54%	11%	55%
Age 14	15%	53%	11%	54%
Age 15	14%	50%	11%	49%
Age 16	13%	48%	11%	45%
Age 17	13%	50%	12%	47%
Age 18	11%	42%	10%	40%
Age 19-21	2%	27%	21%	20%

Exhibit VIII.10
Rates for Adults' Access to Preventive and Ambulatory Health Services
By Cohort Population

Legend to compare to statewide average result:
- (green) rate more than 3% above statewide average
- (red) rate more than 3% below statewide average

	Healthy Indiana Plan 2.0 Denominator = 236,232		Hoosier Care Connect Denominator = 48,818	
	% Population	Rate	% Population	Rate
Total Population	**100%**	**82%**	**100%**	**85%**
Gender				
Female	67%	86% (green)	53%	90% (green)
Male	33%	72% (red)	47%	79% (red)
Region				
Northwest	16%	80%	15%	83%
North Central	7%	83%	8%	84%
Northeast	10%	83%	10%	86%
West Central	8%	83%	8%	86%
Central	29%	80%	28%	83%
East Central	10%	82%	11%	87%
Southwest	11%	84%	10%	87%
Southeast	9%	82%	9%	87%
Race/Ethnicity				
Caucasian	73%	83%	68%	87%
African-American	17%	78% (red)	25%	80% (red)
Hispanic	5%	78% (red)	3%	86%
All Other	4%	78% (red)	4%	71% (red)
Managed Care Entity				
Anthem	44%	84%	66%	86%
CareSource	9%	72% (red)		
MDwise	29%	81%		
MHS	18%	82%	34%	82%
Age				
Age 19-44	65%	79%	42%	78% (red)
Age 45-64	35%	86% (green)	58%	90% (green)

Prevalence of Well Care Utilization, Primary Care Utilization, or No Care Among the Study Populations

As mentioned earlier in this section, the definition to assign a well care visit to a member is based on select CPT/HCPCS codes or the presence of certain diagnosis codes (which were found most commonly with immunization services when not on the well care visit itself). Primary care visits are defined only by CPT E&M codes and do not include well care visits. B&A examined among the members in the W15, W34 and AWC populations which members had a well care visit, which members did not have a well care visit but did have a primary care visit, and which had neither.

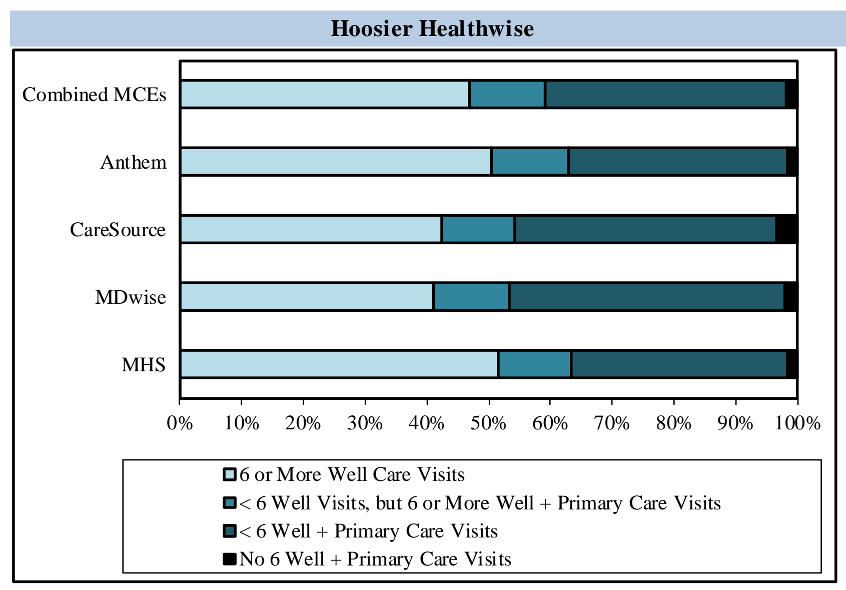
Exhibits VIII.11 – VIII.13 on the next pages examine the W15 population (Exhibit VIII.11), the W34 population (Exhibit VIII.12) and the AWC population (Exhibit VIII.13) separately. The horizontal bars are arranged to show, from left to right, the percent of total children in the population who had a well care visit (lightest color) to the percent of children with neither a well care visit or a primary care visit during the study period (darkest color). The color(s) in the middle represent children who did not have a well care visit but did have a primary care visit.

The horizontal bars in Exhibit VIII.11 differ slightly from what is shown in Exhibits VIII.12 and VIII.13 due to the HEDIS requirement for W15. In the W15 measure, the threshold is six or more well care visits. Overall, 47 percent of HHW children and 55 percent of HCC children had six or more well care visits (the lightest color bar). Only two percent of HHW had neither a well care nor a primary care visit (the darkest color bar). Because this is a study using paid claims only, this small group could include members with third-party coverage in addition to Medicaid. The next darkest color (12% of the HHW total, 29% of the HCC total) represents children who had less than six well visits, but six or more visits in the study period when well care and primary care visits are combined. This was done to assess the total visit count in case there were situations where incomplete coding of a visit prevented it from being classified as a well care visit. The next darkest color (39% of the HHW total, 16% of the HCC total) represents children who had some visits during the study period, but less than six when considering well care and primary care visits together.

The variation in numerator compliance across MCEs (the lightest portion of the bar) was reviewed in Exhibit VIII.7. What appears to be more common across the MCEs is the rate of "missed opportunities" to meet numerator compliance; that is, the percentage of children with six or more visits in the first 15 months of life, but not all visits were classified as well care visits.

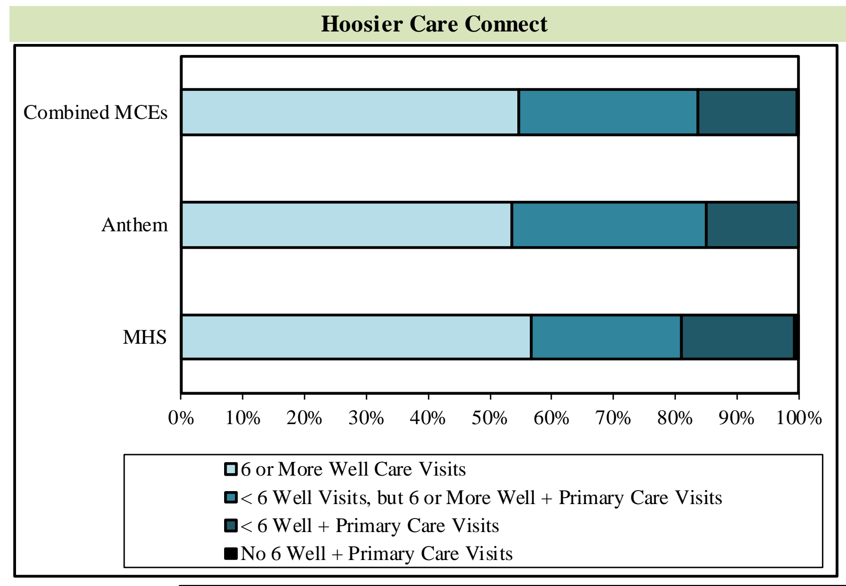
Exhibit VIII.11
Utilization of Well Care and Primary Care Among HEDIS W15 Population

Hoosier Healthwise



	6 or More Well Care Visits	< 6 Well Visits, but 6 or More Well + Primary Care Visits	< 6 Well + Primary Care Visits	No 6 Well + Primary Care Visits
Combined MCEs	47%	12%	39%	2%
Anthem	50%	13%	35%	2%
CareSource	42%	12%	42%	4%
MDwise	41%	12%	45%	2%
MHS	51%	12%	35%	2%

Hoosier Care Connect



	6 or More Well Care Visits	< 6 Well Visits, but 6 or More Well + Primary Care Visits	< 6 Well + Primary Care Visits	No 6 Well + Primary Care Visits
Combined MCEs	55%	29%	16%	0%
Anthem	53%	32%	15%	0%
MHS	57%	24%	18%	1%

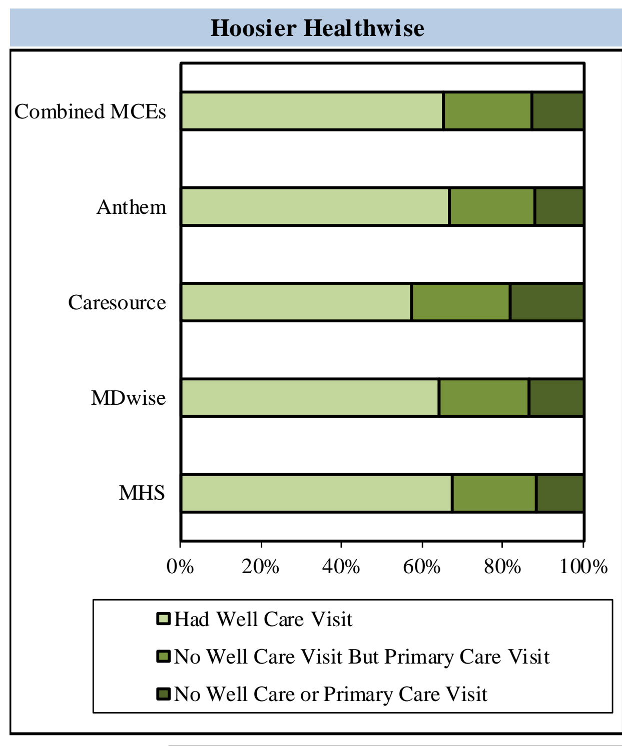
Exhibit VIII.12 below presents information for the W34 population in both HHW and HCC. In this exhibit, a member could have both a well care visit and a primary care visit. When this occurs, the child is included only in the "had well care visit" group.

Children in HCC are much more likely to have had a well care visit (71%) than their peers in HHW (65%). In both programs, near 22 percent of the total eligible members considered had a primary care visit during the year that was not a well care visit. In HCC, this percentage was 34 percent. The rate of children with neither a well care nor a primary care visit was 13 percent in HHW and 7 percent in HCC.

At the MCE level, Anthem and MHS once again had similar findings in both HHW and HCC. In HHW, the rate of numerator compliance is lower for MDwise and lowest for CareSource. The percentage of potential "missed opportunities", however, is similar for all MCEs in both programs.

Exhibit VIII.12
Utilization of Well Care and Primary Care Among HEDIS W34 Population

Hoosier Healthwise



	Had Well Care Visit	No Well Care Visit But Primary Care Visit	No Well Care or Primary Care Visit
Combined MCEs	65%	22%	13%
Anthem	67%	21%	12%
CareSource	57%	24%	18%
MDwise	64%	22%	13%
MHS	67%	21%	12%

Hoosier Care Connect

Combined MCEs
Anthem
MHS
0% 20% 40% 60% 80% 100%
Had Well Care Visit
No Well Care Visit But Primary Care Visit
No Well Care or Primary Care Visit

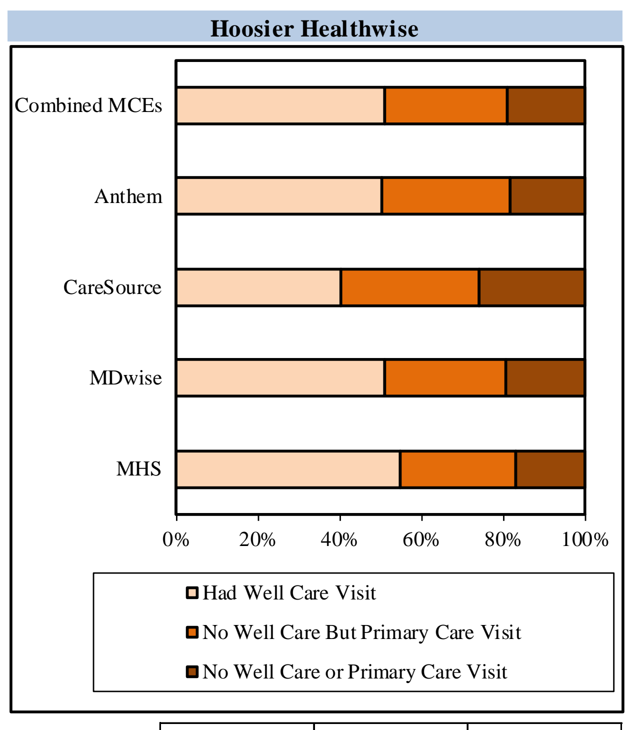
	Had Well Care Visit	No Well Care Visit But Primary Care Visit	No Well Care or Primary Care Visit
Combined MCEs	71%	23%	7%
Anthem	71%	22%	7%
MHS	70%	23%	6%

Exhibit VIII.13 below presents information for the AWC population in both HHW and HCC. Children in HHW are much more likely to have had a well care visit (51%) than their peers in HCC (44%). In HHW, near 30 percent of the total eligible members considered had a primary care visit during the year that was not a well care visit. In HCC, this percentage was 38 percent. The rate of children with neither a well care nor a primary care visit was 19 percent in HHW and 18 percent in HCC.

At the MCE level, three of the MCEs (Anthem, MDwise, MHS) had similar rates of both numerator compliance to meet the measure as well as the percentage of members with "missed opportunities". CareSource had a lower rate of compliance and a higher rate of missed opportunities. In HCC, the findings are very similar between Anthem and MHS.

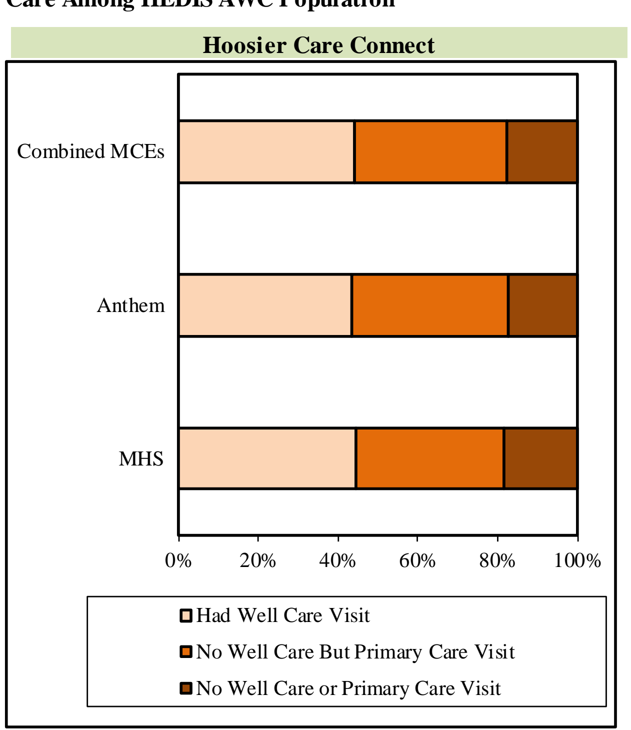
Exhibit VIII.13
Utilization of Well Care and Primary Care Among HEDIS AWC Population

Hoosier Healthwise



	Had Well Care Visit	No Well Care But Primary Care Visit	No Well Care or Primary Care Visit
Combined MCEs	51%	30%	19%
Anthem	50%	32%	18%
CareSource	40%	34%	26%
MDwise	51%	29%	19%
MHS	55%	28%	17%

Hoosier Care Connect



	Had Well Care Visit	No Well Care But Primary Care Visit	No Well Care or Primary Care Visit
Combined MCEs	44%	38%	18%
Anthem	44%	39%	17%
MHS	44%	37%	18%

Investigation of Members in the Study and Emergency Department Use

Exhibits VIII.14 through VIII.18, which appear on the next four pages, examine the rate of emergency department (ED) use among the eligible populations (the denominators) for each HEDIS measure examined in this study. Each exhibit represents one of the HEDIS measure populations. The exhibits are formatted in the same manner. The denominator population within each measure is split into three sub-groups:

- Members with no ED visits during CY 2018
- Members with one or more ED visits during CY 2018, but all were determined to be non-PPVs
- Members with one or more ED visits during CY 2018, but at least one was determined to be a PPV

B&A reviewed this data to determine if there was a correlation between numerator compliance for the HEDIS measure and inappropriate ED use. In other words, if higher PPV rates were found in populations with lower HEDIS numerator compliance.

Information in each exhibit is presented by program and by MCE. A summary of the findings across these four exhibits appears below.

For the W15 measure (Exhibit VIII.14):

- The statewide rate for no ED use among the W15 population was 44 percent in HHW; in HCC, 31 percent. These rates did not vary considerably by MCE.
- Half of all W15 members in HHW in every MCE had an ED visit where at least one visit was determined to be potentially preventable (a PPV). In HCC, this was two-thirds of the children.

For the W34 measure (Exhibit VIII.15):

- The statewide rate for no ED use among the W34 population was 69 percent in HHW; in HCC, 59 percent. These rates did not vary considerably by MCE.
- Almost one quarter of all W34 members in HHW in every MCE had an ED visit where at least one visit was determined to be a PPV. In HCC, this was one-third of the children.

For the AWC measure (Exhibit VIII.16):

- The statewide rate for no ED use among the AWC population was 76 percent in HHW; in HCC, 66 percent. These rates did not vary at all by MCE.
- Sixteen percent of all AWC members in HHW in every MCE had an ED visit where at least one visit was determined to be a PPV. In HCC, this was 25 percent of the adolescents.

