

2023 Annual

EQR Technical Report

Indiana Family and Social Services (FSSA)

Office of Medicaid Policy and Planning (OMPP)

Final



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AAP Adults' Access to Preventative/Ambulatory Health Services
 ACA Affordable Care Act
 ACO Accountable Care Organization
 ADT Admissions, Discharge, and Transfer
 ANA Annual Network Adequacy
 Anthem Blue Cross Blue Shield Anthem, Managed Care Entity
 AOD Alcohol and Other Drug Abuse/Dependence
 AON Area of Noncompliance
 ArcGIS™ a trademark of Environmental Systems
 Research Institute, Inc.
 CareSource CareSource Indiana, Managed Care Entity
 CBO Community-Based Organization
 CCTP Community-Based Care Transitions Program
 CDC Centers for Disease Control and Prevention
 CDJ Cash Disbursement Journal
 CET Care Engagement Team
 CFR Code of Federal Regulations
 CHIP Children's Health Insurance Program
 CHW Community Health Worker
 CIS Childhood Immunization Status
 CM Care-Case Management / Manager
 CMS Centers for Medicare & Medicaid Services
 COS Categories of Service
 CPT Current Procedural Terminology
 CY Calendar Year
 ED Emergency Department
 EMS Emergency Medical Services

EQR External Quality Review
 EQRO External Quality Review Organization
 ER Emergency Room
 FAC Fiscal Agent Contractor
 FFS Fee for Service
 FORHP Federal Office of Rural Health Policy
 FSSA Indiana Family and Social Services Administration
 FUA Follow-up After Emergency Department Visit for
 Drug Abuse or Dependence
 HCBS Home- and Community-Based Services
 HCC Hoosier Care Connect
 HEDIS® Healthcare Effectiveness Data and Information Set,
 a registered trademark of the NCQA
 HHW Hoosier Healthwise
 HIP Healthy Indiana Plan
 HME/DME Home and Durable Medical Equipment
 HNS Health Needs Screening
 HRSN Health-Related Social Needs
 ICD-10 International Classification of Diseases
 ICF/IDD Intermediate Care Facility for Individuals
 with Intellectual Disabilities
 ICN Internal Control Number
 ID Identification
 IDOH Indiana Department of Health
 IHCP Indiana Health Coverage Programs
 IHIE Indiana Health Information Exchange
 IOP Intensive Outpatient
 IS Information System(s)

¹ Other company and product names may be trademarks of the respective companies with which they are associated. The mention of such companies and product names is with due recognition and without intent to misappropriate such names or marks.

Acknowledgements, Acronyms, and Initialisms

ISCA/ISCAT Information Systems Capability Assessment Tool
 LAMA..... Left Against Medical Advice
 LOS Length of Stay
 LTAC Long-Term Acute Care
 MCE Managed Care Entity
 MCP Managed Care Plan
 MDwise..... Managed Care Entity
 MHS Managed Health Services, Managed Care Entity
 MMIS Medicaid Management Information System
 MSLC Myers & Stauffer Limited Liability Company
 MSR Minimum Submission Review
 MY Measurement Year
 N No/Number
 N/A Not Applicable
 NCQA National Committee for Quality Assurance
 NCQA HEDIS Compliance Audit™ a trademark of NCQA
 NICU..... Neonatal Intensive Care Unit
 NP Nurse Practitioner
 NPI National Provider Identifier
 OB/GYN Obstetrician/Gynecologist
 OMPP..... Office of Medicaid Policy and Planning
 PA..... Physician’s Assistant
 P&P Policy and Procedure
 PCP Primary Care Provider/Physician

PDF Portable Document Format
 PDSA..... Plan-Do-Study-Act
 PEPY Per Enrollee Per Year
 PHP Partial Hospitalization
 PMP..... Primary Medical Provider
 PMV..... Performance Measure Validation
 PPC Postpartum Timeliness
 PRS Peer Recovery Specialist
 PRTF Psychiatric Residential Treatment Facility
 QIP Quality Improvement Project
 QMORE Quality Member Outreach Recovery Engagement
 Qsource® EQRO, a registered trademark
 SDOH Social Determinants of Health
 SNF Skilled Nursing Facility
 SQL Structured Query Language
 SUD Substance Use Disorder
 TOC Transitions of Care
 UHC..... UnitedHealthcare
 VBR Value-Based Reimbursement
 W15 Well-Child Visits During the First 15 Months
 W30 Well-Child Visits During the First 30 Months
 WCV Well-Child Visits

Overview

In accordance with Title 42 *Code of Federal Regulations* (CFR) § 438.364, Qsource has produced this *2023 Annual EQRO Technical Report* to summarize the quality, timeliness, and accessibility of care furnished to enrollees in the Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) program by the managed care entities (MCEs). Indiana's MCEs include Anthem Blue Cross and Blue Shield (Anthem), CareSource Indiana (CareSource), MDwise, Managed Health Services (MHS), and UnitedHealthcare (UHC).

OMPP contracted with Qsource to conduct external quality review (EQR) activities and ensure that the results of those activities are reviewed to perform an external, independent assessment and produce an annual report. Qsource serves as OMPP's external quality review organization (EQRO) and prepared this *2023 Annual EQRO Technical Report* to document the Indiana Health Coverage Programs' MCE performance in providing services to enrollees and to identify areas for improvement and recommend interventions to improve the process and outcomes of care.

This section provides a brief history of OMPP, the population(s) served by each MCE, enrollee data for each Indiana Health Coverage Program (IHCP), OMPP's quality improvement initiative descriptions with 2022 results, the mandatory EQR activities conducted by Qsource in 2023 (including targeted

quality objectives), guidelines provided by CMS for reporting EQR activities, and the intended utilization for this report.

OMPP Background

The FSSA OMPP manages the administration of Medicaid health coverage programs to Hoosiers in the state of Indiana. OMPP's collection of programs offered, known as Indiana Health Coverage Programs (IHCPs), includes three risk-based managed care programs, described below. Each serves as a safeguard for providing necessary services to distinct, susceptible populations throughout the state of Indiana.

- ◆ **Healthy Indiana Plan (HIP)** was created in January 2008 under a separate Section 1115 waiver authority. The HIP 2.0 model is a health insurance program that offsets medical, vision, and dental service costs for adults between the ages of 19 and 64 that meet designated income limitations. The HIP program provides qualified adults with access to comprehensive benefits without high-cost premiums or expensive copays. HIP is responsible for supplying preventive health care and services to thousands of Indiana residents while encouraging appropriate usage of the emergency room (ER).
- ◆ **Hoosier Care Connect (HCC)** provides health coverage for individuals who require similar services but do not qualify for Medicare; these populations include those who are aged, blind, disabled, and/or receiving Supplemental Security Income (SSI). The program also provides health coverage for many of Indiana's foster children. The program was implemented April 2015, under a 1915(b)-waiver authority. Members enrolled in the HCC program receive all Indiana

Medicaid-covered benefits in addition to care coordination services that are individualized based on assessed member needs. The care of Hoosier Care Connect members is managed through a contracted network of primary medical providers (PMPs), specialists, and other care providers.

- ◆ **Hoosier Healthwise** (HHW) services Indiana’s Children’s Health Insurance Program (CHIP) population that provides health insurance programs to children and pregnant women who earn too much to qualify for traditional Medicaid, but also not enough to purchase private health insurance. The program began in 1994 with members having the option to voluntarily enroll with an MCE in 1996. By 2005, enrollment with an MCE was mandatory for low-income families, pregnant women, and children. The HHW program’s objective is to improve the health of Indiana residents by focusing on the healthy growth and development of Indiana children and pregnant women.

Five MCEs are contracted with the state of Indiana:

- ◆ Anthem Insurance Companies, Inc.;
- ◆ CareSource;
- ◆ MDwise, Inc.;
- ◆ MHS; and
- ◆ UnitedHealthcare.

Anthem and MHS service the HHW, HIP and HCC lines of business for risk-based managed care, while CareSource and MDwise service only the HHW and HIP lines of business. UnitedHealthcare services only the HCC line of business.

Enrollees

During calendar year 2022, the population of individuals enrolled in one of the three programs (HIP, HCC, and HHW) increased by 169,068 members. With approximately one in four Indiana residents currently utilizing benefits from Medicaid and/or CHIP — a net increase of 82% since the first Marketplace Open Enrollment Period and related Medicaid program changes in October 2013.

[Table 1](#) presents the IHCP enrollment for 2022 by month.

Table 1. Total IHCP Enrollees by Month

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Healthy Indiana Plan												
Anthem	343,744	346,050	349,492	352,698	355,238	358,420	362,233	366,137	369,358	372,334	376,176	380,136
CareSource	72,590	73,301	74,331	75,322	76,020	77,005	78,054	79,184	80,197	81,165	82,823	84,515
MDwise	169,351	169,830	170,825	171,649	172,190	173,044	174,309	175,253	176,068	176,917	178,001	179,127
MHS	130,685	131,484	132,789	134,090	135,075	136,426	138,114	139,726	141,156	142,604	144,630	146,854
Total	716,370	720,665	727,437	733,759	738,523	744,895	752,710	760,300	766,779	773,020	781,630	790,632
Hoosier Care Connect												
Anthem	62,070	62,251	62,465	62,474	62,568	62,473	62,054	62,177	61,906	61,699	61,587	61,468
MHS	35,738	35,720	35,654	35,555	35,601	35,512	35,260	35,262	35,148	35,058	34,975	34,920
UHC	3,880	4,592	4,925	5,089	5,184	5,283	5,345	5,476	5,555	5,618	5,727	5,844
Total	101,688	102,563	103,044	103,118	103,353	103,268	102,659	102,915	102,609	102,375	102,289	102,232
Hoosier Healthwise												
Anthem	315,837	319,533	323,165	326,234	328,668	331,225	333,122	336,466	339,485	342,399	345,619	349,125
CareSource	75,772	76,975	78,122	78,976	79,685	80,421	81,026	82,147	83,122	84,098	85,118	86,318
MDwise	234,419	235,883	236,674	237,542	238,040	238,396	238,383	239,175	239,481	239,914	240,529	241,248
MHS	186,664	188,412	190,108	191,650	192,940	194,107	194,785	196,569	197,966	199,382	200,982	202,936
Total	812,692	820,803	828,069	834,402	839,333	844,149	847,316	854,357	860,054	865,793	872,248	879,627

OMPP Quality Strategy Overview

Under regulations at 42 CFR 438.340(a) and 42 CFR 457.1240(e), CMS requires state Medicaid agencies that contract with MCEs develop and maintain a Medicaid quality

strategy. The purpose of the strategy is to assess and improve the quality of health care and services provided by MCEs.

In 2021, Indiana outlined specific quality initiatives for the HHW, HIP and HCC programs. The initiatives outlined global

aims that OMPP has identified that support the objectives for all its programs, shown below.

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.

OMPP Strategic Objectives for Quality Improvement

The development of the HHW, HIP, and HCC quality strategy initiatives is based on identified trends in health care issues within the state of Indiana, attainment of the current quality strategy goals, close monitoring by OMPP of the MCEs' performance and unmet objectives, and opportunities for improvement identified in the external quality review.

The initiatives are at the forefront of planning and implementation of this Quality Strategy. Ongoing monitoring will provide OMPP with quality-related data for future monitoring and planning.

The MCEs are required to submit quarterly updates to OMPP about the projects determined in their annual work plan. These reports are shared with the Quality Strategy Committee.

Table 2, [Table 3](#), and [Table 4](#) present the strategic initiatives for each IHCP with their 2021 and 2022 achievement results.

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	2021 Baseline	2021 Results	2022 Results	Goal
Measure: Improvements in Children and Adolescents'	OMPP utilized HEDIS measures for tracking the percentages of well-child	Anthem	At or above 50th percentile.	Above the 50th percentile for well-child visits in the first 30 months of life and above the 50th percentile of adolescent well-care	Above the 50th percentile for well-child visits in the first 30 months of life and above the 50th percentile of	Achieve at or above the 90th percentile of the National Committee for Quality Assurance (NCQA) 2022 Quality Compass improvements in children

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	2021 Baseline	2021 Results	2022 Results	Goal
<p>Well-Care Percentage of members with well-child visits during first 21 years of life. Healthcare Effectiveness Data and Information Set (HEDIS) measures, well-child visits in the first 30 months of life and child and adolescent well-care visits for ages 3-21, using hybrid data.</p> <p>Domain: Quality and Timeliness of Care</p>	services in children and adolescents.			visits for ages 3-21.	adolescent well-care visits for ages 3-21.	and adolescent well-child W30 and WCV HEDIS measures.
		CareSource	At or above 50th percentile.	Above the 50th percentile for well-child visits in the first 30 months of life and above the 50th percentile of adolescent well-care visits for ages 3-21.	Above the 50th percentile for well-child visits in the first 30 months of life and above the 50th percentile of adolescent well-care visits for ages 3-21.	
		MDwise	At or above 50th percentile.	Above the 50th percentile for well-child visits in the first 30 months of life and above the 50th percentile of adolescent well-care visits for ages 3-21.	Above the 50th percentile for well-child visits in the first 30 months of life and above the 50th percentile of adolescent well-care visits for ages 3-21.	
		MHS	At or above 50th percentile.	Below the 50th percentile for well-child visits in the first 30 months of life and above the 50th percentile of adolescent well-care visits for ages 3-21.	Above the 50th percentile for well-child visits in the first 30 months of life and above the 50th percentile of adolescent well-care visits for ages 3-21.	
<p>Measure: Improvements in Childhood Immunization Status – Combination 10</p>	OMPP utilized HEDIS measures for tracking the percentages of well-child services in children and adolescents.	Anthem	N/A*	New for 2022.	Above the 25th percentile.	Achieve at or above the 50th percentile of the NCQA Quality Compass of member childhood immunization status (Combination 10) during the measurement year.
		CareSource	N/A	New for 2022.	Above the 25th percentile.	
		MDwise	N/A	New for 2022.	Below the 25th percentile.	

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	2021 Baseline	2021 Results	2022 Results	Goal
Domain: Quality and Timeliness of Care		MHS	N/A	New for 2022.	Above the 25th percentile.	
Measure: Completion of Health Needs Screen (>60%)	Administrative Reporting	Anthem	N/A	New for 2022.	27.98%	Achieve at or above 60% of all new members completing the health needs screening within 90 days of enrollment.
Domain: Quality and Timeliness of Care		CareSource	N/A	New for 2022.	68.61%	
		MDwise	N/A	New for 2022.	57.41%	
		MHS	N/A	New for 2022.	68.81%	
Measure: Annual Dental Visit	OMPP utilizes HEDIS for tracking the percentage of members, aged 2-20 years, who had at least one dental visit during the measurement year.	Anthem	At or above 25th percentile	At or above the 50th percentile.	At or below the 50th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass of member dental visits during the measurement year.
Domain: Quality and Timeliness of Care		CareSource	At or above 25th percentile	At or above the 50th percentile.	Below the 50th percentile.	
		MDwise	At or above 25th percentile	At or above the 50th percentile.	At or above the 50th percentile.	
		MHS	At or above 25th percentile	At or above the 50th percentile.	At or below the 50th percentile.	
Measure: Lead Screening in Children	OMPP utilized HEDIS for tracking the percentage of children 2 years of age who had one or more capillary or venous blood lead tests for lead poisoning by their second birthday.	Anthem	At or above 25th percentile.	At or above the 25th percentile.	Above the 50th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass of lead screening in children.
Domain: Quality and Timeliness of Care		CareSource	At or above 25th percentile.	At or above the 25th percentile.	Above the 50th percentile.	
		MDwise	At or above 25th percentile.	At or above the 25th percentile.	Above the 50th percentile.	
		MHS	At or above 25th percentile.	At or above the 25th percentile.	Above the 50th percentile.	

Table 2. Hoosier Healthwise Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	2021 Baseline	2021 Results	2022 Results	Goal
Measure: Asthma Medication Ratio Domain: Quality and Timeliness of Care	OMPP utilized HEDIS for tracking the percentage of children aged 5-11 years who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater.	Anthem	At or above 50th percentile.	At or above the 50th percentile.	Above the 75th percentile.	Achieve at or above the 90th percentile of the NCQA 2022 Quality Compass of asthma medication ratio.
		CareSource	At or above 50th percentile.	At or above the 75th percentile.	Above the 75th percentile.	
		MDwise	At or above 50th percentile.	At or above the 50th percentile.	Above the 50th percentile.	
		MHS	At or above 50th percentile.	At or above the 75th percentile.	Above the 75th percentile.	
Measure: Prenatal Depression Screening in Pregnant Women Domain: Quality and Access to Care	OMPP utilized HEDIS for tracking the percentage of women receiving prenatal depression screening in pregnant women	Anthem	NCQA in process of baselining.	Successful submission of results.	Below the 25th percentile on screening and above the 50th percentile on follow-up.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass of prenatal depression screening.
		CareSource	NCQA in process of baselining.	Successful submission of results.	Above the 75th percentile on screening and above the 75th percentile on follow-up.	
		MDwise	NCQA in process of baselining.	Successful submission of results.	No rates given for screening or follow-up.	
		MHS	NCQA in process of baselining.	Successful submission of results.	Below the 25th percentile on screening and above the 50th percentile on follow-up.	

*Not Applicable (N/A)

Table 3. Healthy Indiana Plan Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	2021 Baseline	2021 Results	2022 Results	Goal
<p>Measure: Account Roll-Over (HEDIS AAP) HIP members who obtain a preventive exam during the measurement year receive power account roll-over. Only codes and code combinations listed in the categories 'Preventive Care Counseling Office Visit' and 'Alternative Preventive Care Counseling Visit' apply to this measure.</p> <p>Domain: Quality and Access to Care</p>	<p>OMPP utilized HEDIS for tracking the percentage of HIP members who receive a qualifying preventive exam.</p>	Anthem	At or above the 25th percentile.	At or above the 25th percentile.	Above the 50th percentile.	<p>Achieve rate at or above the 75th percentile of the NCQA 2022 Quality Compass of members who received a preventative exam.</p>
		CareSource	At or above the 25th percentile.	Below the 25th percentile.	Above the 50th percentile.	
		MDwise	At or above the 25th percentile.	At or above the 25th percentile.	Above the 50th percentile.	
		MHS	At or above the 25th percentile.	At or above the 25th percentile.	Above the 50th percentile.	
<p>Measure: Prenatal Depression Screening in Pregnant Women</p>	<p>OMPP utilized HEDIS for tracking the percentage of women receiving</p>	Anthem	NCQA in process of baselining.	Successful submission of results.	Below the 25th percentile in screening and above the 50th percentile in follow-up.	<p>Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass of prenatal depression screening.</p>

Table 3. Healthy Indiana Plan Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	2021 Baseline	2021 Results	2022 Results	Goal
Domain: Quality and Access to Care	prenatal depression screening in pregnant women.	CareSource	NCQA in process of baselining.	Successful submission of results.	Above the 75th percentile in screening and above the 75th percentile in follow-up.	
		MDwise	NCQA in process of baselining.	Successful submission of results.	Below the 25th percentile in screening and below the 25th percentile in follow-up.	
		MHS	NCQA in process of baselining.	Successful submission of results.	Below the 25th percentile in screening and above the 50th percentile in follow-up.	
Measure: Timeliness of Ongoing Prenatal Care Domain: Quality and Timeliness of Care	OMPP utilized HEDIS for tracking the percentage of women receiving timeliness of ongoing prenatal care.	Anthem	At or above the 10th percentile.	At or above the 50th percentile.	Above the 75th percentile.	Achieve at or above the 50th percentile of the NCQA 2022 Quality Compass of the timeliness of prenatal care.
		CareSource	At or above the 10th percentile.	At or above the 25th percentile.	Above the 75th percentile.	
		MDwise	At or above the 10th percentile.	At or above the 50th percentile.	Above the 75th percentile.	
		MHS	At or above the 10th percentile.	At or above the 50th percentile.	Above the 75th percentile.	
Measure: Frequency of Post-partum Care Domain: Quality and Timeliness of	OMPP utilized HEDIS for tracking the percentage of women who receive required post-partum visits.	Anthem	At or above the 25th percentile.	At or above the 75th percentile.	Above the 75th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass of required post-partum visits.
		CareSource	At or above the 25th percentile.	Below the 25th percentile.	Above the 75th percentile.	
		MDwise	At or above the 25th percentile.	At or above the 50th percentile.	Above the 75th percentile.	
		MHS	At or above the 25th	At or above the 50th	Above the 75th	

Table 3. Healthy Indiana Plan Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	2021 Baseline	2021 Results	2022 Results	Goal
Care			percentile.	percentile.	percentile.	
Measure: Completion of Health Needs Screen Domain: Quality	Administrative reporting	Anthem	At or above 60%	45.60%	38.50%	Achieve at or above 60% of all new members completing the health needs screening within 90 days of enrollment.
		CareSource	At or above 60%	35.01%	65.56%	
		MDwise	At or above 60%	60.83%	57.42%	
		MHS	At or above 60%	70.36%	66.35%	
Measure: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 7 day Domain: Quality and Access to Care	HEDIS measure using administrative data	Anthem	At or above the 25th percentile.	At or above the 50th percentile.	Above the 25th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
		CareSource	At or above the 25th percentile.	At or above the 50th percentile.	Above the 75th percentile.	
		MDwise	At or above the 25th percentile.	At or above the 50th percentile.	Above the 25th percentile.	
		MHS	At or above the 25th percentile.	At or above the 50th percentile.	Above the 25th percentile.	
Measure: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 30 day	HEDIS measure using administrative data	Anthem	At or above the 25th percentile.	At or above the 75th percentile.	Above the 25th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
		CareSource	At or above the 25th percentile.	At or above the 75th percentile.	Above the 75th percentile.	
		MDwise	At or above the 25th percentile.	At or above the 50th percentile.	Above the 25th percentile.	

Table 3. Healthy Indiana Plan Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	2021 Baseline	2021 Results	2022 Results	Goal
Domain: Quality and Access to Care		MHS	At or above the 25th percentile.	At or above the 25th percentile.	Above the 25th percentile.	

Table 4. Hoosier Care Connect Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	2021 Baseline	2021 Results	2022 Results	Goal
Measure: Adult Preventive Care (HEDIS) Domain: Quality and Access to Care	OMPP used the adult preventive care HEDIS measure for tracking preventive care.	Anthem	At or above the 25th percentile.	At or above the 75th percentile.	Above the 75th percentile.	Achieve at or above the 75th percentile for NCQA 2022 Quality Compass for members 20 years and older who had a preventive care visit.
		MHS	At or above the 25th percentile.	At or above the 50th percentile.	Above the 75th percentile.	
		UHC*	At or above the 25th percentile.	N/A	At or below the 75th percentile.	
Measure: Completion of Health Needs Screen (≥60%) Domain: Quality and Timely Access to Care	Administrative reporting	Anthem	At or above 60%.	44.45%	47.72%	Achieve completion of a Health Needs Screen for >60% of all members during the first 90 days of enrollment.
		MHS	At or above 60%.	78.08%	70.46%	
		UHC*	At or above 60%	N/A	70.65%	
Measure: Completion of Comprehensive Health Assessment Tool Domain: Quality and Timely Access to Care	Administrative reporting	Anthem	At or above 73%.	77.60%	73.45%	Achieve completion of a comprehensive health assessment of >79% for all members who are stratified into complex case management or the Right Choice Program following the initial screening, during the first 150 days of enrollment.
		MHS	At or above 73%.	87.53%	90.11%	
		UHC*	At or above 73%	N/A	82.14%	

Table 4. Hoosier Care Connect Quality Strategy Initiatives

Measure and Domain	Methodology	MCE	2021 Baseline	2021 Results	2022 Results	Goal
Measure: Annual Dental Visit Domain: Quality and Timely Access to Care	OMPP is utilizing the annual dental visit HEDIS measures for tracking annual dental visits.	Anthem	N/A	New for 2022.	At or above the 50th percentile.	Achieve at or above the 75th percentile for NCQA 2022 Quality Compass for members ages 2 to 20 years who had a dental visit.
		MHS	N/A	New for 2022.	At or above the 50th percentile.	
		UHC*	N/A	N/A	Below the 50th percentile.	
Measure: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 7 Day Domain: Quality and Access to Care	HEDIS measure using administrative data	Anthem	At or above the 25th percentile.	At or above the 50th percentile.	Below the 50th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
		MHS	At or above the 25th percentile.	At or above the 25th percentile.	Below the 50th percentile.	
		UHC*	At or above the 25th percentile.	N/A	Below the 50th percentile.	
Measure: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 30 Day Domain: Quality and Access to Care	HEDIS measure using administrative data	Anthem	At or above the 25th percentile.	At or above the 25th percentile.	At or above the 25th percentile.	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
		MHS	At or above the 25th percentile.	At or above the 25th percentile.	At or above the 25th percentile.	
		UHC*	At or above the 25th percentile.	N/A	At or above the 25th percentile.	

*UHC was not contracted with HCC in 2021, so 2021 measurements were not applicable.

Qsource noted nine performance metrics which had successful increases and/or met HEDIS rate goals for 2022:

- ◆ Completion of Health Needs Screen (>60%) – HHW
 - OMPP utilized administrative reporting for tracking the completion of the health needs screening within 90 days

of enrollment for new enrollees. This was a new measure introduced in 2022.

- Achieve at or above 60% for all new members within 90 days of enrollment.
- MHS achieved the goal with 68.81%.
- CareSource achieved the goal with 68.61%.

- ◆ Lead Screening in Children – HHW
 - OMPP utilized HEDIS for tracking the percentage of children 2 years of age who had one or more capillary or venous blood lead tests for lead poisoning by their second birthday.
 - Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for lead screening in children.
 - None of the plans reached the 75th percentile; however, all four plans improved from the 25th to 50th percentile.
- ◆ Account Roll-Over (HEDIS Adult Access to Preventative/Ambulatory Health Services [AAP]) – HIP
 - OMPP utilized HEDIS for tracking the percentage of HIP members who receive a qualifying preventive exam.
 - Achieve rate at or above the 75th percentile of the NCQA 2022 Quality Compass of members who received a preventative exam.
 - None of the plans reached the 75th percentile; however, all four plans improved from the 25th to the 50th percentile.
- ◆ Frequency of Post-partum Care – HIP
 - OMPP utilized HEDIS for tracking the percentage of women who receive required post-partum visits.
 - Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for required post-partum visits.
 - All four plans achieved the 75th percentile.
- ◆ Timeliness of Post-partum Care – HIP
 - OMPP utilized HEDIS for tracking the percentage of women receiving timeliness of ongoing prenatal care.
 - Achieve at or above the 50th percentile of the NCQA 2022 Quality Compass for required post-partum visits.
 - All four plans achieved the 75th percentile.
- ◆ Completion of Health Needs Screening – HIP
 - OMPP utilized administrative reporting for tracking the completion of the health needs screening within 90 days of enrollment for new enrollees.
 - Achieve at or above 60% of all new members completing the health needs screening within 90 days of enrollment.
 - CareSource and MHS achieved this goal with 65.56% and 66.35% respectively.
- ◆ Adult Preventive Care (HEDIS) – HCC
 - OMPP used the adult preventive care HEDIS measure for tracking preventive care.
 - Achieve at or above the 75th percentile for NCQA 2022 Quality Compass for members 20 years and older who had a preventive care visit.
 - Anthem and MHS reached the 75th percentile.
- ◆ Completion of Health Needs Screening – HCC
 - OMPP utilized administrative reporting for tracking the completion of the health needs screening within 90 days of enrollment for new enrollees.
 - Achieve at or above 60% of all new members completing the health needs screening within 90 days of enrollment.
 - MHS and UHC both achieved this goal with 70.46% and 70.65% respectively.

- ◆ Completion of Comprehensive Health Assessment Tool – HCC
 - OMPP utilized administrative reporting for tracking the completion of comprehensive health assessments.
 - Achieve completion of a comprehensive health assessment of >79% for all members who are stratified into complex case management or the Right Choice Program following the initial screening, during the first 150 days of enrollment.
 - MHS and UHC achieved this goal with 90.11% and 82.14% respectively.

Qsource noted five performance metrics which showed no, or minimal improvements among the plans in reaching goals for 2022:

- ◆ Improvements in Children and Adolescents Well-Care – HHW
 - Percentage of members with well-child visits during first 21 years of life. HEDIS measures, well-child visits in the first 30 months of life and child and adolescent well-care visits for ages 3-21, using hybrid data.
 - Achieve at or above the 90th percentile of the NCQA 2022 Quality Compass improvements in children and adolescent well-child W30 and WCV HEDIS measures.
 - None of the plans reached the 90th percentile, with Anthem, MDwise and CareSource making no change from baseline of 50th percentile and MHS moving from less than baseline of 50th percentile to the baseline of 50th percentile.
- ◆ Annual Dental Visit – HHW

- OMPP utilizes HEDIS for tracking the percentage of members, aged 2-20 years, who had at least one dental visit during the measurement year.
- Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for member dental visits during the measurement year.
- None of the plans reached the 75th percentile. All plans maintained the 50th percentile that they achieved in 2021.
- ◆ Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 7 Day – HIP
 - Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
 - Majority of the plans did not reach the 75th percentile based on published NCQA Benchmarks at the time of data submission. However, CareSource achieved the goal registering just above the 75th percentile.
- ◆ Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 30 Day – HIP
 - Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
 - Majority of the plans did not reach the 75th percentile based on published NCQA Benchmarks at the time of data submission. MHS moved just beyond the 25th percentile baseline; Anthem declined from the 75th percentile but above the 50th percentile. MDwise declined from the 50th percentile range to at or above the 25th percentile baseline. CareSource achieved a rate of 40.3% in the FUA 30-day measure, achieving above the 75th percentile.

- ◆ Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse Dependence 30 Day – HCC
 - Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
 - None of the plans reached the 75th percentile, with all three making no change from the baseline of 25th percentile.