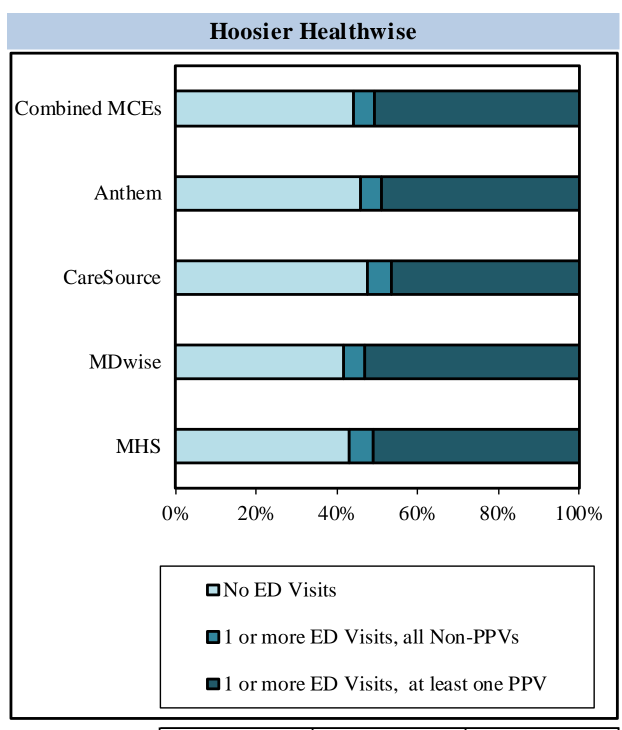
For the AAP measure (Exhibit VIII.17):

- The statewide rate for no ED use among the AAP population was 62 percent in HIP; in HCC, 52 percent. These rates did not vary much by MCE except that CareSource had a slightly higher rate of no ED visits in HIP than other MCEs.
- One quarter of all AAP members in HIP in every MCE had an ED visit where at least one visit was determined to be a PPV. In HCC, this was 38 percent of the adults.

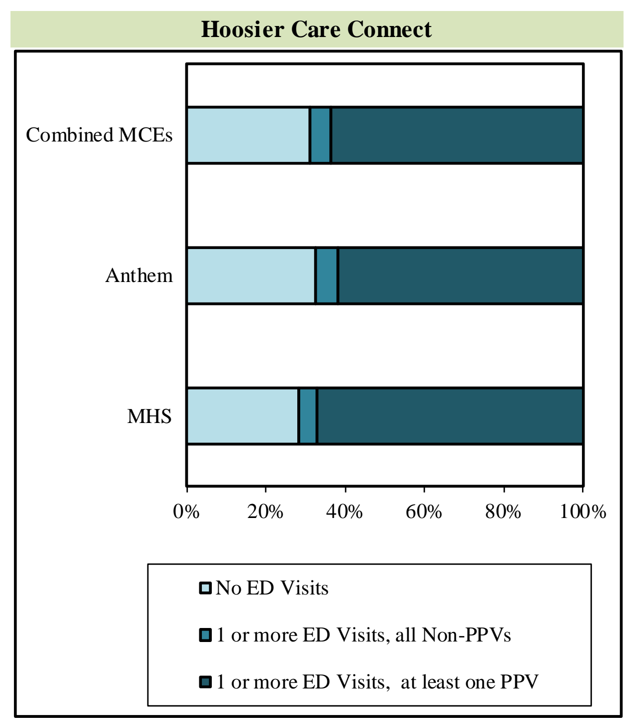
The AWC eligible population had the lowest rate of numerator compliance in the AWC measure. Yet, this population was also least likely to have had an ED visit in CY 2018. It also had the lowest PPV rate among the four populations studied. Conversely, the numerator compliance for AAP is quite high in both HIP and HCC. Yet, at least one quarter of all members in both programs had a PPV in CY 2018. These results seem to imply that the AWC is not replacing primary care with the ED. Conversely, many adults are using both preventive health service outlets (physician offices, clinics) as well as the ED.

Exhibit VIII.14
Utilization of Emergency Department Among HEDIS W15 Population

Hoosier Healthwise



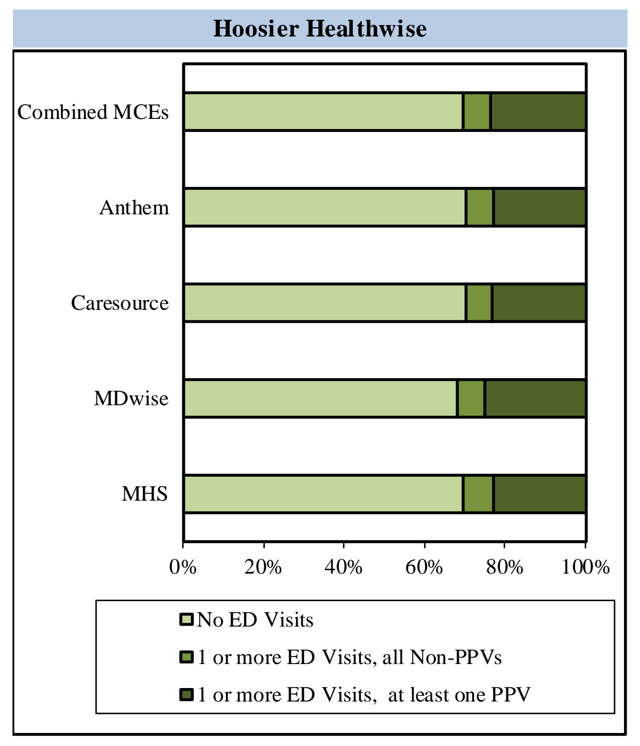
Hoosier Care Connect



	No ED Visits	1 or more ED Visits, all Non-PPVs	1 or more ED Visits, at least one PPV
Combined MCEs	44%	5%	51%
Anthem	46%	5%	49%
CareSource	48%	6%	46%
MDwise	42%	5%	53%
MHS	43%	6%	51%

	No ED Visits	1 or more ED Visits, all Non-PPVs	1 or more ED Visits, at least one PPV
Combined MCEs	31%	5%	64%
Anthem	33%	5%	62%
MHS	28%	5%	67%

Exhibit VIII.15
Utilization of Emergency Dept Among HEDIS W34 Population



Hoosier Care Connect

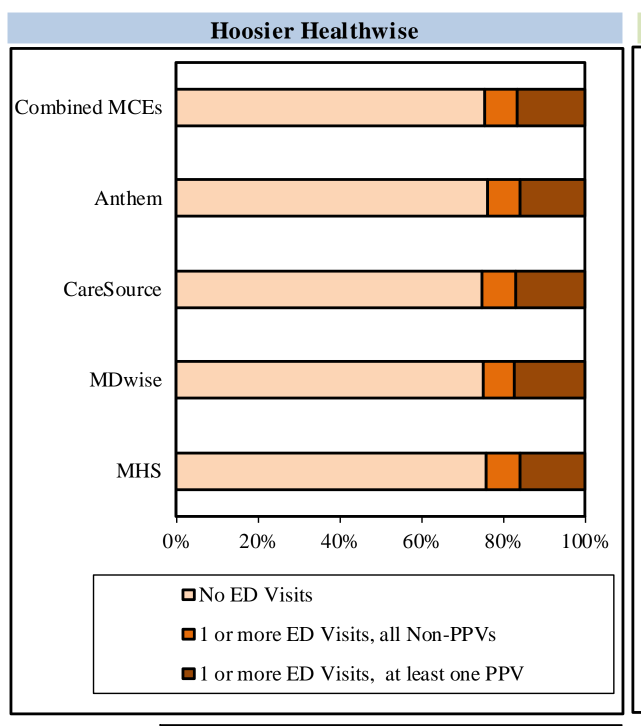
Combined MCEs
Anthem
MHS
0% 20% 40% 60% 80% 100%
No ED Visits
1 or more ED Visits, all Non-PPVs
1 or more ED Visits, at least one PPV

	No ED Visits	1 or more ED Visits, all Non-PPVs	1 or more ED Visits, at least one PPV
Combined MCEs	69%	7%	24%
Anthem	70%	7%	23%
CareSource	70%	7%	23%
MDwise	68%	7%	25%
MHS	70%	8%	23%

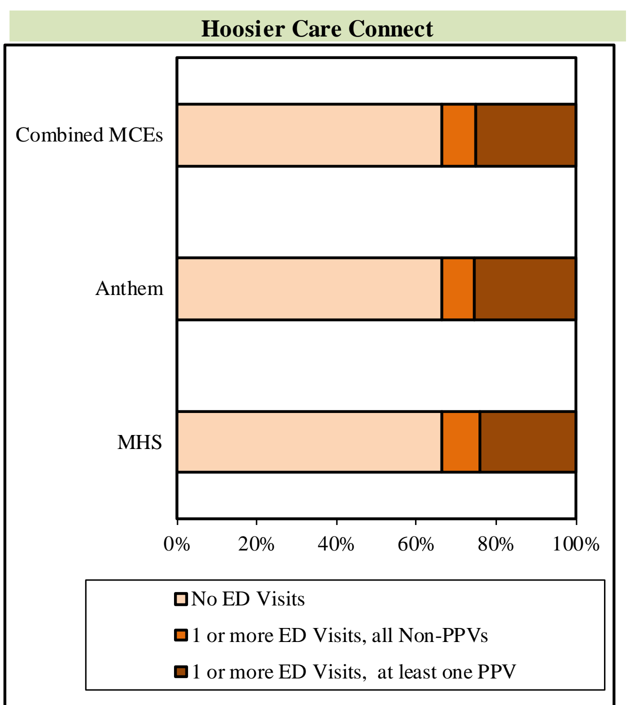
	No ED Visits	1 or more ED Visits, all Non-PPVs	1 or more ED Visits, at least one PPV
Combined MCEs	59%	8%	33%
Anthem	58%	9%	33%
MHS	59%	8%	33%

Exhibit VIII.16
Utilization of Emergency Dept Among HEDIS AWC Population

Hoosier Healthwise



Hoosier Care Connect

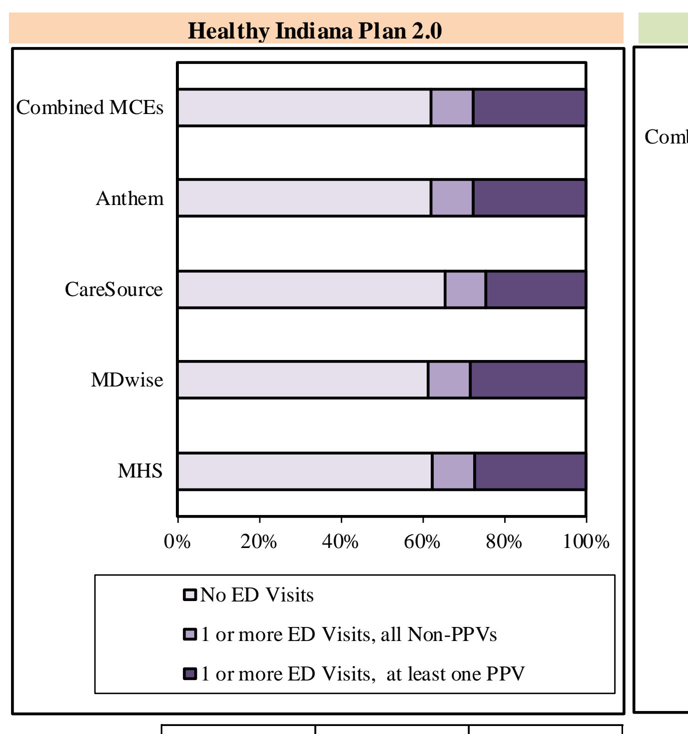


	No ED Visits	1 or more ED Visits, all Non-PPVs	1 or more ED Visits, at least one PPV
Combined MCEs	76%	8%	16%
Anthem	76%	8%	16%
CareSource	75%	8%	17%
MDwise	75%	8%	17%
MHS	76%	8%	16%

	No ED Visits	1 or more ED Visits, all Non-PPVs	1 or more ED Visits, at least one PPV
Combined MCEs	66%	9%	25%
Anthem	66%	8%	26%
MHS	66%	9%	24%

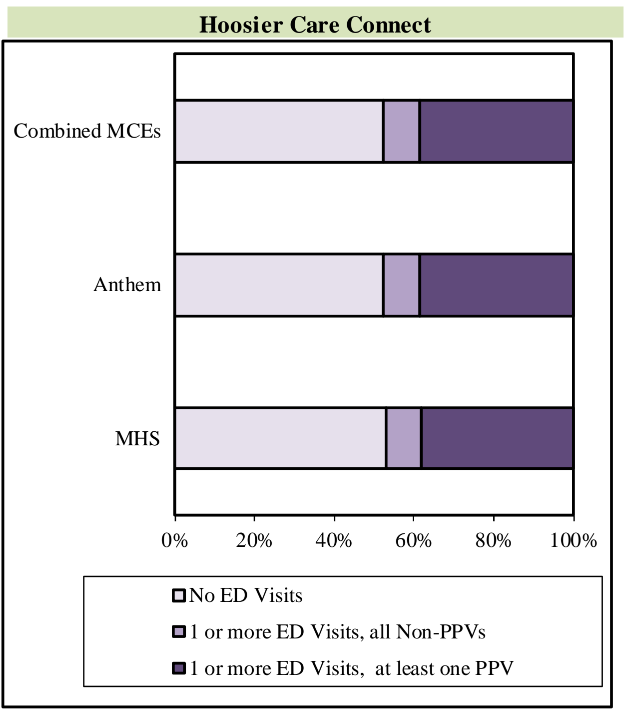
Exhibit VIII.17
Utilization of Emergency Dept Among HEDIS AAP Population

Healthy Indiana Plan 2.0



	No ED Visits	1 or more ED Visits, all Non-PPVs	1 or more ED Visits, at least one PPV
Combined MCEs	62%	10%	27%
Anthem	62%	10%	28%
CareSource	66%	10%	25%
MDwise	61%	10%	28%
MHS	63%	10%	27%

Hoosier Care Connect



	No ED Visits	1 or more ED Visits, all Non-PPVs	1 or more ED Visits, at least one PPV
Combined MCEs	52%	9%	38%
Anthem	52%	9%	39%
MHS	53%	9%	38%

Comparison to Previous EQRs

Most of the elements of the study presented here were also conducted in the CY 2016 EQR. The analysis of results of the AAP measure and the review of HEDIS eligible to ED usage were not completed. Within the child measure populations, however, some results can be compared to the CY 2016 study:

- It was reported in Exhibit VIII.1 in this study that the HEDIS rate reported to NCQA for W15 using the hybrid method has gone down over the three years examined. The rates examined in the CY 2016 study (HEDIS 2014 to HEDIS 2016) were higher for MHS and MDwise, but Anthem's rates have remained steadier in the last six years.

- The NCQA-reported rates for W34 were highest for Anthem in HEDIS 2017 and 2018 when reviewing the last six years. For MHS, the HEDIS 2104 through 2016 years were highest. For MDwise, the rates in the last five HEDIS years have all exceeded 80 percent.

- The rates for AWC reported to NCQA were highest in HEDIS 2016. The rates in HEDIS 2019 were the next highest in the last six years.

- When comparing HEDIS rates computed by B&A in both study years using the claims-based method only, some of the same differences were found across subpopulations in both studies:
  - Within W15, Hispanic children had a higher well care visit rate than the statewide average, but African-American children had a lower well visit rate. This finding occurred in both the CY 2016 and CY 2019 EQR studies.
  - Within W34, in CY 2019 it was found that the rate among Hispanics is higher than the statewide average and Caucasians and African-American children have a similar rate. In CY 2019, Hispanic children also had a higher rate, but Caucasian children had a lower rate than the statewide average while African-American children had a rate at the statewide average.
  - Among the AWC population, the rate among males and females was almost identical in the CY 2016 study. In the CY 2019 study, female members have a higher rate than male members. By race/ethnicity, Hispanic members had a higher rate in both study years than Caucasians and African-Americans. The trend that the greatest numerator compliance is among the youngest members in the age 12-21 cohort within AWC was true in both studies.

- The ability to leverage "missed opportunities" to raise numerator compliance within each measure appeared in both studies, but there appear to be more opportunities now in most cases than what was found in CY 2016. For example,
  - Within W15, in CY 2019, 51 percent of children either had six visits total but not all well visits or less than six well/primary care visits. In CY 2016, this was 38 percent.
  - Within W34, in CY 2019, 22 percent of children had a primary care visit that was not deemed to be a well care visit per the HEDIS specification. In CY 2016, this was 17 percent.
  - Within AWC, in CY 2019, 30 percent of HHW children and 38 percent of HCC children had a primary care visit that was not deemed to be a well care visit per the HEDIS specification. In CY 2016, this was 25 percent in HHW and 35 percent in HCC.

Recommendations

When using the hybrid method, the well-child rates for W15 and W34 have stayed constant or have decreased in the last three years. The rates for AWC have increased. When using the claims-only method, there was some variation found in CY 2018 between the MCEs for each child measure studied. The rate of "missed opportunities" was consistent within a measure across MCEs and the rates themselves were high. There were also differences found in numerator compliance for subgroups within each measure population.

For adults, B&A's results for AAP using the claims-based method were very similar to those reported by each MCE's HEDIS auditor. Variations in numerator compliance were found between the two HEDIS age groups for this measure.

B&A's recommendations from this study apply to all MCEs.

1. The MCEs should confirm that the W15 children found to have no well visits or primary care visits in the study did, in fact, have visits were not counted as such because they may have had other insurance that paid the claim. The OMPP should request each MCE to provide a summary of this research.

2. There appears to be educational opportunities with providers in W15 as each MCE was found to have 12 percentage points in the denominator for potential missed opportunities. The MCEs should consider targeted education to providers on this.

3. The disparities are lowest for W15 with African-American children. Hispanic children actually had the highest rate. The MCEs should research the root cause for this difference and work to close this gap among race/ethnicities.

4. The MCEs are encouraged to research if there is a pattern among the missed opportunities in W34 and AWC since the opportunity is high to close the gaps (e.g., specific providers, specific regions).

5. The MCEs are encouraged to research the PPV rates for each HEDIS denominator to see if these members were numerator-compliant or, through education, could not only reduce PPVs but also increase HEDIS rates.