Quality Strategy Conclusions

OMPP should continue to work with the MCEs and focus on standards that consistently show no improvement or minimal improvement to ensure quality, timeliness, and access to care for the enrollees. OMPP should ensure that the MCEs review their workflows and ensure timely care and reporting of data. OMPP should ensure that all the MCEs are informed of all reporting requirements and reporting timeframes. OMPP should continue to develop reports that follow HEDIS updates, additions, and new guidelines. Overall, the Quality Strategy was an effective tool for measuring and improving OMPP's managed care services, specifically in improving the quality, timeliness, and access to care for the MCE enrollees. The MCEs and the State are making progress towards the Quality Strategy goals and objectives.

EQR Activities

As set forth in Title 42 *Code of Federal Regulations*, Section 438, Part 358 (42 § 438.358), incorporated by 42 CFR § 457.1250, there are four mandated and six optional EQR activities. In addition, a state agency can assign other

responsibilities to its designated EQRO. This section summarizes the activities that Qsource performed for OMPP in 2023, in accordance with the CMS *External Quality Review Protocols* (released in 2019).

EQR Mandatory Activities

Following the CMS Protocols published in October 2019, Qsource conducted the EQR activities shown in **Table 5**.

Table 5. EQR Activities Conducted in 2023

Protocol #	Activity Name	Mandatory or Optional	Measurement Period
1	<i>Validation of Performance Improvement Projects</i>	Mandatory	January 1, 2022 – December 31, 2022
2	<i>Validation of Performance Measures</i>	Mandatory	January 1, 2022– December 31, 2022
4	<i>Validation of Network Adequacy</i>	Mandatory	January 1, 2022– December 31, 2022
5	<i>Encounter Data Validation</i>	Optional	January 1, 2022 – December 31, 2022
9	<i>Focus Studies on Quality of Care</i>	Optional	January 1, 2022 – December 31, 2022

Under CMS requirements, Protocol 3 requires MCEs to undergo a review at least once every three years to determine MCE compliance with federal standards as implemented by the state. OMPP has chosen to review all applicable standards every three

years. Protocol 3 was performed in 2021 (CY2020) and will be performed again in 2024, assessing all applicable standards.

Qsource maintained ongoing, collaborative communication with OMPP and provided technical assistance to the MCEs in their EQR activities. The technical assistance—an EQR-related activity also defined by 42 CFR § 438.358, consisted of targeted support through phone calls, webinars, written guides, and trainings.

Finally, Qsource provided each MCE with an information packet explaining the EQR activities in greater detail and dates for data submission.

CMS National Quality Strategy

Throughout the evaluation and validation of MCE activities, Qsource monitors each MCEs compliance with federally mandated activities and to assess the quality, timeliness and accessibility of services provided the MCEs. Quality of Care, Timeliness of Care and Access to Care are three domains of healthcare quality that must be present in all activities.

Quality of Care

CMS describes quality of care as the degree to which preferred enrollee health outcomes are likely to increase through the efforts of MCEs, along with their organizations and operations that provide enrollee services. OMPP required the MCEs to conduct quality improvement projects (QIPs), which included mechanisms to assess the quality and appropriateness of care

provided to enrollees. Each MCE was required to report on performance measures related to quality of care to the State. OMPP asked the MCEs to meet targets for those performance measures. Qsource conducted Performance Measure Validation to determine if the MCEs were meeting these quality performance measure targets.

Timeliness of Care

For quality care to be effective, it must be delivered in a timely manner. Thus, various standards for timely care were monitored through MCE compliance with federal and state regulations. All program QIPs validated by Qsource addressed the timeliness of care for enrollees: Follow-up After Emergency Department Visit for Drug Abuse or Dependence, Health Needs Screening, and Postpartum Timeliness. Qsource's validation of performance measures evaluated timeliness measures determined by OMPP.

Access to Care

Access to care is equally critical for enrollee health outcomes as quality of care. The MCEs' provider capacity is monitored through annual network adequacy evaluation, which assesses the availability of critical provider specialties by time and distance and how quickly enrollees can obtain needed appointments. Network adequacy was analyzed to determine if enrollees' access to care met requirements. Compliance with applicable federal, state, and contractual regulations also addressed access to care requirements, ensuring accessibility for all enrollees, including those with limited English proficiency and physical or

mental disabilities. The MCE's QIPs are evaluated to ensure quality of care and access to care for all enrollees.

Technical Report Guidelines

Qsource is responsible for the creation and production of this *2023 Annual EQRO Technical Report*, which compiles the results of these EQR activities. To assist both EQROs and state agencies, CMS supplemented the requirements of 42 CFR § 438.364, as incorporated by 42 CFR § 457.1250, and provided guidelines in the 2019 EQR Protocols for producing annual technical reports.

The report includes the following EQR-activity-specific sections:

- ◆ Protocol 1. Validation of Performance Improvement Projects (MCEs reference these as Quality Improvement Projects [QIPs] which is the acronym used throughout this report.)
- ◆ Protocol 2. Validation of Performance Measures
- ◆ Protocol 4. Validation of Network Adequacy
- ◆ Protocol 5: Encounter Data Validation
- ◆ Protocol 9: Focus Studies on Quality Care

Each EQR activity was conducted by Qsource to monitor each MCEs compliance with federally mandated activities and to assess the quality, timeliness and accessibility of services provided by the MCEs. This report includes the following results of these activities:

1. A brief description of the data collection, aggregation, and analyses for each of the EQR compliance activities;

2. A summary of findings from each review;
3. Strengths and weaknesses demonstrated by each MCE in providing healthcare services to enrollees;
4. Recommendations for improving the quality of these services, including how OMPP can target goals and objectives within the quality strategy to better support improvement; and
5. Comparative information regarding the MCEs, consistent with CMS EQR Protocol guidance.

The *2023 Annual EQRO Technical Report* provides OMPP with substantive, unbiased data on the MCEs as well as recommendations for action toward far-reaching performance improvement. This report is based on detailed findings that can be reviewed in the individual EQR activity reports provided to OMPP.

Recommendations for how to utilize Qsource's findings can be found in the [Conclusions and Recommendations](#) section of this report.

The appendices provide additional EQR activity information:

- ◆ [Appendix A](#) | PMV Measure Rates
- ◆ [Appendix B](#) | ANA Excluded Source Data
- ◆ [Appendix C](#) | Detailed Analysis of Provider Network Access
- ◆ [Appendix D](#) | EDV Encounter Matching
- ◆ [Appendix E](#) | EDV Documentation
- ◆ [Appendix F](#) | Focus Study Documentation

EQRO Team

The review team included the following staff:

- ◆ Rebel McKnight, Qsource, Indiana EQR Program Manager
- ◆ Jazzmin Kennedy, Qsource, Clinical Quality Improvement Advisor
- ◆ Albert Kennedy, Qsource, Technical Writer
- ◆ Fidencio Caballero, Qsource, Healthcare Data Analyst
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Quality Improvement Project (QIP) Validation

Overview

The *Balanced Budget Act of 1997* established certain managed care quality safeguards that were described by Title 42 of the *Code of Federal Regulations*, Section 438.320 (42 CFR § 438.320), which defines “external quality review” as the “analysis and evaluation ... of aggregated information on quality, timeliness, and access to health care services.” These reviews, described in 42 CFR § 438.358, include four required external quality review activities, one of which is the validation of quality improvement projects.

As part of its external quality review contract with the Indiana Family and Social Services Administration Office of Medicaid Policy & Planning, Qsource annually validates the QIPs of the managed care entities providing services for Indiana Medicaid members. Qsource’s *Annual QIP Validation Reports* present validation findings by MCE.

The primary objective of QIP validation is to determine each QIP’s compliance with the requirements set forth in Title 42 of the *Code of Federal Regulations*, Section 438.330(d). MCEs

must conduct QIPs that are designed to achieve, through ongoing measurements and interventions, significant and sustained improvement in clinical and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. QIP study topics must reflect enrollment in terms of demographic characteristics and, if applicable, in terms of the prevalence and potential consequences (risks) of disease as well as enrollee needs for specific services. Each QIP must be completed within a timeframe that allows QIP success-related data in the aggregate to produce new information on quality of care every year. QIPs are further defined in 42 CFR § 438.330(d) to include all the following:

- ◆ Measuring performance with objective quality indicators;
- ◆ Implementing interventions for quality improvement;
- ◆ Evaluating intervention effectiveness; and
- ◆ Planning and initiating activities to increase or sustain improvement.

Technical Methods of Data Collection and Analysis

Each MCE was contractually required to submit QIP studies annually to OMPP as requested. QIPs should include the necessary documentation for submitted data collection, data analysis plans, and an interpretation of all results. MCEs should also address threats to validity regarding data analysis.

Each MCE submitted a continuation of their established QIPs as QIPs are typically conducted over a three-year period. Some of the QIPs were in their initial year with new topics being evaluated. To validate QIPs, Qsource assembled a validation team of experienced staff specializing in clinical quality improvement and a healthcare data analyst. The validation process included a review of each QIP's study design and approach, an evaluation of each QIP's compliance with the analysis plan, and an assessment of the effectiveness of interventions.

The QIP validation was based on CMS's EQR Protocol 1: Validation of Performance Improvement Projects (October 2019). Qsource developed a QIP Summary Form (with accompanying QIP Summary Form Completion Instructions) and a QIP Validation Tool to standardize the process by which each MCE delivers QIP information to OMPP and how the information is assessed. Using Qsource's QIP Summary Form, each MCE submitted its QIP studies and supplemental

information in August 2023. The measurement year (MY) for this validation was January 1, 2022, through December 31, 2022.

Qsource's scoring methodology determines whether a QIP is valid by rating the QIP's percentage of compliance with the *Centers for Medicare & Medicaid Services EQR Protocol 1: Validating Performance Improvement Projects (PIPs) 2019*. Qsource developed a QIP Validation Tool used internally by members of the validation team to standardize the process by which each QIP is evaluated across all MCEs. Each QIP involves nine required activities, and each activity consists of one or more elements essential to the successful completion of a QIP. The elements within each activity are scored as Met, Not Met, or Not Applicable.

Table 6 presents the validation status criteria for the QIPs.

Table 6. QIP Validation Status Criteria	
Status	Criteria
High Confidence	Of all elements assessed, 90–100% were met across all activities.
Moderate Confidence	Of all elements assessed, 80–<90% were met across all activities.
Low Confidence	Of all elements assessed, 70–<80% were met across all activities.
No Confidence	Less than 70% of all elements were met.

Table 7 lists the nine QIP steps used for assessing the QIP methodology.

Table 7. QIP Assessment Steps			
QIP Activities			
1	State the Selected QIP Topic	6	Describe Valid and Reliable Data Collection Procedures
2	State the QIP Aim Statement	7	Analyze Data and Interpret QIP Results
3	Identify the QIP Population	8	Describe Improvement Strategies
4	Describe the Sampling Method	9	Assess for Significant and Sustained Improvement
5	Describe the Selected QIP Variables and Performance Measures		

QIP Topics

The MCEs are required to produce QIPs for all IHCP programs it administers—Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect. Qsource received and assessed QIP Summary Forms for the following QIP topics in **Table 8**.

The MCEs were given the option to select their own QIP topics but were also assigned two QIP topics that were conducted across all programs. Anthem, CareSource, and MHS submitted 6 QIPs, MDwise submitted 4 QIPs, and UHC submitted 2 QIPs.

Qsource received and assessed QIP Summary Forms for the following QIP topics:

Table 8. QIP Topics by MCE											
QIP Topic	Anthem			CareSource		MDwise		MHS			UHC
	HIP	HHW	HCC	HIP	HHW	HIP	HHW	HIP	HHW	HCC	HCC
Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)	X	X	X	X	X	X	X	X	X	X	X
Health Needs Screening (HNS)	X	X	X	X	X	X	X	X	X	X	X
Postpartum Care (PPC)				X	X						

Validation Results 2022 QIPs

Table 9 presents each QIP’s element percentages and overall validation status by IHCP and QIP.

Table 9. 2022 QIP Validation Results Summary			
QIP Activities	Elements Met/Applicable		Validation Status (%)
	Met	Applicable	
Anthem			
Healthy Indiana Plan			
QIP 1: <i>Follow-up After Emergency Department Visit for Drug Abuse or Dependence</i>	28	48	No Confidence – 58.33%
QIP 2: <i>Health Needs Screening</i>	32	45	Low Confidence – 71.11%
Hoosier Healthwise			
QIP 1: <i>Follow-up After Emergency Department Visit for Drug Abuse or Dependence</i>	28	48	No Confidence – 58.33%
QIP 2: <i>Health Needs Screening</i>	32	45	Low Confidence – 71.11%
Hoosier Care Connect			
QIP 1: <i>Follow-up After Emergency Department Visit for Drug Abuse or Dependence</i>	28	48	No Confidence – 58.33%
QIP 2: <i>Health Needs Screening</i>	32	45	Low Confidence – 71.11%
CareSource			
Healthy Indiana Plan			
QIP 1: <i>Improve access to timely Prenatal and Postpartum Care through Care Management (CM) Engagement</i>	50	50	High Confidence – 100%
QIP 2: <i>Health Needs Screening</i>	48	48	High Confidence – 100%
QIP 3: <i>Improving outcomes for members with substance use disorder (SUD) through timely member engagement in care-case management following an Emergency Department (ED) Visit</i>	46	46	High Confidence – 100%
Hoosier Healthwise			
QIP 1: <i>Improve access to timely Prenatal and Postpartum Care through Care Management Engagement</i>	50	50	High Confidence – 100%
QIP 2: <i>Health Needs Screening</i>	48	48	High Confidence – 100%
QIP 3: <i>Improving outcomes for members with substance use disorder through timely member</i>	46	46	High Confidence – 100%

Table 9. 2022 QIP Validation Results Summary			
QIP Activities	Elements Met/Applicable		Validation Status (%)
	Met	Applicable	
<i>engagement in care-case management following an ED Visit</i>			
MDwise			
Healthy Indiana Plan			
<i>QIP 1: Follow-up After Emergency Department Visit for Drug Abuse or Dependence</i>	19	45	No Confidence – 42.22%
<i>QIP 2: Health Needs Screening</i>	20	47	No Confidence – 42.55%
Hoosier Healthwise			
<i>QIP 1: Follow-up After Emergency Department Visit for Drug Abuse or Dependence</i>	19	45	No Confidence – 42.22%
<i>QIP 2: Health Needs Screening</i>	20	47	No Confidence – 42.55%
MHS			
Healthy Indiana Plan			
<i>QIP 1: Follow-up After Emergency Department Visit for Drug Abuse or Dependence</i>	42	45	High Confidence – 93.33%
<i>QIP 2: Health Needs Screening</i>	45	45	High Confidence – 100%
Hoosier Healthwise			
<i>QIP 1: Follow-up After Emergency Department Visit for Drug Abuse or Dependence</i>	42	45	High Confidence – 93.33%
<i>QIP 2: Health Needs Screening</i>	45	45	High Confidence – 100%
Hoosier Care Connect			
<i>QIP 1: Follow-up After Emergency Department Visit for Drug Abuse or Dependence</i>	42	45	High Confidence – 93.33%
<i>QIP 2: Health Needs Screening</i>	45	45	High Confidence – 100%
UHC			
Hoosier Care Connect			
<i>QIP 1: Follow-up After Emergency Department Visit for Drug Abuse or Dependence</i>	22	26	Moderate Confidence – 84.62%
<i>QIP 2: Health Needs Screening</i>	20	25	Moderate Confidence – 80.00%

Strengths, Weaknesses and Recommendations

Table 10 includes strengths and **Table 11** includes weaknesses and recommendations. Strengths for the QIP validation indicate that the MCEs demonstrated proficiency on a given activity and this proficiency can be identified regardless of validation rating. The lack of an identified strength should not be interpreted as a shortcoming on the part of an MCE. Weaknesses, or Areas of Noncompliance (AONs), arise from evaluation elements that receive a Not Met score, indicating that those elements were not in full compliance with CMS Protocols. The recommendations were created by Qsource to address the weaknesses evaluated in the QIPs. Strengths, weaknesses, and recommendations are useful to the MCE in determining whether to continue or retire a specific QIP. Any MCE QIP topic that is not listed was determined to have no strengths and/or weaknesses identified.

Table 10. QIP Strengths	
CareSource	
<i>Health Needs Screening HIP/HHW</i>	Element 2, Step 7: The MCE provided tables, graphs, and a run chart that clearly depicted quarterly performance over the life of the QIP and captured strategies and occurrences that may have led to improvement and/or decline in performance.
MHS	
<i>Follow-up After Emergency Department Visit for Drug Abuse or Dependence HIP/HHW/HCC</i>	Element 2, Step 8: The MCE included an exceptional presentation of the QIP's related causes/barriers identified through data analysis and quality improvement processes.
<i>Health Needs Screening HIP/HHW/HCC</i>	Element 1, Step 6: The MCE exceptionally demonstrated a systematic method for collecting valid and reliable data that represented the QIP population.
	Element 2, Step 8: The MCE included an exceptional presentation of the QIP's related causes/barriers identified through data analysis and quality improvement processes.
	Element 7, Step 7: The MCE exceptionally demonstrated data analysis and interpretation in a concise and easily understood manner.

Table 11. QIP Weaknesses (AONs) and Recommendations

Anthem

Follow-up After ED Visit for Drug Abuse or Dependence (HIP / HHW / HCC)

Review the Selected QIP Variables and Performance Measures (Step 5)	<ul style="list-style-type: none"> ◆ The MCE should include a strategy for inter-rater reliability as applied for manual data collection aspects that are applicable to a hybrid data collection methodology. ◆ The MCE should address how performance measures are based on strong evidence that the process being measured is meaningfully associated with outcomes.
Review the Data Collection Procedures (Step 6)	<ul style="list-style-type: none"> ◆ The MCE should address the required qualifications associated with the data abstraction role. ◆ The MCE should describe the intra- and inter-rater reliability processes in place to ensure valid and reliable data are abstracted during medical record reviews. ◆ The MCE should include guidelines developed specifically for data abstraction staff to ensure valid and reliable data are abstracted during medical record reviews.
Review the Data Analysis and Interpretation of QIP Results (Step 7)	<ul style="list-style-type: none"> ◆ The MCE should discuss how data analysis and interpretation were conducted in accordance with the data analysis plan. ◆ The MCE should include a detailed discussion of baseline and each remeasurement year's performance. ◆ The MCE should include a discussion of the statistical significance of any differences between baseline and each repeat measurement(s). ◆ The MCE should include a discussion that interprets the results across multiple entities that includes the current reporting year. ◆ The MCE should consider QIP Summary Form instructions to acknowledge each element in a clear and easily understood way.
Assess the Improvement Strategies (Step 8)	<ul style="list-style-type: none"> ◆ The MCE should include an evidentiary discussion of how improvement strategies were evidence-based. ◆ The MCE should include a discussion that details causes and/or barriers identified through data analysis that directly relate to improvement strategies. ◆ The MCE should include a description of the process used to implement improvement strategies that demonstrates rapid-cycle activities implemented on a Plan-Do-Study-Act (PDSA) basis. ◆ The MCE should include documentation that details the presence of major confounding factors and how these factors were reflected within improvement strategies. ◆ The MCE should include an assessment that measures the success of improvement strategies including appropriate follow-up activities based on the assessment.
Assess the Likelihood that Significant and Sustained Improvement Occurred (Step 9)	<ul style="list-style-type: none"> ◆ The MCE should include an assessment for real improvement that indicates whether the remeasurement methodology is the same as the baseline methodology. ◆ The MCE should include an assessment for real improvement that indicates whether there is quantitative evidence of improvement in processes or outcomes of care. ◆ The MCE should include an assessment for real improvement that indicates whether improvement is present and how likely it is the result of implemented improvement strategies.

Table 11. QIP Weaknesses (AONs) and Recommendations

	<ul style="list-style-type: none"> ◆ The MCE should include an assessment for real improvement that indicates whether statistical evidence of improvement is present and how likely it is the result of implemented improvement strategies. ◆ The MCE should address whether sustained improvement is demonstrated through repeated measurements over time.
Health Needs Screening (HIP / HHW / HCC)	
Review the QIP Aim Statement (Step 2)	<ul style="list-style-type: none"> ◆ The MCE should specifically address the QIP population (members) within the aim statement.
Review the Identified QIP Population (Step 3)	<ul style="list-style-type: none"> ◆ The MCE should identify the QIP population within the aim statement for Step 2 and further define the identified population for Step 3 to include characteristics such as age, diagnoses, applicable services, and/or enrollment requirements.
Review the Selected QIP Variables and Performance Measures (Step 5)	<ul style="list-style-type: none"> ◆ The MCE should include a discussion of how performance measures were based on current clinical knowledge or health services research. ◆ The MCE should address how performance measures are based on strong evidence that the process being measured is meaningfully associated with outcomes.
Review the Data Analysis and Interpretation of QIP Results (Step 7)	<ul style="list-style-type: none"> ◆ The MCE should discuss how data analysis and interpretation were conducted in accordance with the data analysis plan. ◆ The MCE should include a detailed discussion of baseline and each remeasurement year’s performance. ◆ The MCE should include a discussion of the statistical significance of any differences between baseline and each repeat measurement(s).
Assess the Improvement Strategies (Step 8)	<ul style="list-style-type: none"> ◆ The MCE should include a description of the process used to implement improvement strategies that demonstrate rapid-cycle activities implemented on a PDSA basis. ◆ The MCE should include an assessment of member-facing improvement strategies for cultural and linguistic appropriateness.
Assess the Likelihood that Significant and Sustained Improvement Occurred (Step 9)	<ul style="list-style-type: none"> ◆ The MCE should include an assessment for real improvement that indicates whether there is quantitative evidence of improvement in processes or outcomes of care. ◆ The MCE should include an assessment for real improvement that indicates whether improvement is present and how likely it is the result of implemented improvement strategies. ◆ The MCE should include an assessment for real improvement that indicates whether statistical evidence of improvement is present and how likely it is the result of implemented improvement strategies. ◆ The MCE should address whether sustained improvement is demonstrated through repeated measurements over time.
MDwise	
Follow-up After ED Visit for Drug Abuse or Dependence (HHW / HIP)	
Review the QIP Aim Statement (Step 2)	<ul style="list-style-type: none"> ◆ The MCE should provide an aim statement that clearly specifies the improvement strategy. ◆ The MCE should provide the specific QIP population within the aim statement. ◆ The MCE should ensure that the QIP aim statement is written concisely, reflecting the format “will X result in Y.” ◆ The MCE should ensure the aim statement has a realistic goal stated.

Table 11. QIP Weaknesses (AONs) and Recommendations

	<ul style="list-style-type: none"> ◆ The MCE should include specific measurement within the aim statement.
Review the Selected QIP Variables and Performance Measures (Step 5)	<ul style="list-style-type: none"> ◆ The MCE should describe the process of addressing and tracking performance measures at a point in time; including how often data is assessed, compared to benchmarks, and utilized to influence quality improvement strategies. ◆ The MCE should give details and an explanation of how the process being measured was meaningfully associated with outcomes.
Review the Data Collection Procedures (Step 6)	<ul style="list-style-type: none"> ◆ The MCE should identify the specific data elements collected for QIP evaluation. ◆ The MCE should include a description of the data analysis plan to monitor and assess performance. ◆ The MCE should include all data instruments used to ensure the QIP’s data accuracy and availability over time.
Review the Data Analysis and Interpretation of QIP Results (Step 7)	<ul style="list-style-type: none"> ◆ The MCE should provide a discussion of the improvement strategies conducted in accordance with the data analysis plan. ◆ The MCE should include discussion of the baseline measurement and remeasurement(s) of performance measures. ◆ The MCE should include a discussion of the statistical significance of any differences between baseline and repeat measurement(s). ◆ The MCE should identify any factors that may influence comparability of initial and repeat measurements. ◆ The MCE should identify factors that threaten internal or external validity of findings. ◆ The MCE should ensure that data analysis is presented in a concise and easily understood manner.
Assess the Improvement Strategies (Step 8)	<ul style="list-style-type: none"> ◆ The MCE should provide a discussion to indicate the QIP improvement strategies as evidence based. ◆ The MCE should address causes/barriers related to improvement strategies that were identified using data analysis and quality improvement processes. ◆ The MCE should provide evidence that improvement strategies were implemented on a rapid-cycle, PDSA basis. ◆ The MCE should include an assessment of cultural and linguistic appropriateness for the applied interventions. ◆ The MCE should address how improvement strategies are reflective of major confounding factors that could have an impact on QIP outcomes. ◆ The MCE should provide a detailed discussion of the success of QIP interventions or indicate related follow-up activities planned as a result.
Assess the Likelihood that Significant and Sustained Improvement Occurred (Step 9)	<ul style="list-style-type: none"> ◆ The MCE should address quantitative evidence of improvement in processes or outcomes of care. ◆ The MCE should provide a detailed discussion to show how improvements made in QIP performance are likely the result of selected improvement strategies. ◆ The MCE should include statistical evidence, such as significance tests, to show how improvements made in QIP performance are the result of improvement strategies. ◆ The MCE should include a detailed discussion demonstrating the sustainability of QIP improvement through repeated measurements over time.

Table 11. QIP Weaknesses (AONs) and Recommendations

Health Needs Screening (HHW / HIP)

<p>Review the QIP AIM Statement (Step 2)</p>	<ul style="list-style-type: none"> ◆ The MCE should discuss the QIP improvement strategies in the aim statement. ◆ The MCE should specify the QIP population and be more specific than “newly enrolled.” ◆ The MCE should create an aim statement that is clear, concise, and easily understandable. ◆ The MCE should create an aim statement in the form of a question and ensure it is answerable. ◆ The MCE should create an aim statement that is measurable with specific criteria.
<p>Review the Selected QIP Variables and Performance Measures (Step 5)</p>	<ul style="list-style-type: none"> ◆ The MCE should indicate the performance measures are appropriate based on the availability of data and resources to collect the data. ◆ The MCE should address how performance is tracked, compare performance measures to benchmarks; and inform the selection and evaluation of quality improvement strategies.
<p>Review the Data Collection Procedures (Step 6)</p>	<ul style="list-style-type: none"> ◆ The MCE should include a systematic method for collecting valid and reliable data that represent the QIP population. ◆ The MCE should ensure Data sources should be clearly identified. ◆ The MCE should ensure the Data elements to be collected are clearly identified. ◆ The MCE should ensure the data analysis plan is detailed and conveys how appropriate data is available. ◆ The MCE should ensure detailed information is given regarding data collection instruments that allow for consistent and accurate data collection over QIP time periods. ◆ The QIP should include an estimated degree of data completeness for administrative data collection. ◆ The QIP should include qualifications of staff responsible for abstracting data. ◆ The QIP should describe the intra- and inter-rater reliability processes in place. ◆ The QIP should include guidelines developed for abstraction staff.
<p>Review the Data Analysis and Interpretation of QIP Results (Step 7)</p>	<ul style="list-style-type: none"> ◆ The MCE should give a detailed analysis plan within the QIP. ◆ The MCE should ensure the statistical significance of differences between baseline and remeasurements is documented.
<p>Assess the Improvement Strategies (Step 8)</p>	<ul style="list-style-type: none"> ◆ The MCE should include evidence to support the likelihood of success for each improvement strategy implemented. ◆ The MCE should identify causes and/or barriers related to care that resulted in the selection of interventions. ◆ The MCE should document the implementation of interventions within a rapid-cycle, PDSA process. ◆ The MCE should establish any cultural or linguistic needs or barriers related to member outreach interventions. ◆ The MCE should include a detailed discussion of each intervention’s success and any follow-up planned.
<p>Assess the Likelihood that Significant and Sustained Improvement Occurred (Step 9)</p>	<ul style="list-style-type: none"> ◆ The MCE should address quantitative evidence of improvement in processes or outcomes of care. ◆ The MCE should provide a detailed discussion to show how improvements made in QIP performance are likely the result of selected improvement strategies.

Table 11. QIP Weaknesses (AONs) and Recommendations

	<ul style="list-style-type: none"> ◆ The MCE should include statistical evidence, such as significance tests, to show how improvements made in QIP performance are the result of improvement strategies. ◆ The MCE should include a detailed discussion demonstrating the sustainability of QIP improvement through repeated measurements over time.
MHS	
<i>Follow-up after Emergency Department Visit for Drug Abuse or Dependence (HIP / HHW / HCC)</i>	
Review the Selected QIP Variables and Performance Measures (Step 5)	<ul style="list-style-type: none"> ◆ The MCE should address how performance measures are based on strong evidence that the process being measured is meaningfully associated with outcomes.
Review the Data Analysis and Interpretation of QIP Results (Step 7)	<ul style="list-style-type: none"> ◆ The MCE should compare results across multiple entities, as applicable, with clear data descriptions that acknowledge the performance measure being discussed.
Assess the Likelihood that Significant and Sustained Improvement Occurred (Step 9)	<ul style="list-style-type: none"> ◆ The MCE should include assessment results and a discussion that indicate whether sustained improvement is demonstrated through repeated measurements over time.
UHC	
<i>Follow-up after Emergency Department Visit for Drug Abuse or Dependence (HCC)</i>	
Review the Selected QIP Topic (Step 1)	<ul style="list-style-type: none"> ◆ The MCE should specifically indicate how the QIP topic aligns with priority areas identified by the Department of Health and Human Services (HHS) and/or CMS.
Review the QIP Aim Statement (Step 2)	<ul style="list-style-type: none"> ◆ The MCE should provide more detail and clearly define the QIP population within the aim statement.
Review the Selected QIP Variables and Performance Measures (Step 5)	<ul style="list-style-type: none"> ◆ The MCE should specifically state that performance measure is a process measure and furthermore provide strong evidence that links the performance measure to meaningful outcomes.
<i>Health Needs Screening (HCC)</i>	
Review the QIP Aim Statement (Step 2)	<ul style="list-style-type: none"> ◆ The MCE should indicate the QIP population in the QIP aim statement.
Review the Identified QIP Population (Step 3)	<ul style="list-style-type: none"> ◆ The MCE QIP aim statement should include a description of the QIP population.
Review the Selected QIP Variables and Performance Measures (Step 5)	<ul style="list-style-type: none"> ◆ The MCE should provide current clinical knowledge and/or health services research to support the selection of the performance measure.