SECTION IX: FOCUS STUDY ON THE DELIVERY OF PRENATAL CARE SERVICES

Introduction

Maternal health and infant mortality were high-priority areas of focus for the Office of Medicaid Policy and Planning's (OMPP's) quality strategy for Calendar Year (CY) 2018. These are long-standing initiatives of the OMPP that cross all three of its managed care programs.

The OMPP has a Pay for Outcomes (P4O) program in its contracts with the managed care entities (MCEs). Two of the P4O measures are Healthcare Effectiveness Data and Information Set (HEDIS) measures related to pregnancy:

- Timeliness of Prenatal Care (HEDIS PPC)
- Post-Partum Visit within 21 and 56 Days After Delivery (HEDIS PPC)

These P4O measures were originally utilized in the Hoosier Healthwise (HHW) since this is where most pregnant women were enrolled. In CY 2018, a change was made so that most pregnant women are now enrolled in the Healthy Indiana Plan (HIP) program. These P4O measures also moved to HIP in each MCE's contract in CY 2018.

MCEs are paid annual performance bonuses based on the results of these measures. The bonus is stair-stepped in a manner based on the MCE's percentile ranking compared to other Medicaid health plans nationally. Full P4O allocation dollars are awarded if an MCE exceeds the HEDIS rate above the 90th percentile for each of these measures.

The American College of Obstetricians and Gynecologists (ACOG) recommends that women with an uncomplicated pregnancy receive visits every four weeks for the first 28 weeks of pregnancy, every two to three weeks until 36 weeks of pregnancy, and weekly thereafter. For example, for a 40-week pregnancy, this would be 14 visits. An MCE's ability to manage and track prenatal visits will obviously depend on the number of months that the woman is enrolled with an MCE. So, for example, although 14 visits are expected for a 40-week pregnancy, if the woman did not enroll with the MCE until the fifth month, then the expected visits while with the MCE would be nine (14 total minus 5 in the first five months).

The study in this EQR focuses on examining the prevalence of prenatal visits during the last four weeks of pregnancy. This was also the focus of a study conducted by Burns & Associates (B&A) in the CY 2016 EQR. In addition to understanding the overall trend in HIP and HHW, the study examines the prenatal visits in the last four weeks among cohort populations stratified by: the MCE she is enrolled with, the age of the mother, her race/ethnicity, the region where she lives, and the type of delivery (vaginal or Cesarean). Because CY 2018 was a transition year to move pregnant members into HIP, the study populations are distributed relatively even between HIP and HHW. In future years, the focus will be only on the HIP program.

Background

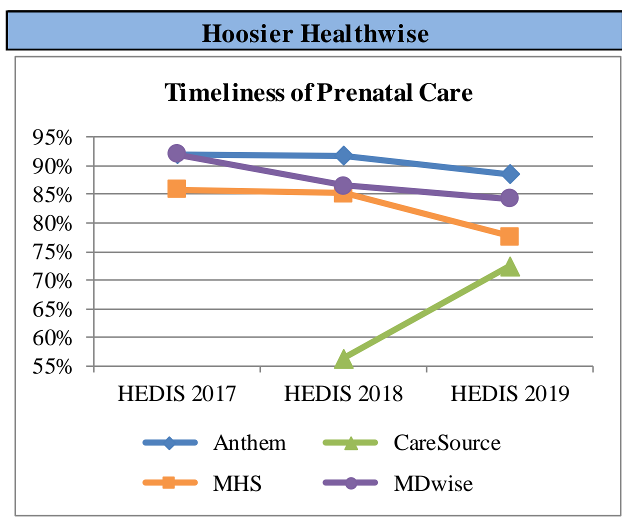
Similar to what was reported in the well visit study in Section VIII of this report, the OMPP requires the MCEs to hire an external certified HEDIS auditor to annually collect results on the HEDIS measure specifically related to pregnancy that is reportable to the National Committee on Quality Assurance (NCQA). All MCEs choose to use the hybrid method for this measure for reporting to NCQA. These results are also used as the basis for any P4O payments from the OMPP. Exhibit IX.1 on the next page

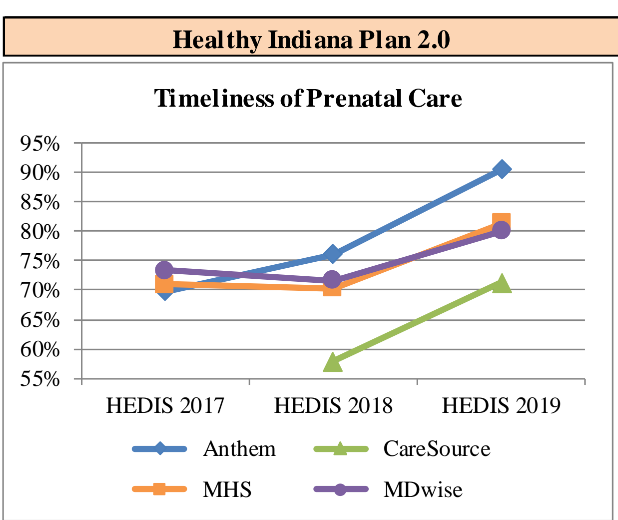
shows the results reported by the HEDIS auditors in each of the last three reporting years for the PPC measure. The reporting years are HEDIS 2017, HEDIS 2018 and HEDIS 2019. This means that the results are based on deliveries that occurred from November 6 of the year prior to the measurement year and November 5 of the measurement year (CY 2016, CY 2017 and CY 2018).

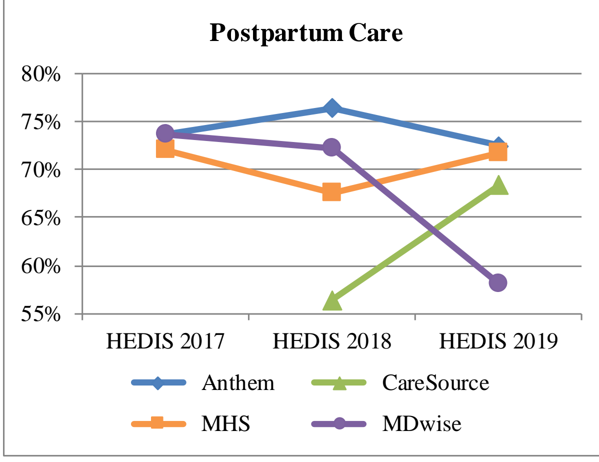
The exhibit shows that the rates reported decreased over the three years in HHW but increased in HIP for timeliness of prenatal care. Anthem decreased slightly in HHW (from 92% to 89%) but increased substantially in HIP (from 70% to 90%). MDwise dropped eight percentage points in HHW (from 92% to 84%) but picked up seven percentage points in HIP (from 73% to 80%). MHS also dropped eight percentage points in HHW (from 86% to 78%) but picked up ten percentage points in HIP (from 71% to 81%). CareSource stood at 73 percent in HHW and 71 percent in HIP in HEDIS 2019.

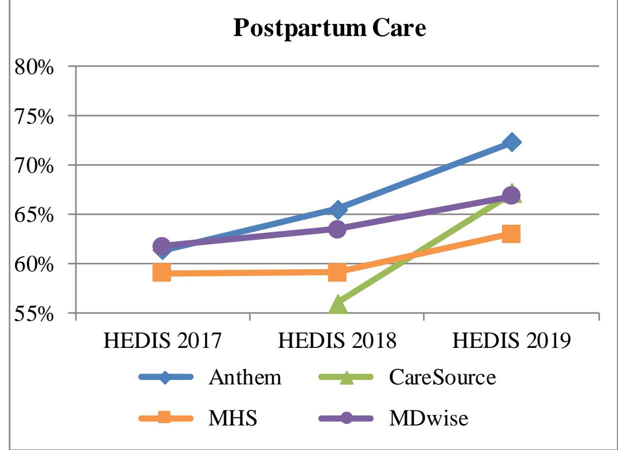
The rates for postpartum visits showed a similar trend to what was seen in the prenatal visit measure. The one difference is that MHS did not drop as much over the three years in HHW for postpartum care as was seen for prenatal care. MDwise, however, dropped further in HHW on the postpartum measure.

Exhibit IX.1
Summary of Results from HEDIS Prenatal and Postpartum Care (PPC)
(Percentage of Total)









Methodology for Defining the Study Sample

For this study, B&A started by considering all eligible members in HHW or HIP for the PPC HEDIS measure by using the HEDIS parameter to define the population. Specifically, this includes women who:

- Delivered a child (or children) between November 6, 2017 and November 5, 2018;
- Were continuously enrolled in HHW or HIP with an MCE at least 43 days prior to delivery and 56 days after delivery; and
- Had a live birth

B&A used the enrollment file from the state's Enterprise Data Warehouse (EDW) to determine the eligibility of a member within a program (HHW or HIP) within an MCE.

The anchor date used in the study is the date of delivery as defined on the professional service claim of the attending doctor at the time of delivery.

Members could have transitioned between HHW and HIP during their pregnancy, or vice versa. If this occurred, the mother was placed in only one program, namely, the program where she was at the time of delivery.

The final study includes 28,997 women distributed by program and MCE as follows:

Exhibit IX.2
Count of Populations Defined in the Study

	HHW	HIP
All MCEs	**13,198**	**15,799**
Anthem	4,227	6,031
CareSource	3,200	1,431
MDwise	3,156	4,989
MHS	2,615	3,348

For comparison, the population in the CY 2016 study was 28,802 women.

Once the members were identified, B&A extracted demographic information about each woman such as her age, race/ethnicity and region from the EDW enrollment file. For the actual deliveries, the diagnosis related group (DRG) assignment was pulled. All paid claims for the claim types for professional services or hospital services (inpatient and outpatient) for each member for the study time period were also compiled.

Using the anchor claim for the delivery date, B&A then counted back 40 weeks and forward eight weeks in order to capture all enrollment information and claims during the time period studied for each pregnant woman. As a result, each member in the study has her own specific 48-week period of study based on her delivery date. Each member's enrollment information and claims utilization were slotted in each of her study weeks. In other words, for each week examined, each member was given a yes or no if she was enrolled with the MCE. She was also given a yes or no if she had a prenatal visit in that week. B&A also tagged yes or no if the member had some visit other than a prenatal visit (as defined by the HEDIS specification) in that week.

One limitation of the data is the specificity related to enrollment. B&A received a file that identified the member's enrollment in an MCE rounded to the month. If a woman had a record of being enrolled in an MCE for the month, we assumed that she was enrolled the entire month of the pregnancy.
When translating this to weekly segments, therefore, B&A gave credit for enrollment if the days in the enrollment month were within any week. For example, a woman was enrolled with an MCE in August 2018. One of her 40-week spans was from Monday July 30 to Sunday August 5. B&A gave her credit as being enrolled with the MCE for this entire week.

Findings

One of the challenges that MCEs have for obtaining 100 percent compliance with the PPC measure is that the member is not enrolled in the MCE over the entire course of her pregnancy. B&A computed the percent of members in the study enrolled with the MCE based on the weeks of her pregnancy. Exhibit IX.3 shows that almost all members in HHW were enrolled with the MCE in weeks 37 through 40. But in HIP, only 96 percent of members were enrolled with the MCE all of these last four weeks. The gray cells indicate where in the pregnancy the percentage of enrollees drops below 90 percent. In HHW, this is usually happening between weeks 17 and 21. In HIP, this is happening between weeks 29 and 33.

Exhibit IX.3
Weeks of Member Enrollment with MCE During Pregnancy
shading indicates when percentage drops below 90%

	All MCEs Combined	Anthem	CareSource	MDwise	MHS
	Hoosier Healthwise				
Total	**13,198**	**4,227**	**3,200**	**3,156**	**2,615**
Enrolled weeks 37-40	99%	99%	100%	100%	96%
Enrolled weeks 33-40	98%	99%	99%	99%	95%
Enrolled weeks 29-40	97%	98%	98%	98%	94%
Enrolled weeks 25-40	95%	96%	95%	96%	92%
Enrolled weeks 21-40	91%	91%	89%	93%	88%
Enrolled weeks 17-40	84%	86%	81%	87%	82%
Enrolled weeks 13-40	74%	76%	69%	79%	73%
Enrolled weeks 9-40	63%	64%	55%	69%	63%
Enrolled weeks 5-40	55%	56%	47%	62%	56%
Enrolled weeks 1-40	45%	46%	36%	53%	47%
	Healthy Indiana Plan 2.0				
Total	**15,799**	**6,031**	**1,431**	**4,989**	**3,348**
Enrolled weeks 37-40	96%	96%	96%	96%	96%
Enrolled weeks 33-40	92%	92%	91%	93%	91%
Enrolled weeks 29-40	88%	89%	86%	89%	86%
Enrolled weeks 25-40	83%	84%	81%	85%	81%
Enrolled weeks 21-40	78%	79%	76%	80%	75%
Enrolled weeks 17-40	73%	73%	70%	76%	69%
Enrolled weeks 13-40	68%	68%	63%	72%	64%
Enrolled weeks 9-40	65%	65%	58%	69%	62%
Enrolled weeks 5-40	63%	63%	52%	68%	60%
Enrolled weeks 1-40	60%	60%	46%	66%	58%

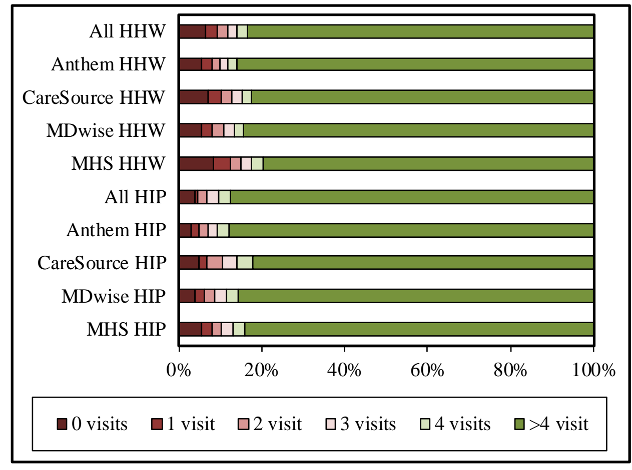
B&A first identified all visits found for each member in the study in her last four weeks of pregnancy. In the left box of Exhibit IX.4 below, the percentages represent the count of visits defined as prenatal visits in the PPC specification. In the right box, the visits considered is expanded to include not only those deemed to be prenatal visits, but also any other visits billed on a professional claim or outpatient hospital claim.

Starting with the information in the left box, it was found that overall in HHW that 86 percent of women had four or more prenatal visits in their last four weeks prior to delivery. In HIP, this was 89 percent. The range across the MCEs in HHW was from a low of 83 percent for MHS to a high of 88 percent for Anthem. In HIP, the range was from a low of 86 percent for CareSource to a high of 91 percent for Anthem. The percentage of women with no prenatal visits identified during these last four weeks was six percent in HHW and four percent in HIP.

When considering other visits besides those defined as prenatal visits in the right box, the percentage of women overall in HHW with four or more services in the last four weeks of pregnancy jumps to 97 percent in HHW and 98 percent in HIP. All MCEs have a rate of 96 to 98 percent in HHW. All MCEs have a rate of 98 or 99 percent in HIP. There are only 81 women out of 28,222 in the sample that were found to have no visits. Another 115 only had one visit.

Exhibit IX.4
Number of Visits in Last 4 Weeks Before Delivery, by Type of Visit

For Visits Flagged as Prenatal



For Prenatal and Other Professional / Outpatient Hospital

All HHW
Anthem HHW
CareSource HHW
MDwise HHW
MHS HHW
All HIP
Anthem HIP
CareSource HIP
MDwise HIP
MHS HIP
0% 20% 40% 60% 80% 100%
0 visits 1 visit 2 visit 3 visits 4 visits >4 visit

	Number of Women (n=28,222)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
All HHW	6%	3%	2%	2%	2%	84%
Anthem HHW	6%	2%	2%	2%	2%	86%
CareSource HHW	7%	3%	3%	3%	2%	82%
MDwise HHW	5%	2%	3%	3%	2%	84%
MHS HHW	8%	4%	3%	2%	3%	80%
All HIP	4%	0%	2%	3%	3%	86%
Anthem HIP	3%	2%	2%	2%	3%	88%
CareSource HIP	5%	2%	4%	3%	4%	82%
MDwise HIP	4%	2%	2%	3%	3%	86%
MHS HIP	5%	3%	2%	3%	3%	84%

	Number of Women (n=28,222)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
All HHW	0%	1%	1%	1%	1%	96%
Anthem HHW	1%	0%	1%	1%	1%	97%
CareSource HHW	1%	1%	1%	1%	1%	95%
MDwise HHW	0%	1%	1%	1%	1%	96%
MHS HHW	0%	1%	1%	1%	1%	97%
All HIP	0%	0%	0%	0%	0%	98%
Anthem HIP	0%	0%	0%	0%	0%	99%
CareSource HIP	0%	0%	0%	0%	1%	98%
MDwise HIP	0%	0%	0%	0%	0%	98%
MHS HIP	0%	0%	0%	1%	1%	98%

Exhibits IX.5 through IX.9 that appear on the following pages and are presented in the same manner. In these exhibits, the focus is only on those visits defined as prenatal visits by the HEDIS PPC specification. The percentage of women based on the number of prenatal visits in their last four weeks prior to delivery are compared. These results can be contrasted with the results shown in the left box of Exhibit IX.4 which stated that 86 percent of HHW women and 89 percent of HIP women had four or more prenatal visits. Each exhibit reviews results of subpopulations of the entire study sample.

A summary of all of these exhibits is listed below.

Exhibit IX.5 (segmented by mother's age):

- There does not appear to be a significant difference in the number of visits received based on the age of the mother.
- In HHW, the percentage of HHW women with four or more prenatal visits was 85 to 87 percent for all four age groups studied. In HIP, the range was from 86 to 91 percent. The youngest women had the lowest percentage.

Exhibit IX.6 (segmented by mother's delivery DRG):

- There is a slight difference in the number of visits received based on the type of delivery recorded in HHW, but not in HIP.
- In HHW, the percentage of HHW women with four or more prenatal visits was a low of 83 percent for vaginal delivery with complications to a high of 90 percent for vaginal delivery with sterilization. In HIP, the range was from 90 to 92 for all delivery types.

Exhibit IX.7 (segmented by mother's race/ethnicity):

- African-American women have a higher rate of prenatal visits than other race/ethnicities in HHW. The findings are more similar in HIP across race/ethnicities.
- In HHW, the percentage of HHW African-American women with four or more prenatal visits was 90 percent compared to 85 percent for all other categories.

Exhibit IX.8 (segmented by mother's MCE and region, HHW only):

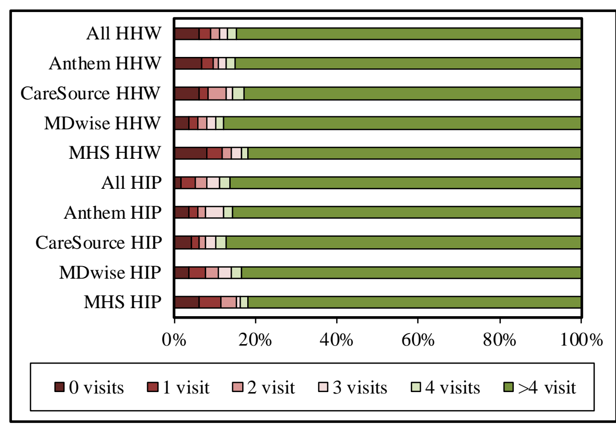
- There was some variation seen in the rates of women with four or more visits across MCEs. There is also some variation within regions for each MCE in the HHW program.
- For Anthem, all regions had 88 percent or more of women with four or more visits except West Central (84%) and Southeast (86%).
- For CareSource, all regions had 85 percent or more of women with four or more visits except Northwest (80%) and North Central (82%).
- For MDwise, the regions were more spread from a low of 84 percent in the Northwest and West Central to a high of 90 percent in the Southeast.
- For MHS, the Northwest and Southeast regions were the lowest at 78 percent. MHS's highest region was the Central region at 87 percent.

Exhibit IX.9 (segmented by mother's MCE and region, HIP only):

- The variations across regions within an MCE were found in HIP as they were found in HHW.
- For Anthem, West Central (88%) and Southeast (85%) were once again their lowest regions.
- For CareSource, their lowest region was Central (83%) which is lower than for its HHW enrollment (87%).
- For MDwise, there was less disparity across the regions in HIP than was found for HHW.
- For MHS, the lowest regions for HIP members were different than what was found in HHW. In HIP, the lowest regions were Southeast (83%), East Central and West Central (both 85%).

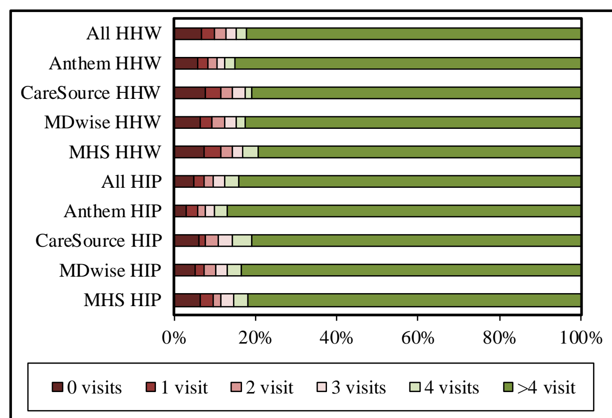
Exhibit IX.5
Number of Prenatal Visits in Last 4 Weeks Before Delivery, by Mother's Age at Delivery

Age 19 and Under



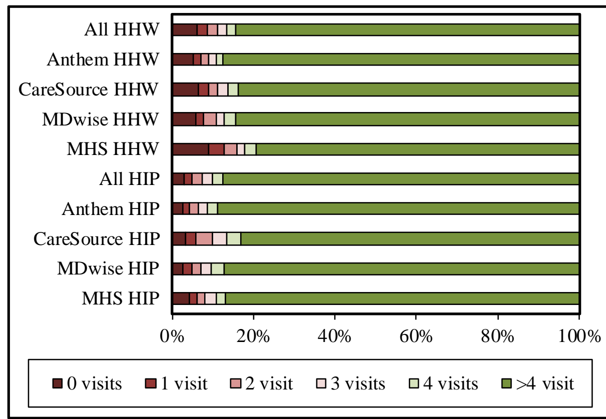
	Number of Women (n=3,323)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
All HHW	6%	3%	2%	2%	2%	85%
Anthem HHW	7%	3%	1%	2%	2%	85%
CareSource HHW	6%	2%	4%	2%	3%	83%
MDwise HHW	4%	2%	2%	2%	2%	88%
MHS HHW	8%	4%	2%	2%	1%	82%
All HIP	2%	3%	3%	3%	2%	84%
Anthem HIP	4%	2%	2%	4%	2%	86%
CareSource HIP	4%	2%	2%	3%	3%	87%
MDwise HIP	3%	4%	3%	3%	3%	83%
MHS HIP	6%	5%	4%	1%	2%	82%

Age 20 to 25



	Number of Women (n=11,601)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
All HHW	7%	3%	3%	3%	3%	82%
Anthem HHW	6%	3%	2%	2%	3%	85%
CareSource HHW	8%	4%	3%	3%	2%	81%
MDwise HHW	6%	3%	3%	3%	2%	82%
MHS HHW	7%	4%	3%	2%	4%	79%
All HIP	5%	3%	2%	3%	3%	84%
Anthem HIP	3%	3%	2%	2%	3%	87%
CareSource HIP	6%	2%	3%	3%	5%	81%
MDwise HIP	5%	2%	3%	3%	3%	84%
MHS HIP	6%	3%	2%	3%	3%	82%

Age 26 to 35



	Number of Women (n=11,779)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
All HHW	6%	2%	3%	2%	2%	84%
Anthem HHW	5%	2%	2%	2%	2%	87%
CareSource HHW	6%	3%	2%	2%	3%	84%
MDwise HHW	6%	2%	3%	2%	3%	84%
MHS HHW	9%	4%	3%	2%	3%	79%
All HIP	3%	2%	2%	3%	3%	88%
Anthem HIP	3%	2%	2%	2%	3%	89%
CareSource HIP	3%	2%	4%	3%	3%	83%
MDwise HIP	3%	2%	2%	3%	3%	87%
MHS HIP	4%	2%	2%	3%	2%	87%

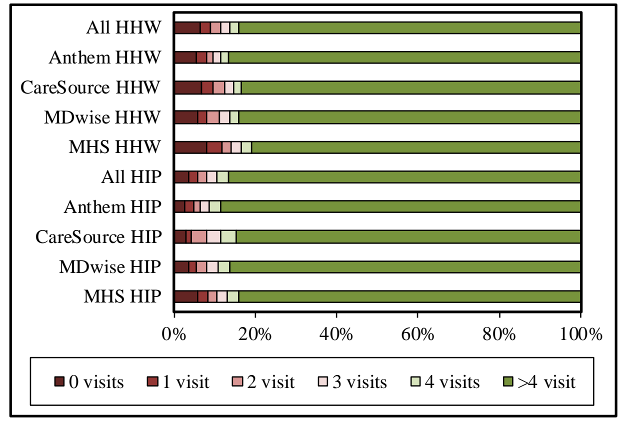
Age 36 and Above

All HHW
Anthem HHW
CareSource HHW
MDwise HHW
MHS HHW
All HIP
Anthem HIP
CareSource HIP
MDwise HIP
MHS HIP
0% 20% 40% 60% 80% 100%
0 visits 1 visit 2 visit 3 visits 4 visits >4 visit

	Number of Women (n=1,519)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
All HHW	8%	3%	2%	2%	2%	83%
Anthem HHW	4%	3%	1%	1%	2%	88%
CareSource HHW	12%	0%	1%	3%	1%	83%
MDwise HHW	4%	3%	3%	3%	3%	84%
MHS HHW	13%	5%	1%	3%	5%	72%
All HIP	3%	3%	2%	3%	3%	87%
Anthem HIP	3%	2%	2%	2%	3%	88%
CareSource HIP	5%	7%	5%	5%	3%	75%
MDwise HIP	3%	2%	2%	2%	2%	89%
MHS HIP	6%	3%	1%	4%	2%	84%

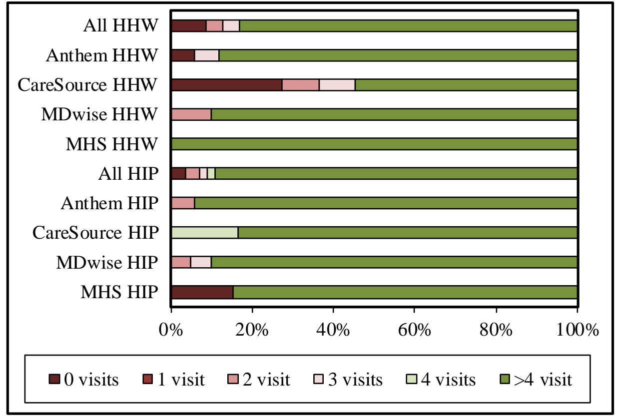
Exhibit IX.6
Number of Prenatal Visits in Last 4 Weeks Before Delivery, by Delivery DRG

Vaginal Deliveries, without complications



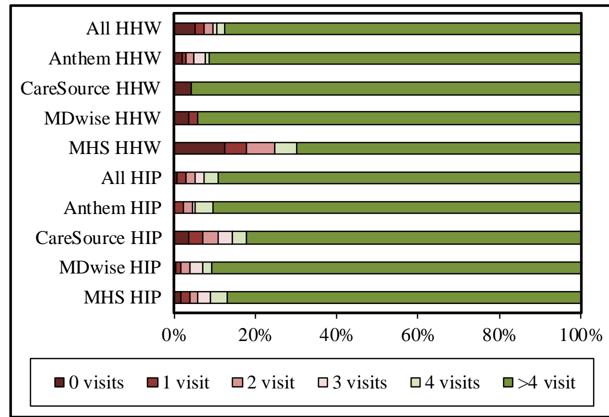
	Number of Women (n=16,760)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
All HHW	6%	3%	2%	2%	2%	84%
Anthem HHW	6%	2%	2%	2%	2%	86%
CareSource HHW	7%	3%	3%	2%	2%	84%
MDwise HHW	6%	2%	3%	3%	2%	84%
MHS HHW	8%	4%	2%	2%	3%	81%
All HIP	4%	2%	2%	2%	3%	87%
Anthem HIP	3%	2%	2%	2%	3%	89%
CareSource HIP	3%	1%	4%	4%	4%	85%
MDwise HIP	4%	2%	3%	3%	3%	86%
MHS HIP	6%	3%	2%	3%	3%	84%

Vaginal Deliveries, with complications



	Number of Women (n=103)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
All HHW	9%	0%	4%	4%	0%	83%
Anthem HHW	6%	0%	0%	6%	0%	88%
CareSource HHW	27%	0%	9%	9%	0%	55%
MDwise HHW	0%	0%	10%	0%	0%	90%
MHS HHW	0%	0%	0%	0%	0%	100%
All HIP	4%	0%	4%	2%	2%	89%
Anthem HIP	0%	0%	6%	0%	0%	94%
CareSource HIP	0%	0%	0%	0%	17%	83%
MDwise HIP	0%	0%	5%	5%	0%	90%
MHS HIP	15%	0%	0%	0%	0%	85%

Vaginal Deliveries, with sterilization



	Number of Women (n=767)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
All HHW	5%	2%	2%	1%	2%	88%
Anthem HHW	2%	1%	2%	3%	1%	91%
CareSource HHW	4%	0%	0%	0%	0%	96%
MDwise HHW	4%	2%	0%	0%	0%	94%
MHS HHW	12%	5%	7%	0%	5%	70%
All HIP	1%	2%	2%	2%	3%	89%
Anthem HIP	0%	2%	2%	1%	4%	90%
CareSource HIP	4%	4%	4%	4%	4%	82%
MDwise HIP	1%	1%	2%	3%	2%	91%
MHS HIP	2%	2%	2%	3%	4%	87%

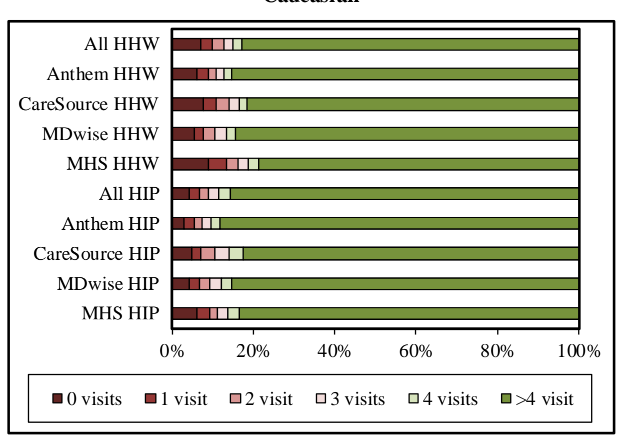
Cesarean Deliveries

All HHW
Anthem HHW
CareSource HHW
MDwise HHW
MHS HHW
All HIP
Anthem HIP
CareSource HIP
MDwise HIP
MHS HIP
0% 20% 40% 60% 80% 100%
0 visits 1 visit 2 visit 3 visits 4 visits >4 visit

	Number of Women (n=7,491)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
All HHW	5%	3%	2%	2%	3%	85%
Anthem HHW	4%	2%	2%	2%	3%	88%
CareSource HHW	6%	2%	2%	2%	2%	86%
MDwise HHW	5%	2%	2%	3%	3%	86%
MHS HHW	8%	5%	3%	2%	3%	78%
All HIP	3%	2%	2%	2%	3%	88%
Anthem HIP	2%	1%	2%	2%	2%	90%
CareSource HIP	4%	3%	3%	4%	4%	82%
MDwise HIP	3%	3%	2%	2%	3%	88%
MHS HIP	5%	2%	2%	3%	3%	86%

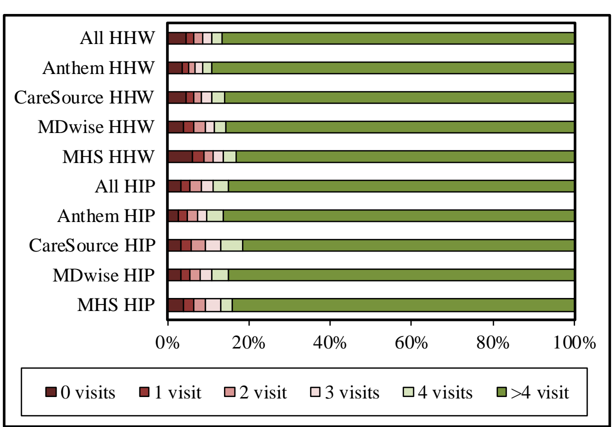
Exhibit IX.7
Number of Prenatal Visits in Last 4 Weeks Before Delivery, by Race/Ethnicity

Caucasian



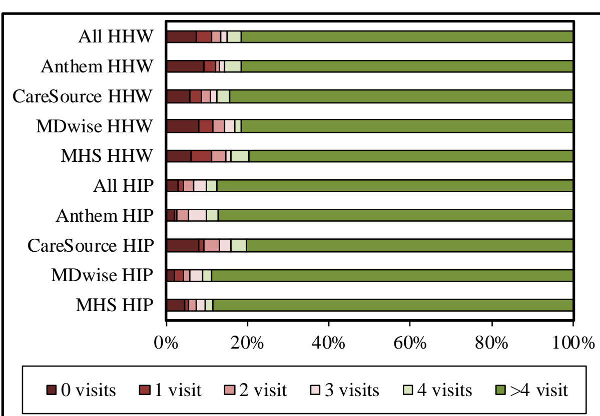
	Number of Women (n=18,695)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
All HHW	7%	3%	3%	2%	2%	83%
Anthem HHW	6%	3%	2%	2%	2%	85%
CareSource HHW	8%	3%	3%	2%	2%	82%
MDwise HHW	6%	2%	3%	3%	2%	84%
MHS HHW	9%	4%	3%	2%	3%	79%
All HIP	4%	2%	2%	3%	3%	86%
Anthem HIP	3%	2%	2%	2%	2%	88%
CareSource HIP	5%	2%	4%	3%	4%	83%
MDwise HIP	4%	2%	3%	3%	3%	85%
MHS HIP	6%	3%	2%	3%	3%	84%

African-American



	Number of Women (n=6,278)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
All HHW	4%	2%	2%	2%	3%	87%
Anthem HHW	4%	2%	2%	2%	2%	89%
CareSource HHW	5%	2%	2%	2%	3%	86%
MDwise HHW	4%	2%	3%	2%	3%	86%
MHS HHW	6%	3%	2%	2%	3%	83%
All HIP	3%	2%	3%	3%	4%	85%
Anthem HIP	3%	2%	3%	2%	4%	86%
CareSource HIP	3%	3%	4%	4%	5%	81%
MDwise HIP	3%	2%	2%	3%	4%	85%
MHS HIP	4%	2%	3%	4%	3%	84%

Hispanic



	Number of Women (n=2,177)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
All HHW	8%	4%	2%	2%	3%	82%
Anthem HHW	9%	3%	1%	1%	4%	82%
CareSource HHW	6%	3%	2%	2%	3%	84%
MDwise HHW	8%	3%	3%	2%	2%	81%
MHS HHW	6%	5%	3%	1%	5%	80%
All HIP	3%	1%	2%	3%	3%	88%
Anthem HIP	2%	1%	3%	4%	3%	87%
CareSource HIP	8%	1%	4%	3%	4%	80%
MDwise HIP	2%	2%	2%	3%	2%	89%
MHS HIP	5%	1%	2%	2%	2%	89%