Table 11. QIP Weaknesses (AONs) and Recommendations

	<ul style="list-style-type: none"> ◆ The MCE should address the performance measure is a process measure and furthermore should provide strong evidence that the process being measured is meaningfully associated with outcomes.
Review the Data Collection Procedures (Step 6)	<ul style="list-style-type: none"> ◆ The MCE should provide a detailed systemic method for collecting valid and reliable data that represent the QIP population.

Interventions

Table 12 presents the reported QIP interventions. The table contains direct quotes from the MCEs.

Table 12. 2022 QIP Interventions

MCE	QIP Title	Interventions
Anthem	<i>Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)</i> HIP / HHW / HCC	Conduct internal Indiana Health Information Exchange (IHIE) coding query to expand the identification of members who may be eligible for post discharge outreach for FUA.
		Deploy Community Health Workers (CHWs) to engage members recently discharged from the ED for substance use disorder or accidental overdose, as identified through IHIE query.
	<i>Health Needs Screening (HNS)</i> HIP / HHW / HCC	Expand Outbound Call Center hours to nights and weekends.
		Increase digital marketing and outreach to drive compliance with HNS completions.
CareSource	<i>Improve access to timely Prenatal and Postpartum Care through Care Management (CM) Engagement</i> HIP / HHW	Implementation of process redesign to increase pregnant member engagement in CM.
		Use of CHWs to drive community-based engagement of Black or African American pregnant members.
		Provides members access to Nurse Practitioners over interactive audio or video, who assess, diagnose and if needed, prescribe medication. It is a convenient and affordable way for members to complete a postpartum visit.
	<i>Health Needs Screening</i> HIP / HHW	Implementation of multiple modalities through a staggered approach for timely HNS completion includes telephonic outreach through the member assessment team, use of Pursuant kiosk, use of the web portal, use of mailers, and offering HNS completion through interactive texting option between days 61-90 of plan enrollment.

Table 12. 2022 QIP Interventions

MCE	QIP Title	Interventions
		Implementation of a standardized member locate strategy for new members identified as unreachable during initial telephonic attempts due to wrong, invalid, or disconnected numbers and/or exhausted attempts. A standardized approach is used to search for updated member contact information using white pages, pharmacy and encounter data, outreach to provider offices, etc. Upon locating members CareSource representatives will attempt to complete the HNS during the outreach call.
	<p data-bbox="401 662 722 821"><i>Improving outcomes for members with substance use disorder (SUD) through timely member engagement in care-case management following an ED Visit</i></p> <p data-bbox="401 829 520 857">HIP / HHW</p>	Use of dedicated CHWs to facilitate timely outreach and care-case management (CM) engagement within 28 days following ED visit for substance use disorder. CHW identifies members through IHIE daily reporting, ED claims, ED facility staff, providers, UM team and referrals. Upon reaching member, CHW assists with arranging appointments, transportation, and referrals for ongoing case management. CM referrals and engagement are analyzed monthly.
		Improve Peer Recovery Specialist (PRS) member notification and handoffs for care-case management within 28 days following a SUD related ED visit. CM referrals and engagement are analyzed monthly to ensure referrals are submitted within 28 days of the ED visit and that the PRS is identifying all eligible members and notifying care-case management. Current facilities with participating Peer Recovery Specialists include Eskenazi Health, Indiana University Health (14 campuses) and Parkview Health Systems, thus this intervention targets 16 ED facilities.
		Impact care coordination and handoffs of high-volume ED facilities through use of peer comparison reports. Peer comparison reports on FUA HEDIS measure compliance rates are used to prompt provider practice change and are shared quarterly to the top 10 high-volume ED facilities. CareSource Behavioral Health initiative Leads meet with providers, at least once per quarter, to provide education on handoffs to care management, outpatient, and treatment providers. CareSource monitors the number of members receiving care through the targeted ED facilities for FUA 7-day compliance. CareSource expects to observe a statistically significant change in FUA 7-day rates from baseline to subsequent reporting periods.
		Impact of value-based reimbursement (VBR) on two ED facilities, Eskenazi Hospital and Community Hospital East, to improve 7-day FUA rates among Black HIP members in Marion County.
<p data-bbox="205 1206 306 1234">MDwise</p>	<p data-bbox="401 1166 695 1243"><i>Follow-up after Emergency Department Visit for Drug Abuse or Dependence</i></p> <p data-bbox="401 1252 520 1279">HIP / HHW</p>	Referred Inpatient, Intensive Outpatient (IOP), Partial Hospitalization (PHP), and Residential prior authorization requests related to SUD automatically into care management (CM).
		Referring Inpatient, Intensive Outpatient (IOP), Partial Hospitalization (PHP) and Residential prior authorization requests related to SUD automatically into CM.
		CM outreaching to all members seen in the ER with a principal diagnosis of alcohol and other drug abuse/dependence to assist in securing a follow-up visit within 7 days and another visit within 30 days.
		Offering a member reward incentive for members accepting and participating in a call from CM at least twice monthly while engaged in CM.

Table 12. 2022 QIP Interventions

MCE	QIP Title	Interventions
	<i>Health Needs Screenings</i> HIP / HHW	Increase completions with telephonic outreach, welcome packets, portal, email, and text to all newly enrolled members with a valid phone number. Welcome packet sent to all newly enrolled members with a paper copy of HNS and return mailer. Community Health Workers or Community/Provider partners to Support.
MHS	<i>Follow-up After Emergency Department Visit for Drug Abuse or Dependence</i> HIP / HHW / HCC	MHS adopted the improvement strategy of Multi-Modal Outreach to Members by the MHS ED Diversion Team following an ED visit with a SUD diagnosis. The ED team makes three attempts to outreach to members identified. A referral is made to the Behavioral Health Disease management team for continued outreach. In the event MHS is unsuccessful in connecting with or engaging a member, then a letter is sent to the member to promote education and facilitate engagement in case management for SUD. A financial incentive (contingency management treatment) is also added to facilitate behavioral modification and encourage member engagement in SUD treatment through Intensive Outpatient Treatment (IOP).
	<i>Health Needs Screening</i> HIP / HHW / HCC	Utilize the MHS Care Engagement Team (CET) to outreach directly to members using the telephone and complete the HNS with member reported information. Additionally, member incentives to facilitate timely completion of the HNS. The methods selected for member engagement included: <ul style="list-style-type: none"> ◆ Telephonic outreach by CET to members to complete HNS; ◆ Email to members with a link to HNS form; ◆ Kiosks at Walmart and participating CVS stores; ◆ Paper copy in Welcome Packet; ◆ Second copy of paper HNS mailed in CET unable to connect with member; ◆ Member can send digital copy of completed HNS by email to MHS; ◆ Member can complete HNS on MHS member portal; and ◆ The member also receives an incentive for timely completion of the HNS (\$30 if completed within 0-30 days of enrollment, \$10 if completed within 31-90 days of enrollment). All members had the ability to complete the form through the paper copy in the welcome packet or through the member portal or at a kiosk in a Walmart store or a participating CVS store. Additionally, members who opted in to be contacted by email could receive a copy of the form by email and send a digital copy of the completed form by email.
UHC	<i>Follow-up After Emergency Department Visit for Drug Abuse or Dependence</i> HCC	During the Planning phase of our PDSA process, key FUA stakeholders met in various arenas and, through barrier analysis activities, determined the need for a member incentive program. This work was finalized and implemented mid-year during the baseline measurement cycle and is ongoing. Currently, due to the barriers noted above, we have not issued any gift cards at this time. The FUA workgroup is presently working toward solutions to overcome our previously identified barriers for this improvement strategy.

Table 12. 2022 QIP Interventions

MCE	QIP Title	Interventions
		To improve FUA HEDIS measure rates, the Quality Analyst developed a provider-specific educational flyer. The Quality Analyst worked with the respective departments to develop the material and it was published in the fourth quarter provider newsletter. If improvement strategy two efforts continue, we believe in long-term change. This intervention will be ongoing at an interval of one time per year. UHCCP plans to utilize data related to interim HEDIS FUA monthly rate trending as well as article publication date data to test for desired improvement.
		Internal Process Change: The policy on frequency of member outreach was modified to reflect a 24-hour expectation with a target goal of compliance 85% of the time and a stretch goal of compliance 100% of the time.
	Health Needs Screening HCC	Member Rewards Program: This member rewards intervention involves sending each member who successfully completes an HNS a 50-dollar gift card. The state goal is >60% completion rate each month, sustained across each quarter. Members are eligible during 90 days of enrollment or 90 days from clock start date if retroactively eligible.
		Strategic Outreach Campaign: UHCCP is confident that telephonic outreach is by far the most effective way to collect HNS and focus our efforts on this method of completion, as it also affords us the greatest opportunity to engage members and help them understand their benefits and coverage. It also allows us to introduce members to care coordination, Social Determinants of Health resources, and initial preventive health education in ways that digital and mail-in options cannot.

Comparison QIP Improvements

Table 13 presents a comparison between QIP validation scores in MY 2021 and MY 2022. Notable improvements from the previous measurement year are indicated using an up arrow (↑) and notable decreases in performance are indicated using a down arrow (↓).

Table 13: QIP Performance Comparison

MCE	QIP Name	MY 2021 Validation Rating	MY 2021 Overall Score	MY 2022 Validation Rating	MY 2022 Overall Score
Anthem – HIP/HHW/HCC	Follow-up After Emergency Department Visit for Drug Abuse or Dependence (FUA)	No Confidence	34.00%	No Confidence	58.33% ↑
	Health Needs Screening (HNS)	No Confidence	24.00%	Low Confidence	71.11% ↑

Table 13: QIP Performance Comparison					
MCE	QIP Name	MY 2021 Validation Rating	MY 2021 Overall Score	MY 2022 Validation Rating	MY 2022 Overall Score
CareSource – HIP/HHW	Improve access to timely Prenatal and Postpartum Care through Care Management (CM) Engagement	High Confidence	93.00%	High Confidence	100% ↑
	Improving outcomes for members with substance use disorder (SUD) through timely member engagement in care-case management following an ED Visit	Moderate Confidence	89.00%	High Confidence	100% ↑
	Health Needs Screening	High Confidence	93.00%	High Confidence	100% ↑
MDwise – HIP/HHW	Follow-up After Emergency Department Visit for Drug Abuse or Dependence	No Confidence	43.00%	No Confidence	42.22% ↓
	Health Needs Screening	No Confidence	38.00%	No Confidence	42.55% ↑
Managed Health Services – HIP/HHW/HCC	Follow-up After Emergency Department Visit for Drug Abuse or Dependence	High Confidence	98.00%	High Confidence	93.33% ↓
	Health Needs Screening	High Confidence	95%	High Confidence	100% ↑
United Healthcare – HCC	Follow-up After Emergency Department Visit for Drug Abuse or Dependence	N/A	N/A	Moderate Confidence	84.46%
	Health Needs Screening	N/A	N/A	Moderate Confidence	80.00%

Table 14 presents how the plans addressed recommendations from MY 2021 in MY 2022.

Table 14: MY 2021 Recommendations Addressed in MY 2022	
Anthem MY 2021 AON	<p>In MY 2021, Anthem submitted 12 QIPs for the HHW, HIP, and HCC programs. Upon validation by Qsource, it was determined that AONs occurred within the following steps:</p> <ul style="list-style-type: none"> ◆ Step 1: Review the Selected QIP Topic ◆ Step 2: Review the QIP Aim Statement

Table 14: MY 2021 Recommendations Addressed in MY 2022

	<ul style="list-style-type: none"> ◆ Step 3: Review the identified QIP Population ◆ Step 5: Review the Selected QIP Variables and Performance Measures ◆ Step 6: Review the Data Collection Procedures ◆ Step 7: Review the Data Analysis and Interpretation of QIP Results ◆ Step 8: Assess the Improvement Strategies ◆ Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred <p>Qsource’s recommendations included:</p> <ol style="list-style-type: none"> 1. The MCE should indicate the type of sampling used to ensure valid and reliable information. 2. The MCE should define their data collection procedures to ensure that the data used to measure performance is valid and reliable. 3. The MCE should create a data collection plan that includes: <ul style="list-style-type: none"> ◆ data to be collected; ◆ data sources; ◆ how and when the data are to be collected; ◆ who will collect the data; and ◆ instruments used to collect the data. 4. The MCE needs to conduct statistical analysis, and present for baseline and each remeasurement period. 5. The MCE could use the CMS guidance for clarification and understanding of each element related to the study.
<p>Results from MY 2022 Validation</p>	<p>In MY 2022, Anthem improved the combined average QIP score for the FUA and HNS QIPs from 29.00% in MY 2021 to 64.72% in MY 2022. However, Anthem’s QIPs continued to lack vital data-related information that compromised the QIP results and the validity of the studies. The majority of Qsource’s recommendations from 2021 were not followed. Qsource engaged with Anthem in CY2022 for additional training and technical assistance with OMPP participating and offering feedback. Qsource discussed each of the recommendations and how Anthem needed to address.</p>
<p>CareSource MY 2021 AON</p>	<p>In MY 2021, CareSource submitted 6 QIPs for the HHW and HIP programs. Upon validation by Qsource, it was determined that AONs occurred within the following steps:</p> <ul style="list-style-type: none"> ◆ Step 1: Review the Selected QIP Topic ◆ Step 5: Review the Selected QIP Variables and Performance Measures ◆ Step 6: Review the Data Collection Procedures ◆ Step 7: Review the Data Analysis and Interpretation of QIP Results ◆ Step 8: Assess the Improvement Strategies <p>Qsource’s recommendations included:</p> <ol style="list-style-type: none"> 1. The MCE should include an estimated degree of data completeness for all administrative data collection. 2. The MCE should conduct cause and barrier analyses more frequently and incorporate quality improvement science such as Plan-Do-Study-Act (PDSA) cycles into its improvement strategies and action plans. The data and results of specific PDSA cycles should be included in the QIP documentation. 3. The MCE should identify barriers through quantitative data analysis. Data to support identified barriers should be documented in the QIP Summary Form.