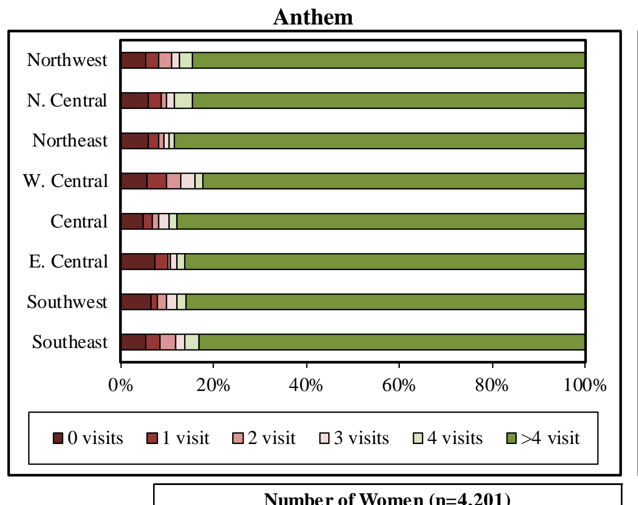
Other

All HHW
Anthem HHW
CareSource HHW
MDwise HHW
MHS HHW
All HIP
Anthem HIP
CareSource HIP
MDwise HIP
MHS HIP
0% 20% 40% 60% 80% 100%
0 visits 1 visit 2 visit 3 visits 4 visits >4 visit

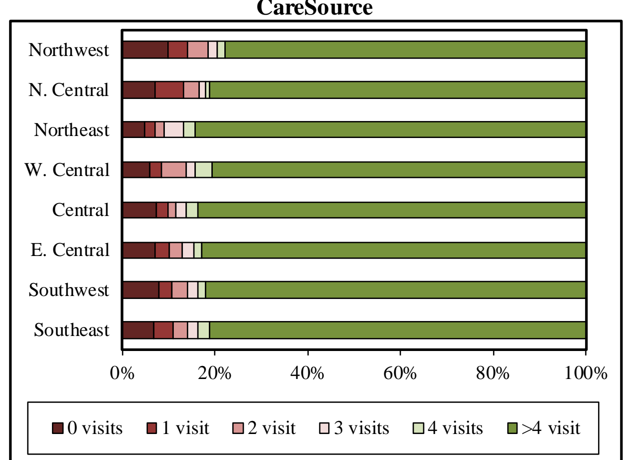
	Number of Women (n=1,072)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
All HHW	6%	2%	2%	4%	3%	82%
Anthem HHW	3%	1%	3%	3%	3%	89%
CareSource HHW	9%	2%	3%	7%	2%	76%
MDwise HHW	6%	2%	0%	2%	5%	84%
MHS HHW	12%	3%	0%	5%	8%	73%
All HIP	3%	1%	1%	2%	2%	90%
Anthem HIP	2%	1%	1%	2%	2%	93%
CareSource HIP	7%	1%	3%	4%	3%	82%
MDwise HIP	2%	3%	1%	2%	3%	89%
MHS HIP	4%	1%	1%	4%	3%	86%

Exhibit IX.8
Number of Prenatal Visits in Last 4 Weeks Before Delivery, by Region in HHW

Anthem



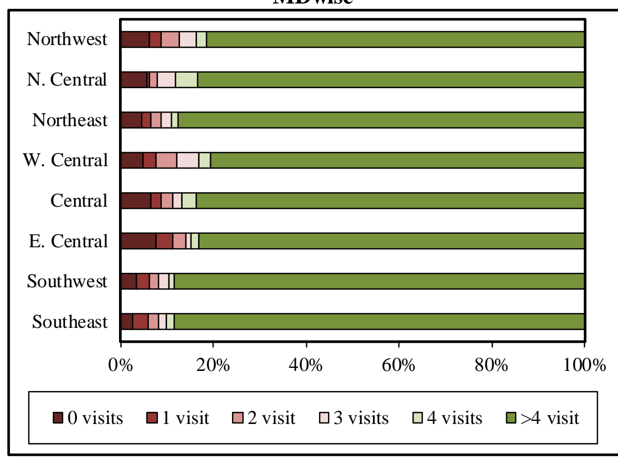
CareSource



	Number of Women (n=4,201)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
Northwest	5%	3%	3%	2%	3%	85%
N. Central	6%	3%	1%	1%	4%	85%
Northeast	6%	2%	1%	1%	1%	89%
W. Central	6%	4%	3%	3%	2%	82%
Central	5%	2%	1%	2%	2%	88%
E. Central	7%	3%	1%	1%	2%	86%
Southwest	7%	1%	2%	2%	2%	86%
Southeast	5%	3%	3%	2%	3%	83%

	Number of Women (n=3,187)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
Northwest	10%	4%	4%	2%	2%	78%
N. Central	7%	6%	3%	1%	1%	81%
Northeast	5%	2%	2%	4%	2%	84%
W. Central	6%	3%	5%	2%	4%	81%
Central	7%	2%	2%	2%	2%	84%
E. Central	7%	3%	3%	3%	2%	83%
Southwest	8%	3%	3%	2%	2%	82%
Southeast	7%	4%	3%	2%	3%	81%

MDwise

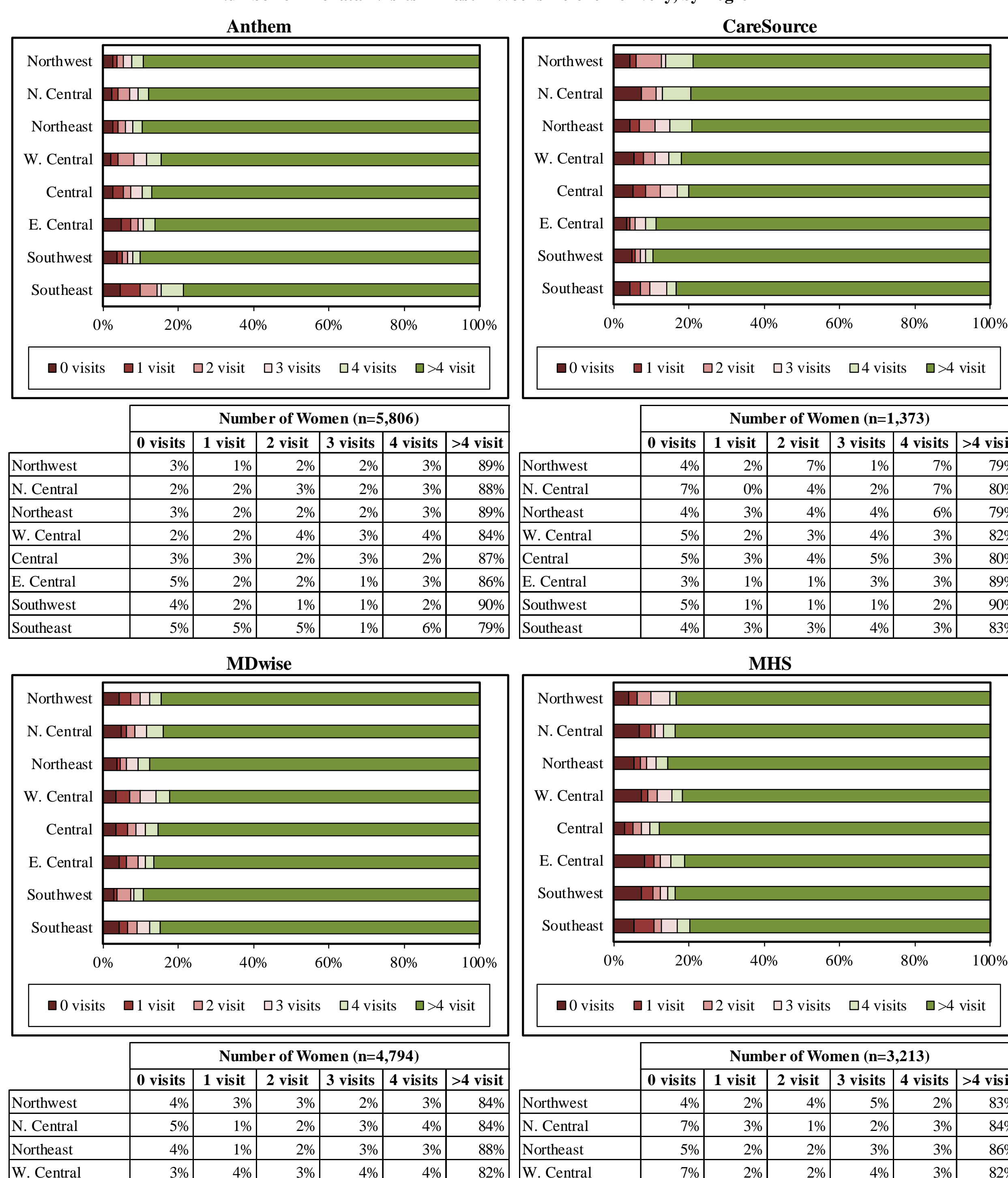


MHS

	Number of Women (n=3,143)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
Northwest	6%	3%	4%	3%	2%	82%
N. Central	6%	0%	2%	4%	5%	84%
Northeast	5%	2%	2%	2%	1%	88%
W. Central	5%	3%	5%	5%	3%	81%
Central	6%	2%	2%	2%	3%	84%
E. Central	8%	4%	3%	1%	2%	83%
Southwest	3%	3%	2%	2%	1%	88%
Southeast	3%	3%	2%	2%	1%	89%

	Number of Women (n=2,498)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
Northwest	4%	3%	0%	3%	5%	84%
N. Central	9%	5%	4%	2%	3%	78%
Northeast	10%	6%	2%	3%	5%	73%
W. Central	6%	6%	3%	2%	5%	77%
Central	7%	3%	2%	1%	2%	85%
E. Central	10%	1%	2%	2%	3%	82%
Southwest	6%	2%	2%	4%	3%	82%
Southeast	10%	6%	4%	2%	3%	75%

Exhibit IX.9
Number of Prenatal Visits in Last 4 Weeks Before Delivery, by Region in HIP



Anthem

	Number of Women (n=5,806)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
Northwest	3%	1%	2%	2%	3%	89%
N. Central	2%	2%	3%	2%	3%	88%
Northeast	3%	2%	2%	2%	3%	89%
W. Central	2%	2%	4%	3%	4%	84%
Central	3%	3%	2%	3%	2%	87%
E. Central	5%	2%	2%	1%	3%	86%
Southwest	4%	2%	1%	1%	2%	90%
Southeast	5%	5%	5%	1%	6%	79%

CareSource

	Number of Women (n=1,373)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
Northwest	4%	2%	7%	1%	7%	79%
N. Central	7%	0%	4%	2%	7%	80%
Northeast	4%	3%	4%	4%	6%	79%
W. Central	5%	2%	3%	4%	3%	82%
Central	5%	3%	4%	5%	3%	80%
E. Central	3%	1%	1%	3%	3%	89%
Southwest	5%	1%	1%	1%	2%	90%
Southeast	4%	3%	3%	4%	3%	83%

MDwise

	Number of Women (n=4,794)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
Northwest	4%	3%	3%	2%	3%	84%
N. Central	5%	1%	2%	3%	4%	84%
Northeast	4%	1%	2%	3%	3%	88%
W. Central	3%	4%	3%	4%	4%	82%
Central	3%	3%	2%	3%	3%	85%
E. Central	4%	2%	3%	2%	2%	87%
Southwest	3%	1%	3%	1%	2%	89%
Southeast	4%	2%	3%	3%	3%	85%

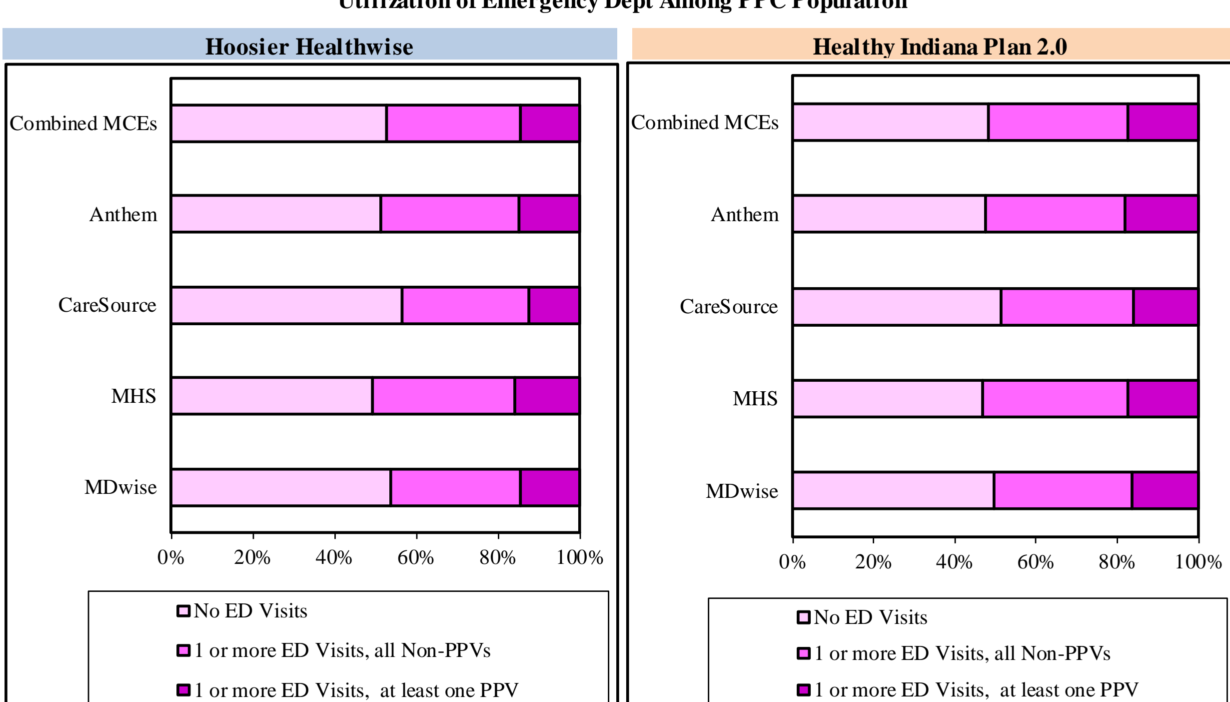
MHS

	Number of Women (n=3,213)					
	0 visits	1 visit	2 visit	3 visits	4 visits	>4 visit
Northwest	4%	2%	4%	5%	2%	83%
N. Central	7%	3%	1%	2%	3%	84%
Northeast	5%	2%	2%	3%	3%	86%
W. Central	7%	2%	2%	4%	3%	82%
Central	3%	2%	2%	2%	2%	88%
E. Central	8%	2%	2%	3%	4%	81%
Southwest	7%	3%	2%	2%	2%	84%
Southeast	5%	6%	2%	4%	3%	80%

As was done in the well visit study, B&A examined the women in the PPC population to determine the rate of ED visits that could be deemed potentially preventable or not (PPVs). Exhibit IX.10 shows these results. For the HHW cohort population, 53 percent of women had no ED visits during their enrollment period with the MCE during their pregnancy. Only 14 percent of women had an ED visit which the 3M software deemed could be a PPV. This rate was similar for all MCEs.

Among the HIP cohort population, 48 percent of women had no ED visits during the enrollment with the MCE while pregnant. Only 17 percent of women had a PPV. The findings were similar for all MCEs in this population as well.

Exhibit IX.10
Utilization of Emergency Dept Among PPC Population



Comparison to Previous EQRs

Elements of the study presented here were also conducted in the CY 2016 EQR. In CY 2016, the analysis of prenatal visits in the four weeks just prior to delivery was computed as an average visit per week. In CY 2019, it is presented as the percentage of women with four or more visits during these four weeks. In CY 2016, a review of HEDIS eligible to ED usage was not completed. With the total population almost the same between the two studies (28,802 in CY 2016 and 28,997 in CY 2019), the data source used being consistent, and the HEDIS specification remaining almost the same across the two study timeframes, trends can be examined across the two studies.

- In the CY 2016 study, the average number of weeks enrolled during the pregnancy was 24.4 weeks. This finding was similar across the MCEs. In the CY 2019 study, 91 percent of HHW women were enrolled with the MCE from week 21 of pregnancy onward. In HIP, only 78 percent of women were enrolled with the MCE from week 21 onward. Therefore, the continuous enrollment period has shrunk since the CY 2016 study.

- In the CY 2016 study, B&A found that the average number of visits in each of the four weeks prior to delivery was 1.0 across the entire study population. The rate was 0.9 visits to 1.0 visits per week across MCEs. There was also little distinction be race/ethnicity.

- In the CY 2019 study, B&A found that 86 percent of HHW women and 89 percent of HIP women had four or more prenatal visits during the last four weeks of pregnancy. African-American women have a higher rate of prenatal visits than other race/ethnicities in HHW. The findings are more similar in HIP across race/ethnicities.

Recommendations

This focus study using just claims data supports the fact that the vast majority of women are receiving the recommended number of prenatal visits, at least during the last four weeks of their pregnancy. Although there are some differences across cohort populations, with the exception of a few regions in the state, there are no notable gaps in this service delivery. ED use among pregnant women appears to usually be legitimate given the low rate of PPVs found.

The recommendations, therefore, are offered in the spirit of aiming for continuous quality improvement.

1. The MCEs appear to be effective in getting prenatal care to its pregnant members. The greatest opportunity appears to be within some regions. The MCEs are encouraged to conduct a review of missed opportunities in the PPC HEDIS measure to determine if the issue is lack of prenatal providers in certain regions of the state or some other issue.