Table 14: MY 2021 Recommendations Addressed in MY 2022

	<ol style="list-style-type: none"> 4. The MCE should address how the performance measure impacts enrollee health or functional status. 5. The MCE should track and show a direct correlation between efforts and benefits is the best way to sustain quality improvement.
<p>Results from MY 2022 Validation</p>	<p>In MY 2022, CareSource improved the combined average QIP score for the FUA and HNS QIPs from 91.00% in MY 2021 to an average of 100% in MY 2022. The PPC QIP also garnered a validation score of 100%. The recommendations from Qsource in MY 2021 were followed.</p>
<p>MDwise MY 2021 AON</p>	<p>In MY 2021, MDwise submitted 5 QIPs for the HHW and HIP programs. Upon validation by Qsource, it was determined that AONs occurred within the following steps:</p> <ul style="list-style-type: none"> ◆ Step 1: Review the Selected QIP Topic ◆ Step 2: Review the QIP Aim Statement ◆ Step 3: Review the identified QIP Population ◆ Step 5: Review the Selected QIP Variables and Performance Measures ◆ Step 6: Review the Data Collection Procedures ◆ Step 7: Review the Data Analysis and Interpretation of QIP Results ◆ Step 8: Assess the Improvement Strategies ◆ Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred <p>Qsource’s recommendations included:</p> <ol style="list-style-type: none"> 1. The MCE should review the QIP Summary Form instructions as a guide for reporting applicable elements included in the protocol. 2. The MCE should indicate whether the QIP is clinical or nonclinical. 3. The MCE should refer to CMS protocol guidance and review examples of an appropriately formatted QIP aim statement. 4. The MCE should ensure that baseline and remeasurement year data represent two consecutive years (example: 2020 & 2021). 5. The MCE should define their data collection procedures to ensure that the data used to measure performance is valid and reliable. 6. The MCE should create a data collection plan that includes: <ul style="list-style-type: none"> ◆ the data elements to be collected; ◆ the data sources; ◆ how and when the data are to be collected; ◆ who will collect the data; and ◆ instruments used to collect the data. 7. The MCE should review quality improvement methods that are significant to QIP execution such as rapid-cycle improvement, PDSA, barrier analysis, and the development of a data analysis plan. 8. The MCE should conduct statistical analysis, and present for baseline and each remeasurement period.
<p>Results from MY 2022 Validation</p>	<p>In MY 2022, MDwise improved the combined average QIP score for the FUA and HNS QIPs from 40.50% in MY 2021 to 42.39% in MY 2022. However, MDwise’s QIPs continued to lack vital information that compromised QIP results and the overall validity of the studies. The majority of Qsource’s recommendations from 2021 were not followed.</p>

Table 14: MY 2021 Recommendations Addressed in MY 2022

<p>MHS MY 2021 AON</p>	<p>In MY 2021, MHS submitted 6 QIPs for the HHW, HIP, and HCC programs. Upon validation by Qsource, it was determined that AONs occurred within the following steps:</p> <ul style="list-style-type: none"> ◆ Step 2: Review the QIP Aim Statement ◆ Step 5. Review the Selected QIP Variables and Performance Measures <p>Qsource’s recommendations included:</p> <ol style="list-style-type: none"> 1. The MCE should review the QIP Summary Form instructions as a guide for reporting applicable elements included in the protocol. 2. The MCE should conduct cause and barrier analyses more frequently and incorporate quality improvement science, such as PDSA cycles, into its improvement strategies and action plans. The data and results of specific PDSA cycles should be included in the QIP documentation. 3. The MCE should identify barriers through quantitative data analysis. Data to support identified barriers should be documented in the QIP Summary Form. 4. The MCE should track and show a direct correlation between efforts and benefits is the best way to sustain quality improvement.
<p>Results from MY 2022 Validation</p>	<p>In MY 2022, MHS slightly improved the combined average QIP score for the FUA and HNS QIPs from 96.50% in MY 2021 to 96.67% in MY 2022. The recommendations from MY 2021 were followed.</p>
<p>UHC</p>	<p>N/A. The MCE did not participate in Quality Improvement Projects during MY 2021.</p>

Conclusions and Recommendations

Anthem

Anthem received an overall validation status of Not Met for the six submitted QIPs for 2022. Anthem’s two OMPP-selected Quality Improvement Project topics, Follow-up within 7 days After Emergency Department Visit for Drug Abuse or Dependence (FUA) and Health Needs Screening (HNS) were conducted consistently across all three programs.

Each of Anthem’s QIP Summary Forms contained varying degrees of missing or incomplete information that could be improved by acknowledging each element according to the QIP

Summary Form Instructions. A detailed data analysis and statistical testing were among the missing details for both QIP topics; therefore, the reported improvement could not be proven valid. The missing performance measure data, lack of statistical analysis, and absence of quality improvement process documentation compromised QIP results and the validity of both studies. The MCE should refer to CMS guidance for clarification and to increase understanding of the protocol requirements.

The FUA QIP topic addresses quality and access to care delivered to members with a principal diagnosis of alcohol or

other drug abuse or dependence (AOD) treated in ED given that high rates of ED use by this population can indicate barriers to quality and access to care. The FUA topic incorporates timeliness of care by assessing timely follow-up visits completed within the target population. The HNS topic addresses the timeliness of completing new member assessments, promotes access to care by early identification of enrollee health needs, and improves quality by using HNS assessments to support care coordination.

The validation status and scores for each submitted QIP indicated that Anthem could address the suggestions noted by Qsource to aid in increasing quality of care, timeliness of care and access to care for enrollees.

The following recommendations should be incorporated into Anthem's HIP, HHW and HCC QIP activities:

1. The MCE should create and document a data analysis plan that includes:
 - ◆ Statistical testing (i.e., Chi-Square, t-test, Fisher's Exact test) performed and presented in a concise manner;
 - ◆ Comparison of performance measures year-over-year consecutively across all programs to which the QIP applies; and
 - ◆ Data displays (i.e., run chart or graph) to effectively demonstrate QIP performance measure tracking.
2. The MCE should incorporate quality improvement processes and provide documentation to demonstrate utilization (i.e.,

Fishbone Diagram, Root-Cause Analysis, PDSA, Adopt/Adapt/Abandon).

3. The MCE should review protocol requirements and ensure that each applicable element is appropriately applied and documented.

CareSource

CareSource demonstrated a sound study design for their six QIPs and created the foundation for CareSource to continue implementing improvement strategies and achieving real, sustained study outcomes. Each of the QIPs scored 100%, attaining Met status and high confidence for validation status.

CareSource appropriately conducted and selected the sampling and data collection activities. These activities ensured that CareSource properly defined and collected the necessary data to produce accurate performance measure rates. CareSource demonstrated sound study designs for its QIPs and achieved real and sustained improvement for the QIPs. In general, the MCE utilized appropriate methodology across all the QIPs, which factored into improvements evidenced from CY2022.

The FUA QIP topic addresses quality and access to care delivered to members with a principal diagnosis of AOD treated in the ED given that high rates of ED use by this population can indicate barriers to quality and access to care. The FUA topic incorporates timeliness of care by assessing timely follow-up visits completed within the target population. The HNS topic addresses the timeliness of completing new member assessments, promotes access to care by early identification of

enrollee health needs, and improves quality by using HNS assessments to support care coordination. The Postpartum Care topic addresses the timeliness and access of prenatal and postpartum care delivered to pregnant and postpartum women.

The validation status and scores for each submitted QIP indicate that CareSource suitably designed their QIPs to aid in increasing quality of care, timeliness of care, and access to care for enrollees.

The following recommendations should be incorporated into CareSource's HIP and HHW QIP activities:

1. The MCE should conduct root cause and barrier analyses frequently throughout the QIP performance year and incorporate quality improvement processes, such as PDSA cycles, into improvement strategy development and follow-up action plans.
2. The MCE should identify internal and external barriers for the QIP through data analyses. Quantitative data to support all identified factors should be documented in the QIP Summary Form.
3. The MCE should track and present a direct correlation between QIP efforts and results; this is the best practice to appropriately demonstrate sustained quality improvement.

MDwise

MDwise's two OMPP-selected Quality Improvement Projects, Follow-up within 7 days After Emergency Department Visit for Drug Abuse or Dependence (FUA-7) and Health Needs Screening both received an overall validation status of Not Met. Although a measured performance rate improvement was noted, each of the QIP Summary Forms contained varying degrees of

missing or incomplete information that could be improved by the MCE acknowledging each element according to the QIP Summary Form Instructions. Data elements, data collection plan, an analysis of results, and statistical testing were among the missing details for both QIPs; therefore, the reported improvement could not be proven valid. The omission of benchmarks, goals, and absence of quality improvement process documentation compromised QIP results and the validity of both studies. The MCE should refer to CMS guidance for clarification and to increase understanding of the protocol requirements.

The FUA QIP topic addresses quality and access to care delivered to members with a principal diagnosis of AOD treated in the ED given that high rates of ED use by this population can indicate barriers to quality and access to care. The FUA topic incorporates timeliness of care by assessing timely follow-up visits completed within the target population. The HNS topic addresses the timeliness of completing new member assessments, promotes access to care by early identification of enrollee health needs, and improves quality by using HNS assessments to support care coordination.

The scores for each submitted QIP indicated that MDwise could address the suggestions noted by Qsource to aid in increasing quality of care, timeliness of care and access to care for enrollees.

The following recommendations should be incorporated into MDwise's HIP and HHW QIP activities:

1. The MCE should create and document a data collection and analysis plan that includes:
 - ◆ The data elements collected to produce performance measures;
 - ◆ The process used to collect, analyze, and compare QIP performance;
 - ◆ Statistical testing (i.e., Chi-Square, t-test, Fisher’s Exact test) performed and presented in a concise manner;
 - ◆ Comparison of performance measures year-over-year consecutively across all programs to which the QIP applies; and
 - ◆ Data displays (i.e., run chart or graph) to effectively demonstrate QIP performance measure tracking.
2. The MCE should incorporate quality improvement processes and provide documentation to demonstrate utilization (i.e., Fishbone Diagram, Root-Cause Analysis, PDSA, Adopt/Adapt/Abandon).
3. The MCE should review protocol requirements and ensure that each applicable element is appropriately applied to the QIP and documented.

MHS

Managed Health Services’ two OMPP-selected Quality Improvement Projects, FUA-7 and HNS, both received an overall validation status of Met. Each QIP reflected the MCE’s comprehensive understanding of the protocol requirements and effective documentation practices. A detailed data analyses, run charts, statistical test results, health services research, and data assurance processes were among the strengths noted for both QIPs. The FUA QIP from MHS lacked overall clarity in comparison to their HNS QIP submission. The MCE should

refer to OMPP guidance regarding the retirement of the HNS QIP as it has completed seven QIP cycles (as of MY6/CY2022).

The FUA QIP topic addresses quality and access to care delivered to members with a principal diagnosis of AOD treated in the ED given that high rates of ED use by this population can indicate barriers to quality and access to care. The FUA topic incorporates timeliness of care by assessing timely follow-up visits completed within the target population. The HNS topic addresses the timeliness of completing new member assessments, promotes access to care by early identification of enrollee health needs, and improves quality by using HNS assessments to support care coordination.

The validation status and scores for each submitted QIP indicate that MHS suitably designed their QIPs to aid in increasing quality of care, timeliness of care, and access to care for enrollees, but should address the suggestions noted by Qsource to improve the clarity of their quality improvement projects.

The following recommendations should be incorporated into MHS’s HIP, HHW and HCC QIP activities:

1. The MCE should address how performance measures are based on strong evidence that the process (for process measures) being measured is meaningfully associated with outcomes.
 - ◆ Process measures indicate what a provider does to maintain or improve health, either for healthy people or for those diagnosed with a health care condition.

- ◆ Outcome measures reflect the impact of the healthcare service or intervention on the health status of patients.
- 2. The MCE should include assessments for real improvement that indicate whether sustained improvement is demonstrated through repeated measurements over time.
- 3. The MCE should track performance measures consistently across all programs and submit clear and consistent documentation that analyzes the results for each performance measure across all programs independently.

UHC

United Healthcare's two OMPP-selected Quality Improvement Projects, FUA-7 and HNS both received an overall validation status of Met, which indicated confidence that QIP activities were performed appropriately. Each of the QIP Summary Forms contained minor degrees of incomplete information that could be improved by acknowledging each element according to the QIP Summary Form Instructions. Comprehensive population descriptions and a data analysis plan were among the missing details for both QIPs. Overall, the MCE performed and reported QIP activity well and should continue to refer to CMS guidance for clarification and to increase understanding of the protocol requirements.

The FUA QIP topic addresses quality and access to care delivered to members with a principal diagnosis of AOD treated

in the ED given that high rates of ED use by this population can indicate barriers to quality and access to care. The FUA topic incorporates timeliness of care by assessing timely follow-up visits completed within the target population. The HNS topic addresses the timeliness of completing new member assessments, promotes access to care by early identification of enrollee health needs, and improves quality by using HNS assessments to support care coordination.

The validation status and scores for each submitted QIP indicate that UHC suitably designed their QIPs to aid in increasing quality of care, timeliness of care and access of care for enrollees, but should address the suggestions noted by Qsource to improve the clarity of their quality improvement projects.

The following recommendations should be incorporated into United Healthcare's Hoosier Care Connect QIP activities:

1. The MCE should create and document a systematic approach to data collection (i.e., data collection plan) that demonstrates assurances that valid and reliable data are collected.
2. The MCE should provide evidence of Health Services Research as indicated by protocol requirements.
3. The MCE should review QIP Summary Form Guidance and CMS protocol requirements to ensure that each applicable element is appropriately applied and demonstrated.

Performance Measure Validation (PMV)

Overview

The Balanced Budget Act of 1997 established certain managed care quality safeguards that were further described by Title 42 of the Code of Federal Regulations, Section 438.320 (42 CFR § 438.320), which defines “external quality review” as the “analysis and evaluation ... of aggregated information on quality, timeliness, and access to health care services.” To satisfy CMS Protocols for the MCEs and to meet the requirements set forth in 42 CFR § 438.330(c), OMPP selected a process for an objective, comparative review of performance measures related to quality-of-care outcomes. The primary aims of PMV are to evaluate the accuracy of MCE-reported measures and to determine whether those measures were calculated according to required technical specifications, which enables OMPP to monitor performance at a point in time, track performance over time, and compare performance among MCEs.

The PMV included validation of performance measures for the MCEs providing care services for enrollees. The measurement year for this validation was January 1, 2022, through December 31, 2022 (MY 2022).

The 2023 PMV, which validates performance measures for MY 2022, was conducted virtually. The validation activities for these measures were conducted as outlined in *Centers for Medicare & Medicaid Services’ EQR Protocol 2: Validation of Performance*

Measures (October 2019). Per the protocol, the MCEs should complete an Information Systems Capabilities Assessment Tool (ISCAT) that the EQRO uses to validate information systems, processes, and data. Protocol guidance indicates that the EQRO may review results from a recent comprehensive, independent assessment of the MCE’s information systems, such as the HEDIS Compliance Audit, conducted in the previous two years provided that the HEDIS measures were calculated using National Committee for Quality Assurance HEDIS-certified software and all non-HEDIS rates were included under the scope of the HEDIS audit.

This report includes findings from the MCE’s ISCAT that the EQRO used to validate information systems, processes, data, and MCE-reported results from the 0511 Translation and Interpretation Services Report.