2. With the findings from access to care in the other focus study in this year's EQR, the MCEs may want to cross-tabulate the areas where women are traveling further for prenatal care against the rate of visits in this study to determine if they are related.

3. This study suggests that when enrolled with the MCE, prenatal care is generally being delivered according to ACOG standards to pregnant members. A large percentage of women are not enrolled with the MCE for their entire pregnancy. The OMPP may want to consider changing its policy on presumptive eligibility (PE) for pregnant women. Right now, if a woman is determined to be presumptively-eligible, she is placed in fee-for-service until final eligibility is determined. The OMPP may want to consider immediate enrollment with an MCE.

SECTION X: FOCUS STUDY ON THE HEALTH NEEDS SCREENING TOOL

Introduction

The Office of Medicaid Policy and Planning (OMPP) requires that its four managed care entities (MCEs) utilize a common Health Needs Screening (HNS) tool. The MCEs are required to screen new members within 90 days of their enrollment with the MCE. The OMPP has set a target of 70 percent completion within this timeframe. Allowances are made for individuals who ultimately terminate during the first 90 days or individuals who had recently been screened by another MCE.

The completion rate for the HNS was a pay for outcomes (P4O) measure in Calendar Year (CY) 2018 in both the Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC) programs. Although HNS completion is also required in the Hoosier Healthwise (HHW) program, it was not a P4O in this program in CY 2018.

The MCEs are required to submit files to the OMPP's vendor that contain information about HNSs that are completed. The files submitted are in a format pre-established by the OMPP. In addition to enrollment-related information, the MCE submits the member responses to each of the questions on the HNS. The HNS tool used in CY 2018 by the MCEs contained 63 questions. For most questions, the allowable response is "yes", "no", "not applicable", or "refused to answer". A "not applicable" response would be used, for example, for questions on the HNS that are either gender-specific or age-specific. Some questions offer other pre-set responses. An example would be a question related to ability to complete activities of daily living (ADLs). Each ADL is asked separately under this question on the HNS. There are no open-ended or qualitative questions on the HNS.

The MCEs administer the HNS under multiple modalities. These include one-on-one phone interviews conducted by the MCE or its contractor, member self-completion of the tool online, member self-completion of the tool through kiosks located in Walmart stores throughout Indiana, and member self-completion on paper.

The OMPP's vendor intakes the files submitted by the MCEs and verifies the format and completeness of the file itself. A check is made for duplicate entries. The vendor also determines the denominator (less any exclusions) that is used to compute the MCE's completion rate within 90 days for new members. Although a review is conducted to review that the data elements on the file are filled in with valid values, there is not a specific analysis completed of the values.

The focus of Burns & Associates (B&A) in this study, therefore, is to analyze the actual responses to HNS that were completed in CY 2018. The results of this information were joined with data collected by B&A from each MCE of its members enrolled in complex case or care management in CY 2018. B&A assessed if there were connections between the responses given in the HNS and case/care management participation of new members.

Methodology

B&A was provided with the HNS files delivered to OMPP's vendor that conducts the completion analysis. B&A limited the records examined to those HNS that were completed in CY 2018. This means that it may include some members who started with an MCE in late CY 2017. It also means that some members who started with an MCE in late 2018 were not included because the 90-day time span had not yet expired when they could have been administered an HNS.

B&A used the member's Medicaid ID and the MCE's ID to identify duplicate HNS records on a file for the same person. Typically, the record that showed the most recent completion date was used. However, B&A also checked for the total number of questions completed. In some cases, multiple records for a person were submitted because the HNS was started but only half-way completed in one session with the member. A second record was submitted for the remaining questions. When this occurred, B&A retained one record; namely, the record with the most questions completed.

B&A matched the member's Medicaid ID to enrollment file provided to B&A from the OMPP's Enterprise Data Warehouse. Information such as the member's age and gender were tracked to independently validate the demographic information provided on the HNS record. B&A divided the HNS records by gender and by age groups. The age groups selected were tied to questions on the HNS tool since some questions are limited to members age 14 and over.

Exhibit X.1 shows a profile of the 102,336 unduplicated HNS records included in the study. The gender split is fairly equal in both HHW and HCC, but it is split two-thirds female and one-third male in HIP. Due to the composition within each program, most of the HNS completed in HHW are for children under age 14 (the HNS is administered to the child's parent). Under one-third of the HNS completed in HCC are in this age group. By definition of its program, all HNS completed in HIP are for adults.

Exhibit X.1
Profile of Respondents to Health Risk Screener in CY 2018 (n = 102,336)

	Hoosier Healthwise				Healthy Indiana Plan				HCC	
	Anthem	**Care Source**	**MDwise**	**MHS**	**Anthem**	**Care Source**	**MDwise**	**MHS**	**Anthem**	**MHS**
Total Respondents	**14,403**	**8,113**	**18,366**	**13,012**	**13,262**	**6,716**	**16,474**	**8,551**	**1,688**	**1,751**
Female	52%	48%	50%	52%	68%	65%	62%	61%	55%	47%
Male	48%	48%	50%	48%	32%	32%	38%	37%	45%	53%
Unknown gender	0%	4%	0%	0%	0%	3%	0%	1%	0%	0%
Age < 14	80%	86%	86%	83%					21%	34%
Age 14 and over	20%	14%	14%	17%	100%	100%	100%	100%	79%	66%
Age 4 through 20	58%	58%	49%	54%					23%	31%
All Other Ages	42%	42%	51%	46%	100%	100%	100%	100%	77%	69%

B&A selected a sample of physical health and behavioral health questions from the 63 questions to track responses by MCE and by program. Using case and care management rosters delivered by each MCE in a standardized format requested by B&A at the start of this year's EQR, B&A then cross-walked the member IDs on the CY 2018 to the case/care management rosters. Analytics were completed to assess the percentage of members who responded to select physical and behavioral health questions to their enrollment in the MCE's case or care management program in CY 2018.

Key Findings

On the next two pages, Exhibit X.2 (physical health) and Exhibit X.3 (behavioral health) display the percentage of members that answered in specific ways to a sample of the questions on the HNS. When percentages of those that responded are shown, the potential number of respondents (the denominator) is sometimes limited to who the question was asked (e.g., females only, children age 4-20 only).

B&A observed that there are some of these questions that appear to have either incomplete or incorrect data from at least some of the MCEs because a specific MCE will have results that differ significantly from its peers.

Key findings from Exhibit X.2 are shown below.

- Q51, In general, how would you say your health is?
  - In HIP, 24-25% of Anthem, CareSource and MDwise members responded "fair" or "poor". For MHS, it was 22%. Rates were higher for HCC (38% Anthem, 32% MHS). HHW was low.
- Q5, Are you currently pregnant (female members only)?
  - In HIP, the rate for female respondents range from 5.5% (CareSource) to 14.6% (MDwise and MHS). Rates for HHW and HCC members were low.
- Q17, Do you (or your child) use special equipment such as a breathing machine or oxygen?
  - Although rates were generally low, the values were 0% for MHS.
- Q26, Have you (or your child) ever been diagnosed with HIV/AIDS?
  - Low percentages were found across MCEs except CareSource which appears to have incorrect HHW data.
- Q27, Do you (or your child) have or have you had a blood disorder?
  - The most common response was "Other". It is unclear what this means without further review.
- Q31, Do you (or your child) have diabetes (Type 1 or 2)?
  - Higher percentages were found in HCC (22% Anthem, 6.5% MHS), but Anthem was also higher than other MCEs in HIP.
- Q32, Do you (or your child) have or have you had kidney disease?
  - Near 3% of all HCC respondents answered yes to this question, while closer to 1% among all HIP respondents.
- Q33, Do you (or your child) have any problems with your liver (like hepatitis or cirrhosis)?
  - Different rate of responses in HCC between Anthem (5.9%) and MHS (1.5%).
  - Anthem and CareSource also higher in HIP (3% range) than MDwise and MHS.
- Q34, Do you (or your child) have or have you had epilepsy or seizures?
  - Higher rate for HCC (Anthem at 4.0%, MHS at 5.7%) than HIP (1.1% - 1.7% range).

Key findings from Exhibit X.3 are shown below.

- Q10, Over the past two weeks, how often have you had little interest in doing things (asked only of adults and children age 14+)?
  - Higher percentages reported by Anthem and CareSource in HHW.
  - Significantly higher percentages reported by Anthem and CareSource in HIP (23-30%) which were similar to results shown in HCC population.

- Q11, Over the past two weeks, have you (or your child) felt down, depressed or hopeless?
  - "Nearly every day" reported nearly 2% of the time in HHW but near 8% in HIP (MDwise slightly lower) and near 12% in HCC (both MCEs).

- Q12, Do you have any concerns about your child they may be depressed?
  - Significant concern was cited in HHW in 9.8% - 17.0% of responses across MCEs. The rate for HCC was low.

- Q13, Do you feel safe in your home?
  - A rate of 2.3% was reported for CareSource HHW and 1.8% for MDwise HHW. The rate was near 2% for both of the MCEs in HCC as well.

- Q28, Do you (or your child) currently have or have had alcohol or drug problems?
  - The rate varied between 1.3% and 3.1% in HIP and almost same in HCC (1.6 and 1.8%).

- Q30, Do you (or your child) have or have you had a mental health condition?
  - Anthem data may be incorrect (significantly higher than other MCEs, all programs).

- Q62, Has your child (age 4-20) experienced physical or sexual abuse, neglect, or been exposed to violent behavior?
  - Near 5% of respondents reported this in HHW for three MCEs, but MHS is 0%. Anthem is at 14% in HCC, but MHS is at 0%.

- Q63, Does your child (age 4-20) exhibit unusual or uncontrollable behavior?
  - One third of all respondents in HCC answered yes for both MCEs. For HHW, the rates were from 2.7% to 6.1%.

Exhibit X.2
Profile of Responses to Selected Physical Health Questions from the Health Risk Screener

	Hoosier Healthwise				Healthy Indiana Plan				Hoosier Care Connect	
	Anthem	CareSource	MDwise	MHS	Anthem	CareSource	MDwise	MHS	Anthem	MHS
Question 51: In general, would you say your health is?										
Fair	2.0%	2.6%	1.6%	2.0%	20.6%	21.4%	18.1%	17.8%	27.5%	22.8%
Poor	0.3%	0.2%	0.2%	0.2%	5.3%	5.9%	5.9%	4.2%	10.8%	9.1%
Question 5: Are you currently pregnant (female members only)?										
Yes	5.6%	0.9%	3.6%	5.7%	9.1%	5.5%	14.6%	14.6%	1.6%	0.5%
Question 17: Do you (or your child) use special equipment, such as:										
Breathing machine/ nebulizer	3.2%	4.3%	3.3%	0.0%	1.9%	3.6%	2.2%	0.0%	5.0%	0.0%
Oxygen	0.1%	0.0%	0.1%	0.2%	0.1%	0.3%	0.1%	0.3%	0.5%	2.2%
Question 26: Have you (or your child) ever been diagnosed with HIV or AIDS? If yes, have you received treatment?										
Yes	0.0%	0.0%	0.0%	0.0%	0.4%	0.4%	0.4%	0.5%	0.5%	0.6%
Yes, refusal	0.0%	66.0%	6.1%	2.4%	0.4%	3.8%	1.6%	6.0%	0.0%	8.0%
Question 27: Do you (or your child) have or have you had a blood disorder?										
Hemophilia	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.1%	0.0%
Sickle Cell Disease	0.1%	0.1%	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.5%
Other	0.5%	0.3%	0.6%	0.0%	3.2%	1.1%	2.2%	0.0%	3.9%	0.0%
Question 31: Do you (or your child) have Diabetes (Type 1 or 2)?										
Yes	0.5%	0.3%	0.0%	0.2%	9.1%	4.8%	0.0%	5.0%	14.7%	6.5%
Type 1	0.2%	0.1%	0.1%	0.0%	0.9%	0.4%	1.0%	0.0%	1.2%	0.0%
Type 2	0.1%	0.2%	0.1%	0.0%	4.7%	2.3%	4.8%	0.0%	6.8%	0.0%
Question 32: Do you (or your child) have or have you had Kidney Disease?										
Current	0.2%	0.3%	0.2%	0.1%	1.2%	1.0%	0.8%	1.1%	3.5%	2.9%
Question 33: Do you (or your child) have any problems with your liver (like hepatitis or cirrhosis)?										
Yes	0.2%	0.3%	0.3%	0.0%	3.3%	3.0%	2.5%	1.4%	5.9%	1.5%
Question 34: Do you (or your child) have or have you had Epilepsy or Seizures?										
Current	0.5%	0.5%	0.6%	0.4%	1.1%	1.7%	1.6%	1.5%	4.0%	5.7%

Exhibit X.3
Profile of Responses to Selected Behavioral Health Questions from the Health Risk Screener

	Hoosier Healthwise				Healthy Indiana Plan				Hoosier Care Connect	
	Anthem	CareSource	MDwise	MHS	Anthem	CareSource	MDwise	MHS	Anthem	MHS
Question 10: Over the past two weeks, how often have you or your child (age 14+) had little interest or pleasure in doing things?										
Several days	4.6%	6.4%	3.7%	2.2%	21.1%	17.1%	9.3%	13.1%	22.4%	15.2%
More than half the days	2.0%	1.7%	1.1%	0.6%	8.8%	6.0%	3.3%	5.4%	13.1%	8.2%
Question 11: Over the past two weeks, how often have your or your child (age 14+) felt down, depressed, or hopeless?										
Several days	4.6%	6.4%	3.7%	2.2%	21.1%	17.1%	9.3%	13.1%	22.4%	15.2%
More than half the days	2.0%	1.7%	1.2%	0.6%	8.8%	6.0%	3.3%	5.4%	13.1%	8.2%
Nearly every day	1.8%	2.6%	1.6%	1.4%	9.5%	8.5%	6.2%	8.3%	11.5%	12.8%
Question 12: Do you have any concerns about your child (children) that they may be depressed or are showing less interest in doing things they usually do?										
Yes	10.3%	17.0%	9.8%	12.0%					2.0%	3.3%
Question 13: Do you feel safe in your home?										
No	0.1%	2.3%	1.8%	0.9%	1.0%	0.9%	0.8%	0.8%	1.9%	2.3%
Question 28: Do you (or your child) currently or have ever had alcohol or drug problems?										
Current	0.6%	3.6%	3.5%	0.3%	2.2%	2.0%	3.1%	1.3%	1.8%	1.6%
Question 30: Do you (or your child) have or have you had a Mental Health Condition?										
Current	12.1%	26.2%	9.3%	0.0%	22.0%	0.0%	9.6%	0.0%	40.6%	0.0%
Question 62: Has your child (age 4-20) experienced physical or sexual abuse, neglect, or been exposed to violent behavior?										
Yes	4.3%	4.4%	5.2%	0.0%					14.1%	0.0%
Question 63: Does your child (age 4-20) exhibit unusual or uncontrollable behavior?										
Yes	6.1%	4.2%	2.7%	5.1%					31.1%	33.3%

Exhibits X.4 and X.5 that appear on the next two pages consider the same questions and the cross-walk of HNS respondents to their enrollment in care or case management (CR/CM) with each MCE. The key findings from both exhibits are summarized together below.

- All MCEs had very few respondents in CR/CM from what might be expected for those that responded with significant physical health issues on the questions reviewed.

- That being said, each MCE's percentage of members in case/care management among these questions were usually in line with its peers with the following exceptions.
    - Anthem was higher for members in CR/CM in HCC for the question related to HIV/AIDS diagnosis. Anthem had 37.5% enrolled, the HCC average was 13.4%.
    - Anthem was higher for members in CR/CM in HCC and HHW for the question related to epilepsy or seizure.
    - CareSource was lower for members in CR/CM in HHW and HIP for the question related to diabetes (CareSource near 2% in both programs, all-MCE HHW rate was 9.9%, all-MCE HCC rate was 6.6%).
    - MDwise was higher for members in CR/CM in HHW for the question related to diabetes.
    - MDwise was lower for members in CR/CM in HIP for the question related to kidney disease). MDwise had 9.3% enrolled, the HIP average was 16.5%.
    - MHS was higher than other MCEs for members in CR/CM in HHW and HIP when members answered that their health was "fair" or "poor" on the self-assessment question.
    - MHS was higher than other MCEs for members in CR/CM in HHW and HIP for the question related to kidney disease.

- Although higher than what was found among the physical health questions, all MCEs had few respondents in CR/CM in the HHW and HIP populations from what might be expected for those that responded with significant mental health issues on the questions reviewed.

- Most MCEs were in line with each other with respect to the percentage of members identified in these questions that were enrolled in CR/CM.
    - The exception to this is CareSource. For most questions, CareSource's rate of members enrolled was even lower than its peers.

- Among the questions reviewed, both Anthem and MHS did usually have one-quarter to one-third of HCC members expected to be candidates for CR/CM enrolled.