MCE and IHCP Information

Qsource validated Grievance and Appeals – Substance Use Disorder (SUD) performance measures calculated and reported by each MCE, which manage the following Indiana Health Coverage Programs: Healthy Indiana Plan, Hoosier Healthwise, and Hoosier Care Connect. Information about the IHCPs appears in [Table 15](#).

Table 15. IHCP Information	
Anthem	
IHCP Name	Healthy Indiana Plan / Hoosier Healthwise / Hoosier Care Connect
IHCP Location	Conducted Virtually
Review Date	September 20, 2023
CareSource	
IHCP Name	Healthy Indiana Plan / Hoosier Healthwise
IHCP Location	Conducted Virtually
Review Date	September 12, 2023
MDwise	
IHCP Name	Healthy Indiana Plan/Hoosier Healthwise
IHCP Location	Conducted Virtually
Review Date	September 13, 2023
MHS	
IHCP Name	Healthy Indiana Plan / Hoosier Healthwise / Hoosier Care Connect
IHCP Location	Conducted Virtually
Review Date	September 18, 2023
UHC	
IHCP Name	Hoosier Care Connect
IHCP Location	Conducted Virtually
Review Date	September 14, 2023

Description of Performance Measures Data Obtained for Validation

Qsource validated the set of two performance measures identified by OMPP which are listed in **Table 16**. Qsource accepted the MCE’s data submissions from OMPP for each reported measure. The data consisted of MCE-reported totals for each quarter.

Table 16. MCE Performance Measures		
Measure Name	Measure Steward	Domain of Care
Total Substance Use Disorder (SUD) Grievance Calendar Year (CY) 2022	OMPP	Quality and Access to Care
Total SUD Expedited and Non-Expedited Appeals CY 2022	OMPP	Quality and Access to Care

Technical Methods of Data Assessment

Pre-Review Strategy

Qsource defined the scope of the validation to include the OMPP required metrics. This validation included data source, reporting frequency, and format of those measures.

Qsource obtained the list of performance measures selected by OMPP for validation and requested each MCE’s Information Systems Capabilities Assessments (ISCAs), a required part of other mandatory EQR protocols. ISCAs help ensure that each MCE maintains a health information system that can accurately and completely collect, analyze, integrate, and report data on

member and provider characteristics, and on services furnished to members.

Methods of Data Collection and Analysis

Qsource followed CMS’s EQR *Protocol 2*, which identifies key data sources that should be reviewed as part of the validation process:

- ◆ **Information Systems Capability Assessment (ISCA)**—Completed ISCA’s received from the MCE’s were reviewed to ensure all sections were complete and all attachments were available.
- ◆ **Source Code (Programming Language) for Performance Measures**—The validation team completed review and observation of program logic flow to ensure compliance with measure technical specifications. Areas of deviation were identified to evaluate the impact of the deviation on the measure and assess the degree of bias (if any).
- ◆ **Performance Measure Reports**—Qsource reviewed calculated rates for the current measurement period.
- ◆ **Supporting Documentation**—Qsource reviewed additional information to complete the validation process, including, but not limited to, policies and procedures (P&Ps), file layouts, system flow diagrams, system log files, and data collection process descriptions. Issues or areas needing clarification were flagged for follow-up.

Review Activities

The MCE’s virtual reviews occurred in September 2023. Qsource conducted interviews with key staff involved in the production of performance measures using questions tailored to the MCE’s processes for producing performance measures based on findings from the ISCAT. Qsource observed a live

demonstration of the data systems and key processes required for performance measure calculation. Qsource assessed the MCE’s ability to link data from multiple sources and the extent to which they have created processes to ensure the accuracy of the calculated performance measures. A data file review was conducted as well as a review of all systems contributing to the performance measure calculations, including:

- ◆ **Claims and Encounter System Review**—The validation team reviewed information systems focusing on the processing of claims and encounter data.
- ◆ **Enrollment Systems Review**—The validation team reviewed information systems focusing on enrollment data and processing.
- ◆ **Data Integration and Primary Source Review**— The validation team discussed source code logic and reviewed the process for integrating all data sources to produce the analytic file for reporting of selected measures.

Data Integration, Data Control, and Performance Measure Documentation

Table 17 presents the validation findings across all four MCE’s and three IHCP’s.

Table 17. Data Integration, Data Control, and Performance Measure Documentation			
Measure	Healthy Indiana Plan	Hoosier Healthwise	Hoosier Care Connect
Data Integration	Acceptable	Acceptable	Acceptable
Data Control	Acceptable	Acceptable	Acceptable

Table 17. Data Integration, Data Control, and Performance Measure Documentation

Measure	Healthy Indiana Plan	Hoosier Healthwise	Hoosier Care Connect
Performance Measure Documentation	Acceptable	Acceptable	Acceptable

Data Integration

Accurate data integration is essential to calculating valid performance measures. The steps used to combine various data sources, and other administrative data must be carefully controlled and validated. Qsource validated the data integration process used by the MCEs, which included a review of file consolidations or extracts, comparison of source data to

warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms.

Data Control

The organizational infrastructure of an MCE must support all necessary information systems. Qsource validated the data control processes used by each IHCP, which included a review of disaster recovery procedures, data backup protocols, and related P&Ps.

Performance Measure Documentation

Sufficient, complete documentation is necessary to support validation activities. Qsource reviewed all related documentation, which included the completed Roadmap, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of performance measure calculations, and other related documentation.

Performance Measure Specific Findings

Based on all validation activities, Qsource determined validation results for each performance measure for each IHCP. **Table 18** displays the key review results. Actual reported measure rates are included in [Appendix A](#).

Table 18. Key Performance Measure Review Results

Measure	Key Review Findings and Recommendations
Anthem (HIP / HHW / HCC)	
Total SUD Grievance CY 2022	Met all specifications for the measure.
Total SUD Expedited and Non-Expedited Appeals CY 2022	Met all specifications for the measure.
CareSource (HIP / HHW)	
Total SUD Grievance CY 2022	Met all specifications for the measure.
Total SUD Expedited and Non-Expedited Appeals CY 2022	Met all specifications for the measure.

Table 18. Key Performance Measure Review Results	
Measure	Key Review Findings and Recommendations
MDwise (HIP / HHW)	
Total SUD Grievance CY 2022	Met all specifications for the measure.
Total SUD Expedited and Non-Expedited Appeals CY 2022	Met all specifications for the measure.
MHS (HIP / HHW / HCC)	
Total SUD Grievance CY 2022	Met all specifications for the measure.
Total SUD Expedited and Non-Expedited Appeals CY 2022	Met all specifications for the measure.
UHC (HCC)	
Total SUD Grievance CY 2022	Met all specifications for the measure.
Total SUD Expedited and Non-Expedited Appeals CY 2022	Met all specifications for the measure.

Strengths, Weaknesses, and Improvements

Strengths and Weaknesses

No strengths or weaknesses were noted among MCEs, as each were independently deemed as fully compliant with all NCQA-defined Information System Standards for HEDIS-applied data and processes. Qsource did not identify any areas for improvement related to any of the MCE’s processes for data collection and performance measure reporting during the 2022 CY PMV protocol, as with the 2021 CY PMV activities.

Improvements

As no weaknesses were identified for the MCEs in the 2021 CY PMV, there are no improvements to report for 2022 CY.

Conclusions

Anthem

The IS capabilities assessment from 2022, corresponding documentation, and the virtual interview conducted with Anthem staff, found that Anthem fully met requirements. This indicates that its systems have the capability to provide quality and timely care. Qsource validated data integration, data control processes and ensured performance measure documentation was complete and sufficient to support validation activities. Anthem uses NCQA-certified software for measure production ensuring reconciliation and monitoring for accurate data reporting. These results indicated an overall high confidence in Anthem’s ability to provide quality and timely care for its enrollees.

CareSource

The IS capabilities assessment found that CareSource fully met requirements, indicating that its systems have the capability to provide quality and timely care. Qsource validated data integration, data control processes, and ensured performance measure documentation was complete and sufficient to support validation activities. CareSource's claims encounter data system, TriZetto Facets, had edit criteria in place to ensure accurate claims processing. Throughout the various phases of the enrollment file receipt process, reports were generated for validation and edit purposes; an audit trail was provided. CareAnalyzer, an NCQA-certified software program, was used for measure production ensuring reconciliation and monitoring for accurate data reporting. These results indicated an overall high confidence in CareSource's ability to provide quality and timely care for its enrollees.

MDwise

The IS capabilities assessment found that MDwise fully met requirements, indicating that its systems have the capability to provide quality and timely care. Qsource validated data integration, data control processes and ensured performance measure documentation was complete and sufficient to support validation activities. These results indicated an overall high confidence in MDwise's ability to provide quality and timely care for its enrollees.

MHS

The IS capabilities assessment found that MHS fully met requirements, indicating that its systems have the capability to provide quality and timely care. Qsource validated data integration, data control processes and ensured performance measure documentation was complete and sufficient to support validation activities. MHS's claims encounter data system had criteria in place to ensure accurate claims processing. Throughout the various phases of the enrollment file receipt process, reports were generated for validation and edit purposes and an audit trail was provided. These results indicated an overall high confidence in MHS's ability to provide quality and timely care for its enrollees.

UHC

The IS capabilities assessment found that UHC fully met requirements, indicating that its systems have the capability to provide quality and timely care. Qsource validated data integration, data control processes and ensured performance measure documentation was complete and sufficient to support validation activities. UHC's claims encounter data system had edit criteria in place to ensure accurate claims processing. Throughout the various phases of the enrollment file receipt process, reports were generated for validation and edit purposes and an audit trail was provided. These results indicated an overall high confidence in UHC's ability to provide quality and timely care for its enrollees.

Annual Network Adequacy (ANA) Overview

As the external quality review organization (EQRO) for the Indiana Family & Social Services Administration (FSSA) Office of Medicaid Policy & Planning (OMPP), Qsource is required by the Balanced Budget Act of 1997 to assess each managed care entity's (MCE's) "strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries," according to Title 42 of the Code of Federal Regulations (CFR), Part 438.364 (a)(3) (42 CFR § 438.364). One activity included in the external quality review (EQR) contract with OMPP is to complete an annual review of the adequacy of each MCE's provider network. This activity is conducted by Myers & Stauffer Limited Liability Company (MSLC), Qsource's subcontractor, at the direction of OMPP.

This report presents the results of the Annual Network Adequacy (ANA) review. It describes the review methodologies, the findings for each task, and MSLC's recommendations for improvement.

Qsource evaluated each MCE to determine if it had an adequate provider network to ensure the effective and efficient delivery of healthcare to enrollees, pursuant to 42 CFR § 438.68. Geographic network adequacy analysis was conducted to assess the network adequacy of each MCE.

Methodology

The 2023 ANA review was conducted based upon a specific point in time, October 1, 2022, and measured member access to psychiatrists and OB/GYN providers. Myers and Stauffer analyzed the following:

- ◆ Percentage of enrollees who live within 60 miles of 2 psychiatrists;
- ◆ Percentage of female enrollees who live within 30 miles of 1 OB/GYN provider (obstetrician/gynecologist, certified midwife, and obstetric nurse practitioner);
- ◆ Percentage of female enrollees who live within 60 miles of 2 OB/GYN providers (obstetrician/gynecologist, certified midwife, and obstetric nurse practitioner);
- ◆ Psychiatrist accessibility by geography;
- ◆ Ratio of providers to enrollees;
- ◆ Accuracy of ANA reports to the state; and
- ◆ Completeness of provider directories issued to plan members.

Standards

The ANA review measures whether members have a provider within a reasonable distance from their residence. The 2023 ANA review of CY 2022 focused on member access to two provider categories: psychiatrists and OB/GYNs. The contractual requirement for the accessibility standard for psychiatrists is 2 providers within 60 miles of each health plan enrollee. The contractual requirement for the accessibility

standard for 1 OB/GYN provider within 30 miles and 2 providers within 60 miles of each female Anthem health plan enrollee.

Source Data

Postal addresses of providers' service locations and enrollees' residences were necessary to measure adherence to provider network accessibility standards. Other provider data necessary for the analysis were provider type, provider specialty, and providers' patient restrictions, if any, regarding age or gender. Accordingly, each enrollee's gender and date of birth were also required for the analysis.

Qsource requested and received from the MCEs a roster of the psychiatrists and OB/GYN providers and members under the MCE's purview for the following programs, when applicable:

- ◆ Healthy Indiana Plan (HIP)
- ◆ Hoosier Healthwise (HHW)
- ◆ Hoosier Care Connect (HCC)

In addition to including the detailed data outlined above, Qsource's written request to the MCEs specified the listings should include only members and providers who were eligible on October 1, 2022. The written request also specified that the provider listings should include a separate record for each location at which the individual practitioner was eligible to perform services for the plan on that date. Additionally, the written request specified the IHCP provider types and specialties that qualify as providers.

All MCEs were requested to submit copies of the annual reports regarding provider networks submitted to the State as of the assessment time period (October 2022), specifically *Report 0902 (Count of Providers)* and *Report 0903 (Member Access to Providers)*.

Additionally, all MCEs were asked to submit copies of the provider directories issued to the MCE members as of the assessment time period (October 2022).

Information provided by the MCEs was assumed to be complete and accurate unless otherwise noted in [Appendix B](#).

Analysis

ArcGIS mapping software was used to assign standardized addresses and geocodes to postal addresses submitted by the MCEs, and to calculate the driving distance from the members' residence to the closest provider, factoring in any patient restrictions reported for providers. Results were validated and further analyzed in Structured Query Language (SQL) in a Microsoft SQL Server database. Duplicative and invalid data records were excluded from the analysis. A summary of these exclusions is found in [Appendix B](#). Results were summarized by county and program to identify potential issues. Underserved members were measured by count and by percentage of members impacted within analysis groupings.

All analyses were conducted based on a specified point in time, October 1, 2022. Results were based on the assumption that all

variables utilized in the analyses were consistent across the entire period being reviewed.

Findings are presented in Summary Form, with highlights regarding areas of concern and a summary of strengths, suggestions for improvement, and Areas of Noncompliance (AONs).

Technical Methods Utilized for Data Collection, Validation, and Analysis

MCEs are contractually obligated to ensure all members have access to a provider within a reasonable driving distance of the member's residence. The tables in this section measure the MCE's network accessibility by program and provider network category.

Table 19 measures the percentage of MCE members who have sufficient access to PMP and OB/GYN providers.