Exhibit X.4
Assessing Case/Care Management Enrollment Based on Selected Responses to a Sample of Physical Health HNS Questions

	Percent of Respondents to Each Question Who Were Enrolled in Complex Case or Care Management at Some Point in CY2018					
	HHW		**HIP**		**HCC**	
Question on the Health Needs Screening Tool	**All MCE Average**	**MCE Range**	**All MCE Average**	**MCE Range**	**All MCE Average**	**MCE Range**
Among respondents who answered "Fair" or "Poor" to *In general, would you say your health is?*	6.0%	0.9 - 13.3%	7.0%	2.0 - 16.6%	30.9%	24.2 - 36.6%
Among female respondents who answered "Yes" to *Are you currently pregnant?*	5.7%	3.6 - 9.1%	5.8%	3.8 - 8.8%	5.6%	0.0 - 6.7%
Among respondents who indicated "Breathing machine/nebulizer" or "Oxygen" to *Do you (or your child) use special equipment, such as....*	1.4%	0.0 - 3.4%	3.9%	0.8 - 21.7%	38.6%	35.9 - 39.4%
Among respondents who answered "Yes" to *Have you (or your child) ever been diagnosed with HIV or AIDS and If yes, currently receiving treatment?*	0.4%	0.0 - 2.2%	5.4%	0.4 - 7.5%	13.4%	11.9 - 37.5%
Among respondents who answered "Hemophilia", "Sickle Cell Disease", or "Other" to *Do you (or your child) have or have you had a blood disorder?*	2.3%	0.0 - 4.2%	7.5%	2.1 - 66.7%	32.0%	0.0 - 35.3%
Among respondents who answered "Yes", "Type 1" or "Type 2" to *Do you (or your child) have Diabetes (Type 1 or 2)?*	9.9%	2.0 - 34.8%	6.6%	2.6 - 19.8%	39.1%	27.4 - 42.4%
Among respondents who answered "Current" to *Do you (or your child) have or have you had Kidney Disease?*	6.1%	0.0 - 15.8%	16.5%	1.4 - 49.5%	37.1%	32.0 - 40.7%
Among respondents who answered "Yes" to *Do you (or your child) have any problems with your liver (like hepatitis or cirrhosis)?*	3.6%	0.0 - 4.3%	9.5%	0.0 - 22.5%	32.8%	18.5 - 36.4%
Among respondents who answered "Current" to *Do you (or your child) have or have you had Epilepsy or Seizures?*	3.7%	0.0 - 7.9%	8.9%	3.4 - 17.7%	28.4%	18.2 - 42.6%

Exhibit X.5
Assessing Case/Care Management Enrollment Based on Selected Responses to a Sample of Behavioral Health HNS Questions

Question on the Health Needs Screening Tool	Percent of Respondents to Each Question Who Were Enrolled in Complex Case or Care Management at Some Point in CY2018					
	HHW		**HIP**		**HCC**	
	All MCE Average	**MCE Range**	**All MCE Average**	**MCE Range**	**All MCE Average**	**MCE Range**
Among respondents who answered "Several days" or "More than half the days" to *Over the past two weeks, how often have you or your child (age 14+) had little interest or pleasure in doing things?*	12.9%	1.1 - 59.7%	6.9%	1.7 - 17.1%	29.0%	21.0 - 33.4%
Among respondents who answered "Several days", "More than half the days" or "Nearly every day" to *Over the past two weeks, how often have your or your child (age 14+) felt down, depressed, or hopeless?*	14.2%	0.8 - 65.2%	7.3%	2.0 - 16.9%	29.6%	22.2 - 34.4%
Among respondents that answered "Yes" to *Do you have any concerns about your child (children) that they may be depressed or are showing less interest in doing things*	3.2%	0.0 - 6.0%	Question not applicable to HIP since no child members		26.6%	23.7 - 29.6%
Among respondents that answered "No" to *Do you feel safe in your home?*	0.0%	0.0%	10.3%	1.7 - 20.0%	31.0%	18.5 - 42.3%
Among respondents that answered "Current" to *Do you (or your child) currently or have ever had alcohol or drug problems?*	3.2%	0.0 - 16.7%	12.2%	4.4 - 21.1%	26.4%	15.8 - 33.3%
Among respondents that answered "Current" to *Do you (or your child) have or have you had a Mental Health Condition (like schizophrenia, depression, PTSD, Obsessive-Compulsive Disorder, an eating disorder, or bipolar disorder)?*	6.5%	0.3 - 10.5%	8.3%	7.3 - 10.2%	35.7%	only 1 MCE had responses
Among respondents that answered "Yes" to *Has he/she (child) experienced physical or sexual abuse, neglect, or been exposed to violent behavior?*	3.5%	1.0 - 5.8%	Question not applicable to HIP since no child members		24.1%	only 1 MCE had responses
Among respondents that answered "Yes" to *Does he/she (child) exhibit unusual or uncontrollable behavior?*	5.3%	0.0 - 7.6%	Question not applicable to HIP		21.8%	16.8 - 28.9%

Recommendations

As B&A was completing its CY 2019 EQR, it was learned that the OMPP was working with the MCEs to work on a "revamp" of the HNS tool. The OMPP was soliciting feedback from the MCEs on how to curtail the number of questions to those most pertinent to obtain information on initial enrollment. With this reduction in questions, the OMPP is requiring that each MCE create a roadmap to determine the next step to work with their new member if there is an affirmative response to each question on the HNS. Additional rigor related to HNS record accuracy and completeness is also underway.

Recognizing that these activities are already underway as of the writing of this report, B&A offers the following recommendations as a result of our independent study of the HNS.

Recommendations to the OMPP

1. The HNS instrument goes beyond initial screening and is more comprehensive in nature. Recognizing that the OMPP is open to changing the instrument, B&A recommends the following:
    - Significantly shortening the instrument (e.g., close to 10 questions)
    - Add filtering logic if some questions are not applicable to children
    - Require the MCEs to map out what the process flow is for members that answer positively to each question (e.g., transfer to care management for additional screening)
    - Require the MCEs to track the counts of members through each step of the process flow

2. If filtering logic is applied to a revised HNS, then the response "not applicable" should no longer be allowed.

3. If a revised HNS is cut back to a limited number of questions, then the response "member refused" should not be considered a valid response when defining a completed HNS.

4. The OMPP should require the MCEs to conduct more rigor on the actual responses stored in each assessment record. This should be easier if the size of the tool is reduced.

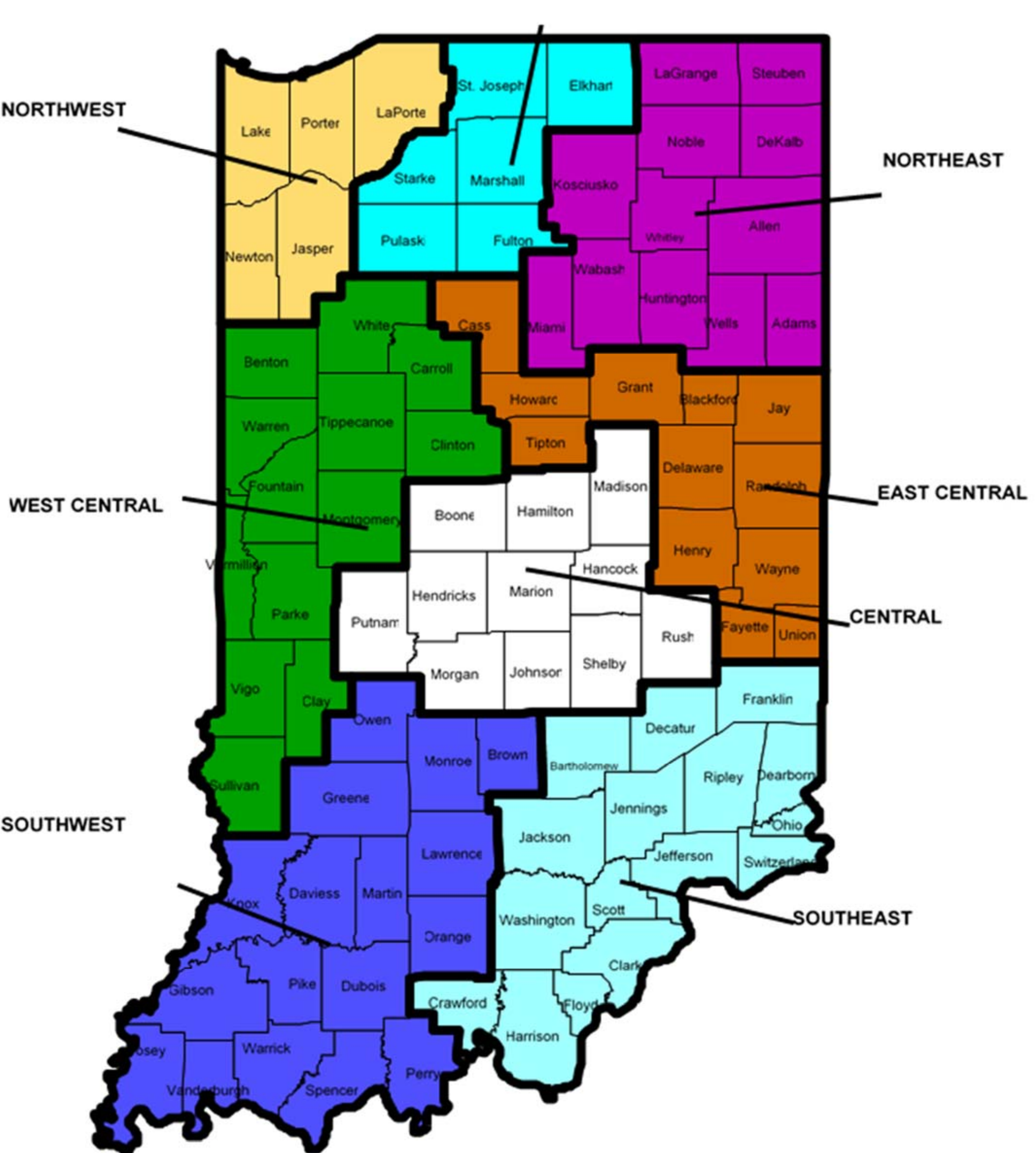
5. The OMPP should more closely tie its case/care management reporting to the HNS reporting in a manner similar to what was reported in this study so that the OMPP can better assess the utility of the HNS itself.

Recommendations to the MCEs

1. B&A found challenges with the completeness and integrity of the responses to HNS questions. There appears to be significant opportunity by all MCEs to validate the responses within each question.

2. The results of the assessments appear to be little utilized by the MCEs with respect to CR/CM activities. Although not every question on the instrument would yield potential eligibility for case or care management, many questions would, particularly if these are responses from new members for which there is no historic claims utilization. The MCEs should crosswalk responses to selected questions to map when/if members should be considered for CR/CM. It is recognized that not every member who responds affirmatively to certain questions will ultimately be enrolled in CR/CM, but a process should be designed to document why the member ultimately does not need CR/CM (or they refused).

Appendix A
Map of Indiana's 92 Counties to Eight Regions



APPENDIX B

2019 EXTERNAL QUALITY REVIEW GUIDE FOR THE HOOSIER HEALTHWISE, HOOSIER CARE CONNECT AND HEALTHY INDIANA PLAN 2.0 PROGRAMS
(Review of CY 2018 Operations)

TABLE OF CONTENTS

Section A: Summary of This Year's Topics, Timeline and Review Team 1

Section B: Details on Topics in this Year's EQR 3

Section C: Detailed Schedule of Meetings.. 10

Section D: Information Requests Related to the EQR 11

Separate Excel File:

Tab 1 Meeting Schedule Preferences form for the Onsite Meetings
Tab 2 Template for Contracted Provider Attributes
Tab 3 Template for Roster of Members in Complex Case/Care Management in CY2018

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 2019 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:

1. Focus Study on Provider Retention and Network Adequacy
2. Focus Study on Potentially Preventable Emergency Department Visits (PPVs)
3. Focus Study on Preventive Care Visits for Adults and Well Child Visits for Children
4. Focus Study on Prenatal Care Visits
5. Examination of the Return on Investment of the Health Needs Screening Tool
6. Redesign of the MCE Reporting Manual
7. Validation of MCE Quality Improvement Projects

This review will encompass activities in Calendar Year (CY) 2018 for all activities. The redesign of the MCE Reporting Manual is an ongoing real-time activity and will be in lieu of the validation of specific performance measures. All topics will be reviewed for the HHW, HCC and HIP populations with the exception of the focus study on prenatal care visits which will be exclusive to HIP.

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. As you are aware, the redesign of the MCE Reporting Manual has been an ongoing activity and will continue throughout this year's EQR. For the other tasks, the schedule effectively begins with the release of this EQR Guide.

The first items that are being requested from the MCEs are **due June 14**. Onsite meetings are scheduled in the months of July and August. Webinars related to findings from data analytics from the multiple focus studies are scheduled for July and August as well. All data collection activities and MCE responsibilities are scheduled to be concluded by August 31. 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. A full schedule may be found in Section C of this Guide.

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, but will most likely occur at the end of October. 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 13 EQRs of the HHW program, ten EQRs of the HIP and three 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.

- *Dr. Linda Gunn*, Subcontractor: Linda has assisted B&A on ten 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 network adequacy study.

- *Kristy Lawrance*, Subcontractor: Kristy assisted on six previous EQRs encompassing all three of OMPP's programs. In this EQR, she will work on the validation of QIPs and participate in onsite interviews related to other focus studies.

- *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. In this EQR, he will serve as the lead programmer for the studies of network adequacy, adult and child preventive visits, and prenatal visits.

- *Akhilesh Pasupulati*, SAS Programmer, B&A: Akhilesh has worked on the most recent two EQRs with a specific focus on medication adherence and pharmacy utilization. In this year's EQR, he will serve as the lead programmer for studies of potentially preventable ED visits and the return on investment of the HNS.

- *Barry Smith*, Data Analyst, B&A: Barry has over 13 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. In this EQR, he will primarily work on activities related to the network adequacy study and the redesign of the reporting manual.

B. Details on Topics in this Year's EQR

Topic #1—Focus Study on Provider Retention and Network Adequacy

This focus study is intended to be multi-faceted to review multiple items:

- To assess if the enhanced provider reimbursement in the HIP program has assisted in growing the provider network in the program and/or to retain providers already contracted in the MCE's network for HIP;
- To assess if the MCEs are meeting the contractual requirements related to network adequacy for selected specialties; and
- To assess the accuracy of the information displayed in MCE provider directories.

For the first item, B&A will be requesting a file from each MCE that contains information on all contracted providers that are listed in its online provider directory. Specifically, we will track provider rosters as of the end of each calendar year in 2016, 2017 and 2018. B&A will assess, by MCE/program, over the multi-year period the number of providers that were successfully recruited (added), the number that departed the program, and the overall net impact on access. This will be done at the provider specialty level.

Additionally, B&A will use each MCE's provider directory database file to summarize provider information by:

- Program (HHW, HIP, HCC)
- Specialty (e.g., primary care, radiology, cardiology)
- County

For the second item, B&A will use encounter data for services rendered in CY 2018 to match member trips to providers and compute an average driving distance. This information will be available at a granular level (that is, by MCE/program/provider specialty/county) and also at a macro level (that is, a dashboard that shows potential areas of access issues by specialty within each OMPP program).

For the third item, B&A will use the provider directory database file submitted by the MCE to draw a representative sample of providers from each program, ensuring that some providers are included that serve more than one program. With this sample, we will conduct calls to provider offices to ensure the accuracy of the information given to us (and to members). The information that we intend to verify with the provider from the data that we are given will include:

- Office phone number (as evident if we reach the office)
- Office address
- Provider specialty
- If the provider accepts members in the program (HHW, HIP, and/or HCC depending on the information given to us by the MCE)
- If the provider is accepting new members in the program(s)

B&A will also verify information across MCEs for providers that are enrolled with multiple MCEs to ensure consistency in the source data.

Our results will be tabulated in a Microsoft Access database. The results will be summarized and shared with each MCE and with the OMPP.

The specific tasks anticipated in this study include the following:

For first item in review:

1. Tabulate data from the EDW Provider files provided to B&A to track the count of rendering providers by specialty category that were enrolled in IHCP as of December 31, 2016, 2017 and 2018.
2. From the results in Step 1, cross-reference this list to the provider directory database file submitted by each MCE to B&A for this review.
3. Track at the individual specialty level the net change in the count of providers, by MCE and by program, from 12/31/16 to 12/31/17. Repeat this to assess net change from 12/31/17 to 12/31/18.
4. Build summary tables to show provider recruitment and departures at the specialty level for each program and specifically for each MCE. Determine if there is any pattern at the program level, the MCE level, or the regional level.
5. Assess individual provider participation across MCEs and across OMPP programs. The IHCP provider ID will be used to cross-reference.
6. Build a dashboard to display member-to-provider ratios for individual specialties. For primary care and dental, this will be calculated at the regional level. For other specialties, this may be computed at the statewide or regional level.

For second item in review:

7. Compute the average driving distance travelled for members in each county to the provider that they actually received care from (as opposed to the closest provider).
8. Determine the average driving distance by county and flag those counties that do not meet the access distance target for the specialty.
9. Create a dashboard that assesses the number of counties for specialty/program/MCE in which the standard is met. Information will be available at the individual county level, but a tolerance level will be built. From the data computed, if more than 90% of members live in areas where the average distance travelled was below the OMPP target for the given specialty, then the finding will be that the MCE met the target.
10. For a sample of counties that did not meet the OMPP target, determine if the distance travelled may have been necessity (no other provider in region) or choice (member wanted to travel to a specialist in Indianapolis). B&A will look to see if other contracted specialists in the same category are closer to the member than the specialist that the member chose.

For third item in review:

11. Build a sample of providers from each MCE's provider directory for phone audits. The sample will ensure that each program and region in the state is represented. The sample will be heavily weighted for primary medical and dental providers.
12. Conduct the phone audit of each provider office to assess the accuracy of the data published in the MCE's online directory.

Other than the submission of the provider directory files to B&A, it is anticipated that this focus study will be conducted as a desk review only with no onsite interviews at the MCE. There will be a webinar scheduled, however, with each MCE to serve as a touch-point to share preliminary findings.

Topic #2—Focus Study on Potentially Preventable Emergency Department Visits (PPVs)

A focus study on PPV rates was completed in the CY 2015 EQR. The data examined was CY 2014 visits in HHW and HIP. B&A will re-run this analysis in the CY 2019 EQR. This time, the PPV rates will be examined for all three OMPP programs and will be conducted on CY 2016, CY 2017 and CY 2018 data. For the CY 2018 utilization in particular, the results will be risk-adjusted by MCE and program using 3M's clinical risk groups (CRGs). The specific tasks anticipated in this study are similar to what was conducted in CY 2015 and include the following:

1. Run data from the EDW in 3M's PPV grouper and tabulate PPV rates by MCE, by age group, by region, by EAPG (enhanced ambulatory patient group) and by hospital.
2. B&A will assign each member with an ED visit in CY 2018 into one of 3M's CRGs. There are over 1,000 CRG categories established by 3M, but these can be rolled up into 38 aggregated CRGs (ACRGs). B&A will risk adjust the PPV results using the 38 ACRGs. B&A will compute PPV rates for each ACRG.
3. The MCE's PPV rates and each hospital's PPV rate is risk-adjusted using the CRG assignment for each member.
4. An actual-to-expected ratio is computed for each MCE and each hospital that assesses the entity's actual PPV rate to its risk-adjusted rate.
5. The PPVs will be quantified based on payment to assess the cost to the State of the PPVs as each MCE.
6. B&A will also examine utilization of urgent care centers for members at each MCE/program. The PPV rates and the urgent care utilization will be joined to determine if there are trends in PPV rates that may be explained by urgent care centers (that is, are PPV rates lower in areas where the MCE has contracted with an urgent care center).
7. Overall trends in the proportion of ED visits and urgent care visits will also be reported by MCE, by program and by age group.

This focus study will be conducted as a desk review only with no onsite interviews at the MCE. There will be a webinar scheduled, however, with each MCE to serve as a touch-point to share preliminary findings.

Topic #3—Focus Study on Preventive Care Visits for Adults and Well Child Visits for Children

B&A completed a focus study in the CY 2016 EQR on well child and adolescent well visits and this study will be repeated in the CY 2019 EQR. In this year's study, adults will also be included. The populations of greatest interest will be those members who meet the criteria for the HEDIS measures W15, W34, AWC and AAP. In addition to what was completed in the CY 2016 EQR, B&A will also layer in information that relates to other studies in this year's EQR pertaining to PPVs and HNS completion.

The results tabulated in this year's study can be compared to what was found in the CY 2016 study (lookback period of CY 2015). In the prior study, children in HHW and HCC were examined as well as 19- and 20-year-olds in HIP. In this year's study, the same populations will be included as well as adults in HCC and HIP. The adults will be further segmented into age groups such as 19-29, 30-39 and 40 and over.

Data will be collected from encounters in the EDW, the HNS results and HEDIS Auditor compilations of each MCE's results on the measures mentioned above. The specific areas of focus proposed by B&A are as follows:

1. Track results of the audited HEDIS W15, W34, AWC and AAP measures for each MCE over the last five years.
2. Determine the place of service for well care visits—office-based, clinic-based, or hospital-based. Does this vary by MCE and/or region in the state?
3. Assess if there are other visits members are receiving (other than the ED, referenced below) that are not tagged as well care visits. In other words, identify missed opportunities to improve the HEDIS rates for each MCE and cohort age group.
4. Review well care visit compliance based on MCE and by
    a. Age of the member (for AWC and AAP)
    b. Race/ethnicity of the member
    c. Region of the state
    d. Presence of a behavioral health comorbidity
    e. Presence of a substance abuse comorbidity
5. Compare PPV rates for each age cohort and MCE against well care visits. Are some members not numerator-compliant for well care visits but have PPVs? Do some members have both? Do members who are numerator-compliant less likely to have PPVs?

Most of this focus study will be conducted as a desk review only. There will be one onsite interview conducted with each MCE on this topic the week of July 8. The purpose of this interview will be to learn about any strategies or techniques that the MCE utilizes to improve the rate of access to primary care for children and adults. The interview will cover strategies employed in all three OMPP programs (HHW, HIP and HCC). Separate from this onsite interview, there will be a webinar scheduled with each MCE to serve as a touch-point to share preliminary findings from the desk review.

Topic #4—Focus Study on Prenatal Care Visits

B&A completed a focus study in the CY 2016 EQR on prenatal visits and recommends repeating the components of that study again with additional information layered in that relates to other studies in this year's EQR pertaining to PPVs and HNS completion.

The results tabulated in this year's study can be compared to what was found in the CY 2016 study (lookback period of CY 2015). In the prior study, women in HHW and HCC were examined. In this year's study, women in HIP will be examined (it was found that the sample size of pregnant women in HCC was small in the last study).

Data will be collected from encounters in the EDW, the HNS results and HEDIS Auditor compilations of each MCE's results on the PPC measure. The specific areas of focus proposed by B&A are as follows:

1. Track results of the audited HEDIS PPC measure for each MCE over the last five years (will consider HHW during the earlier time period since this is where the mothers were enrolled previously).
2. Track the timeliness and cadence of prenatal visits of women to measure the percent of women compliant with ACOG-recommended visits based on trimester in the pregnancy. Women will be segmented into groups based on their enrollment with the MCE since it is known that not all pregnant women are enrolled with the MCE for the full term.
3. Determine the place of service for prenatal care visits—office-based, clinic-based, or hospital-based.
4. Assess if there are other medical encounters during the pregnancy that are not tagged as prenatal visits.
5. Review prenatal compliance based on MCE and by
    a. Number of weeks enrolled with the MCE during the pregnancy

   b. Age of the mother
   c. Race/ethnicity of the mother
   d. Vaginal and Cesarean deliveries
   e. Outcome of child's birth (well baby or complications)
   f. Region of the state
   g. Presence of a behavioral health comorbidity
   h. Presence of a substance abuse comorbidity
6. B&A will profile the women receiving Cesarean deliveries to determine if there is a pattern on who uses this method (e.g. higher volume in certain age groups, physicians, etc.).
7. B&A will request information from the MCEs on the women who were pregnant during the study period who were enrolled in complex case or care management. In addition to reporting the actual percentage of pregnant women enrolled, B&A will look for trends or missed opportunities related to prenatal care for those women not enrolled in case or care management.
8. B&A will cross-tabulate the PPVs found for women during their pregnancy to see if there is any association between PPVs and lack of prenatal care visits in an office or clinic setting.

Most of this focus study will be conducted as a desk review only. There will be one onsite interview conducted with each MCE on this topic the week of July 8. The purpose of this interview will be to learn about any strategies or techniques that the MCE utilizes to improve the rate of access to prenatal care. Separate from this onsite interview, there will be a webinar scheduled with each MCE to serve as a touch-point to share preliminary findings from the desk review.

Topic #5—Examination of the Return on Investment of the Health Needs Screening (HNS) Tool

The purpose of this study is to determine if the HNS is appropriate for every new member enrolled in HHW, HIP and HCC or if there are other means to receive timely information on a new member's health care needs. Further, even if an HNS is completed, other outcome data will be analyzed to determine if the MCEs are using the information obtained from the HNS in their engagement with the member.

B&A will request the files that the MCEs deliver to Optum related to the HNS for the CY 2018 time period. From here, we will isolate the new members who received an HNS and those that did not. B&A will also validate the turnaround time for those members that received an HNS. Specific analyses proposed in this study are as follows:

1. Assess the rate of HNS completion by program, by MCE, by age group, by race/ethnicity and by region.
2. Assess the mode in which HNSs are completed by program, by MCE and by region.
3. Contrast the members within each MCE/program who completed a timely HNS and those that did not. For each cohort, compare the results of key health outcome measures such as:
   a. PPV rate
   b. PPR rate
   c. Well care rates (W15, W34, AWC, AAP)
   d. Comprehensive diabetes care
   e. Medication management for people with asthma
   f. FUH 7-day and 30-day
   g. Utilization of SUD services
4. Follow a sample of individuals for a 12-month period after their initial enrollment with the MCE. Track health care expenditures for each individual. Is there any pattern found whereby those with a completed HNS are less expensive, more expensive or about the same as those without a completed HNS? This will be further segmented by age group since the results may vary based on age group.

5. B&A will cross-tabulate those that received an HNS with those enrolled in complex case or care management. For those with a completed HNS, what percentage get identified for case or care management? What are the likely trigger responses on the HNS that are most prevalent for identification? How many members with these triggers are not nominated for case or care management? What percentage of members are enrolled in case or care management that did not have an HNS completed until they were enrolled in case or care management?

Most of this focus study will be conducted as a desk review only. There will be one onsite interview conducted with each MCE on this topic the week of July 8. The purpose of this interview will be to learn about any strategies or techniques that the MCE utilizes to improve the rate of HNS completions. Separate from this onsite interview, there will be a webinar scheduled with each MCE to serve as a touch-point to share preliminary findings from the desk review.

Topic #6—Redesign of the MCE Reporting Manual

As you are aware, most of the work on the redesign of the MCE Reporting Manual has been completed in the January – April 2019 time period through the five meetings scheduled with all MCEs and the OMPP on specific changes to the Manual. The updated report templates and instructions were released on April 19.

For the internal OMPP team, B&A is building templates so that the information reported by the MCEs in each report template can be seamlessly integrated into trend reports for ongoing monitoring and management reporting. B&A is also building procedures for the intake and response back to MCEs on the reports submitted, including version control.

Upon submission of the first set of reports using the new templates on May 31, 2019, B&A will work closely with the OMPP team to validate the results. There will be a review to determine if, after the first set of submissions by the MCEs, there are areas where the reporting manual table shells or instructions can be improved.

Specific feedback will be given to each MCE independently on areas of potential improvement based on the May 31 submissions. A follow-up meeting will be scheduled with the OMPP, all MCEs and B&A to discuss the findings from the first round of submission on a broader scale with the opportunity to suggest areas for continued quality improvement of the data submitted.

Topic #7—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.

This is a required component of each annual EQR. In past years, B&A has conducted a desk review of each MCE's QIPs and then conducted onsite interviews with each MCE about the results reported in their annual QIP submissions.

In this year's EQR, B&A proposes to add an additional level of rigor to the review by requesting additional information that is not reported in the annual QIP but supports the information reported. Specifically, we will request analytic files that each MCE tabulated to assess the effectiveness of

interventions. We will also track the method in which this data is collected to assess the integrity and completeness of the data used to assess each intervention.

As in prior years, Mark Podrazik and Kristy Lawrance will be conducting this part of the review. Data that each MCE used to capture the results of what they reported in the QIP Reporting template will be submitted in an ad hoc format based on how the MCE synthesized their results. In other words, no standardized reporting template is being released for the QIP validations. The actual QIP annual reports will be submitted to B&A simultaneous to when they are submitted to the OMPP by **August 1**. The data that was used in support of QIP findings will be submitted by each MCE to B&A by **August 8**. Onsite meetings will be held at with each MCE the week of **August 26** to go over the QIPs under review. This will include a walk-through of the data files used in support of each QIP report, follow-up questions from our desk review, and 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.

C. Detailed Schedule of Meetings

The table below presents all onsite meetings and webinars scheduled for this year's EQR. 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.

Please submit the Meeting Schedule Preferences tab in the accompanying file directly to Mark Podrazik no later than **Thursday May 9** at mpodrazik@burnshealthpolicy.com. Specific dates/times for meetings set and the final schedule will be released to the MCEs by **Thursday May 23**.

Unless specifically requested in advance, MCE staff do not need to bring any materials to the onsite interview sessions or the webinars. For the onsite interviews, a semi-structured process will take place. The questions that the B&A team intends to ask will be sent out in advance of the meeting so that the MCE can ensure that the appropriate team members can attend the meeting.

This year, B&A is asking for written responses to each interview session in advance of the meeting so that the onsite time can be most efficiently used. During the onsite, additional follow-up questions may be asked by the B&A team to elaborate on the written responses provided.

Please note that all onsite interviews will cover all OMPP programs—HHW, HIP and HCC.

Type of Meeting	Date	Time	Topic
Webinar hosted by B&A	July 9	10:00 – 12:30 1:30 – 4:00	The B&A team will share initial findings on: ▪ PPVs ▪ Network access reports
	July 10	10:00 – 12:30 1:30 – 4:00	
Onsite at MCE	July 16	9:00 – 12:00 1:00 – 4:00	Interviews covering three topics: ▪ Initiatives to encourage member well visits ▪ Initiatives to encourage member prenatal visits ▪ Initiatives to encourage new member HNS completion and internal processes to conduct HNS (Topics 1 and 2 approx 45 min. each. Topic 3 approx. 75 min.)
	July 17	9:00 – 12:00 1:00 – 4:00	
Onsite at OMPP	TBD		Debriefing on May 31 MCE first submissions under the new Reporting Manual structure
Webinar hosted by B&A	July 30	10:00 – 12:30 1:30 – 4:00	The B&A team will share initial findings on: ▪ Well visits ▪ Prenatal visits ▪ HNS study
	July 31	10:00 – 12:30 1:30 – 4:00	
Onsite at MCE	Aug 27	9:00 – 12:00 1:00 – 4:00	Onsite review of each MCE's QIPs
	Aug 28	9:00 – 12:00 1:00 – 4:00	

D. Information Requests Related to the EQR

The table below 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\2019\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.

Please contact Mark Podrazik directly at 703-785-2371 or by email if you have specific questions about the report templates that accompany this EQR Guide.

Information Due for Submission Directly to Mark Podrazik via email by **May 9**:

- Meeting preference form

Information Due for Submission to Sharepoint by **June 14**:

- Template for Contracted Provider Attributes
- Template for Roster of Members in Complex Case/Care Management in CY2018
- Where you have identified items relevant to the topic, please provide:
    - Any policy or procedure which you believe is specifically relevant to the engagement of providers and/or members for the timeliness of prenatal care.
    - Any communication or guidance materials that you may give providers relevant to the timeliness of prenatal care. If timeliness of prenatal care is an element of a larger provider report or dashboard that you give to providers, please submit an example of how this is shown on the provider report.
    - Any communication or guidance materials that you may give members relevant to the timeliness of prenatal care, including any member incentives.
- Where you have identified items relevant to the topic, please provide:
    - Any policy or procedure which you believe is specifically relevant to the engagement of providers and/or members for obtaining preventive care services for children or adults.
    - Any communication or guidance materials that you may give providers relevant to the preventive care services to children or adults. If preventive services are elements of a larger provider report or dashboard that you give to providers, please submit an example of how this is shown on the provider report.
    - Any communication or guidance materials that you may give members/parents relevant to obtaining preventive care services for children or adults, including any member incentives.

Information Due for Submission Directly to Mark Podrazik via email by **June 28**:

- Responses to Interview Questions for Onsites

Information Due for Submission Directly to Mark Podrazik via email by **August 1**:

- Annual QIP Reports

Information Due for Submission to Sharepoint by **August 8**:

- Supporting files related to each QIP regarding analytics related to measure results and interventions results

MCE Name:

Providers Under Contract with the MCE During CYs 2016, 2017 and 2018

Notes:

1. Please provide the names of each provider your MCE contracted with that has an IHCP Provider ID.
2. Individual providers can be shown on more than one line in this report if:
   The provider started contracting with one OMPP program earlier or later than they started in a different program.
   The provider termed from one OMPP program but is still contracted under other programs.
3. For Column K, it is expected that some Date Contract Began dates will be prior to 1/1/16.
4. For Column L, it is expected that most providers were still under contract as of 12/31/18.
   If the provider was under contract after 12/31/18, type "Still Under Contract" in Column L.
   This includes any provider that may have termed already in 2019 but was active on 1/1/19.

IHCP Provider ID (not MCE's unique ID)	Tax ID	NPI	Enter H if Hospital, G if Group other than Hospital, I if Individual Provider	Individual Provider's Last Name (leave blank if a provider group)	Individual Provider's First Name (leave blank if a provider group)	Hospital Name, Facility Name or Group Practice Name (leave blank if an individual provider)	Check X if Contracted Under HHW	Check X if Contracted Under HIP

Check X if Contracted Under HCC	Date Contract Began mm/dd/yy	Date Contract Ended mm/dd/yy	Specialty as Assigned by the MCE	Street Address Location of Provider	City Location of Provider	State Location of Provider	Zip Code Location of Provider	County Location of Provider	Phone Number Location of Provider	Accepting New Patients? Type Y or N	Any Language in Addition to English? Type Y or N

MCE Name:

Active Enrollees in Complex Case or Care Management During CY 2018

Notes:

1. Please provide the names of each individual you counted in the QR-C3MR under 'Active Ever Enrolled' in the reports you submitted to OMPP on

April 30, 2018	July 31, 2018
Oct 31, 2018	Jan 31, 2019

2. Individual members can be shown on more than one line in this report if:
   - The member moved up from care management to complex case management and you track the duration of these events separately.
   - The member moved down to care management from complex case management and you track the duration of these events separately.
   - There was a gap during CY 2018 when the member was in case or care management, disenrolled, then re-enrolled later in the year.
3. For Column F, it is expected that some Date Began Enrollment dates will be in CY 2017.
4. For Column G, it is expected that some Date Disenrolled dates will be in CY 2019. If the member is still enrolled as of 4/30/19, enter "Still Enrolled".

CR = care mgmt
CM = complex case mgmt

							Place an X in every column th			
Medicaid RID (not MCE's unique ID)	Member Last Name	Member First Name	Program (enter HHW, HIP or HCC)	Participation Level (enter CR or CM)	Date Began Enrollment mm/dd/yy	Date Disenrolled mm/dd/yy	Pregnancy	Asthma	Diabetes	COPD

hat is applicable to the member for the condition(s) of interest that pertain to why the member is in Case or Care Management.											
Coronary Artery Disease	Congestive Heart Failure	Chronic Kidney Disease	Right Choices Program	MCE-specific Acute Care Condition(s)	Depression	ADHD	Autism/ Pervasive DD	Inpatient Discharges from Psychiatric Hospital	Bipolar Disorder	SUD	MCE-specific BH Condition(s)