Table 19. Percentage of Members Having Sufficient Access to Providers						
	Provider Network Category	Geographic Accessibility Standard	HHW	HIP	HCC	All Programs
Anthem	Psychiatrist	1 within 30 miles	100%	100%	100%	100%
	OB/GYN	1 within 30 miles	99.9%	99.9%	99.9%	99.9%
		2 within 60 miles	100%	100%	100%	100%
CareSource	Psychiatrist	1 within 30 miles	100%	100%		100%
	OB/GYN	1 within 30 miles	100%	100%		100%
		2 within 60 miles	100%	100%		100%
MDwise	Psychiatrist	1 within 30 miles	100%	100%		100%
	OB/GYN	1 within 30 miles	100%	100%		100%
		2 within 60 miles	100%	100%		100%
MHS	Psychiatrist	1 within 30 miles	100.0%	100.0%	100.0%	100.0%
	OB/GYN	1 within 30 miles	99.9%	99.9%	99.8%	99.9%
		2 within 60 miles	100.0%	100.0%	100.0%	100.0%

Table 19. Percentage of Members Having Sufficient Access to Providers

Provider Network Category		Geographic Accessibility Standard	HHW	HIP	HCC	All Programs
UHC	Psychiatrist	1 within 30 miles			100.0%	100.0%
	OB/GYN	1 within 30 miles			99.6%	99.6%
		2 within 60 miles			100.0%	100.0%

100% of Anthem enrollees had sufficient access to psychiatrist providers, and 100% of female Anthem enrollees had access to OB/GYN providers for all programs using the accessibility standard of 2 providers within 60 miles. For the accessibility standard of 1 OB/GYN within 30 miles, all 3 programs scored 99.9%.

100% of CareSource enrollees had sufficient access to psychiatrists, and 100% of female CareSource enrollees had access to OB/GYN providers in both accessibility standards.

100% of MDwise enrollees had sufficient access to psychiatrists, and 100% of female MDwise enrollees had access to OB/GYN providers in both accessibility standards.

100% of MHS enrollees had sufficient access to psychiatrist providers, and 100% of female MHS enrollees had sufficient access to OB/GYN providers for the accessibility standard of 2 providers within 60 miles. For the accessibility standard of 1 practitioner within 30 miles, the percentage of female MHS enrollees who had sufficient access was 99.9% for HHW, 99.9% for HIP, and 99.8% for HCC.

100% of UHC enrollees had sufficient access to psychiatrist providers, and 100% of female enrollees had sufficient access to OB/GYN providers for the accessibility standard of 2 providers within 60 miles. 99.6% of female enrollees had sufficient access to OB/GYN providers for the accessibility standard of 1 provider within 30 miles.

Provider Network Adequacy by Geography

The figures in this section graphically depict each MCE's member population by provider network category (psychiatrist or OB/GYN), IHCP program (HHW, HCC, and HIP), and county, along with the number of available provider service locations available by county. Provider service locations are calculated as each unique combination of provider and address.

These figures depict providers with physical addresses in the state of Indiana. Providers with out-of-state addresses can also be utilized to satisfy network adequacy requirements. All participating or in-network providers were included in the accessibility analysis, including out-of-state providers within contractual distances.

Anthem Psychiatrist Network
Anthem HHW

Figure 1. HHW – Enrollee Population

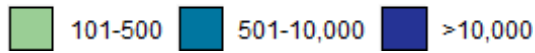
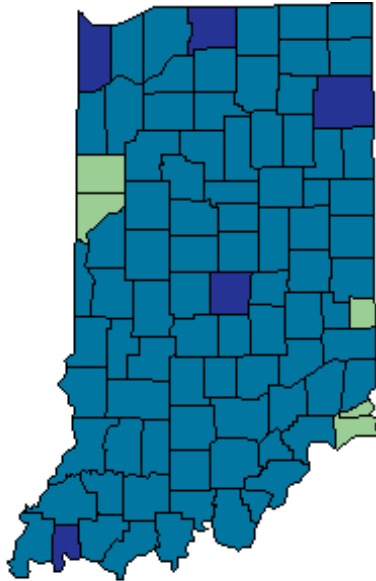
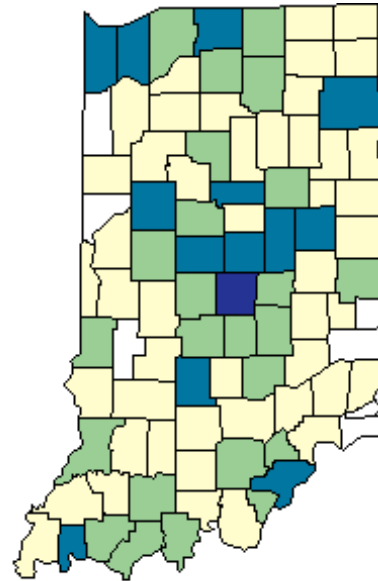


Figure 2. HHW – Psychiatrist Locations



Anthem HIP

Figure 3. HIP – Enrollee Population

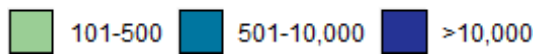
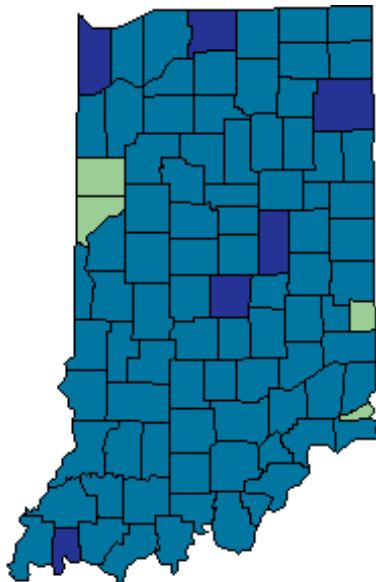
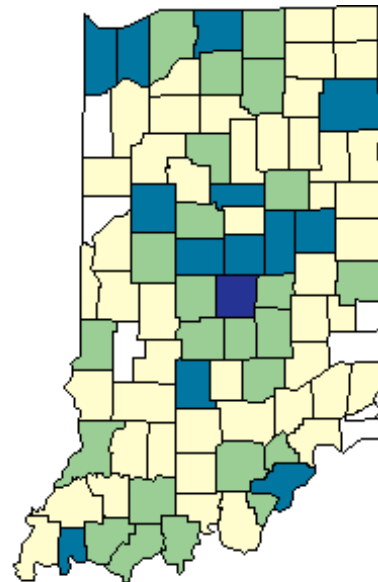


Figure 4. HIP – Psychiatrist Locations



Anthem HCC

Figure 5. HCC – Enrollee Population

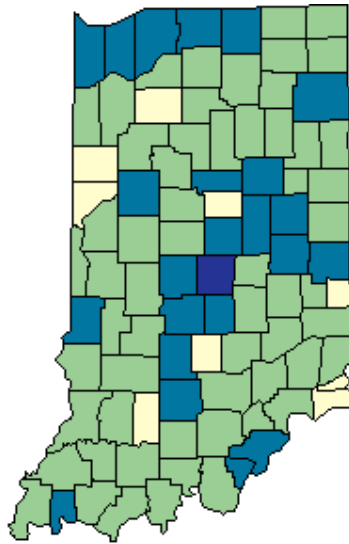
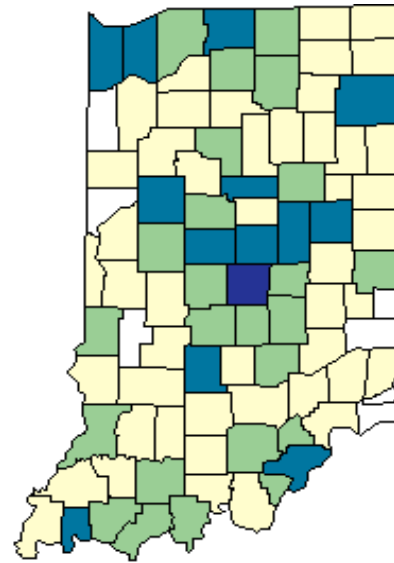


Figure 6. HCC – Psychiatrist Locations



Anthem OB/GYN Network
Anthem HHW

Figure 7. HHW – Female Population

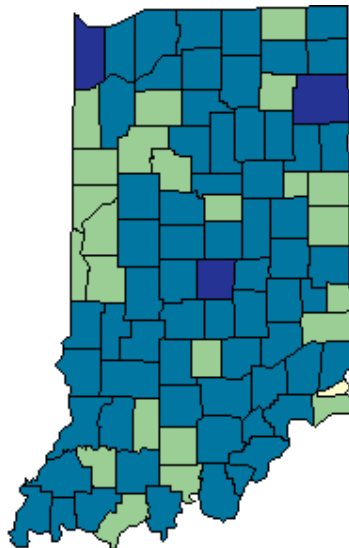
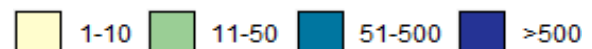
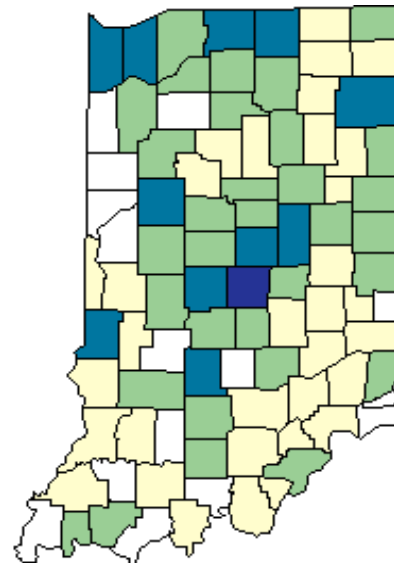


Figure 8. HHW – OB/GYN Locations



Anthem HIP

Figure 9. HIP – Female Population

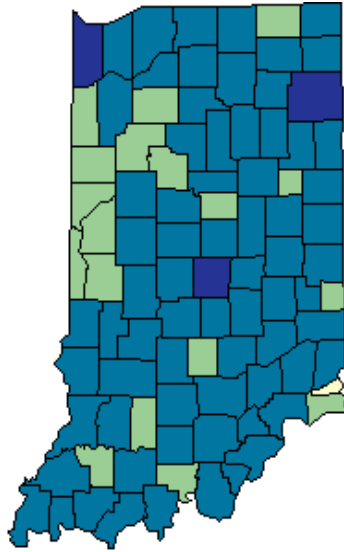
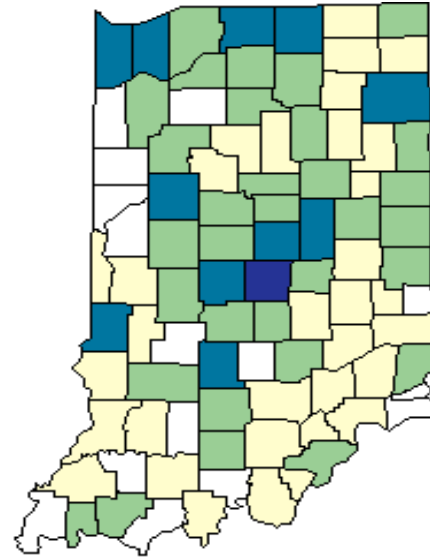


Figure 10. HIP – OB/GYN Locations



Anthem HCC

Figure 11. HCC – Female Population

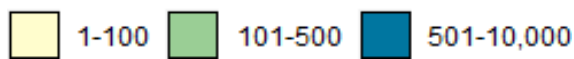
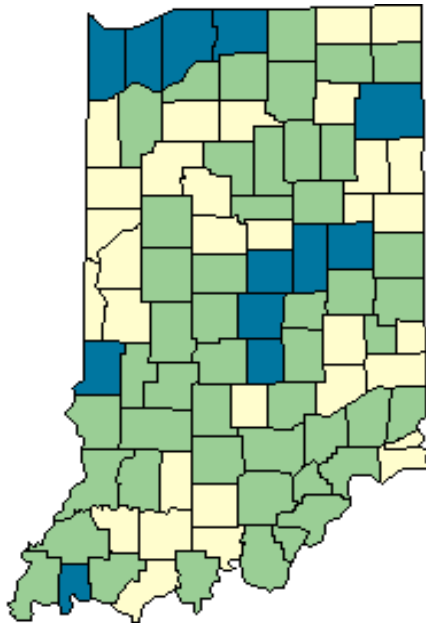
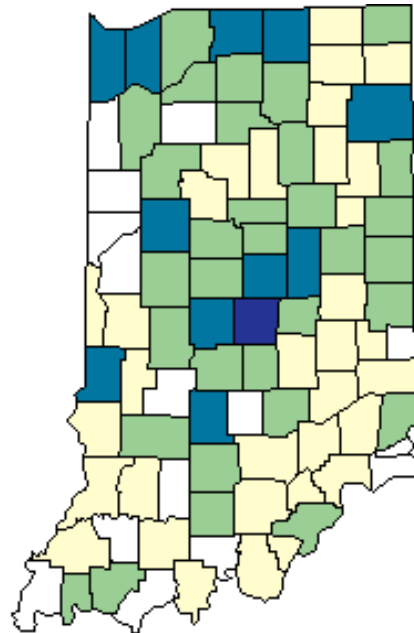


Figure 12. HCC – OB/GYN Locations



CareSource Psychiatrist Network

CareSource HHW

Figure 13. HHW – Enrollee Population

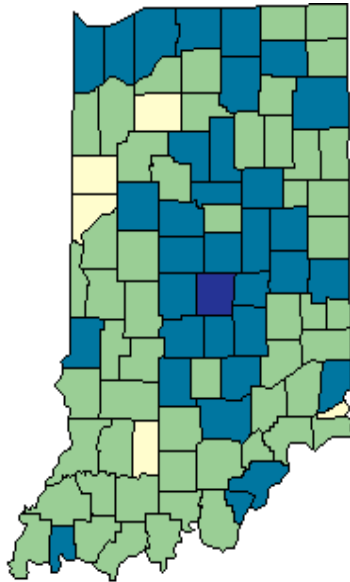
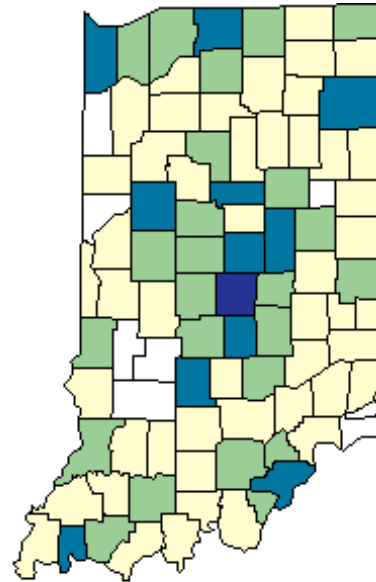


Figure 14. HHW – Psychiatrist Locations



CareSource HIP

Figure 15. HIP – Enrollee Population

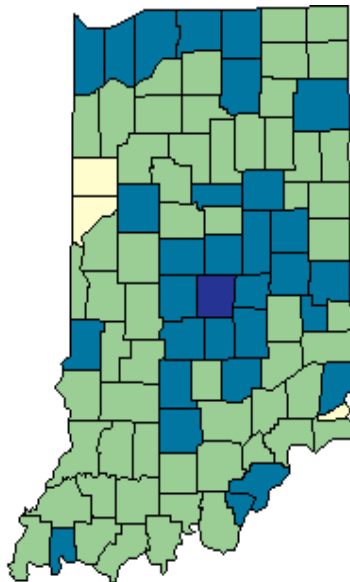
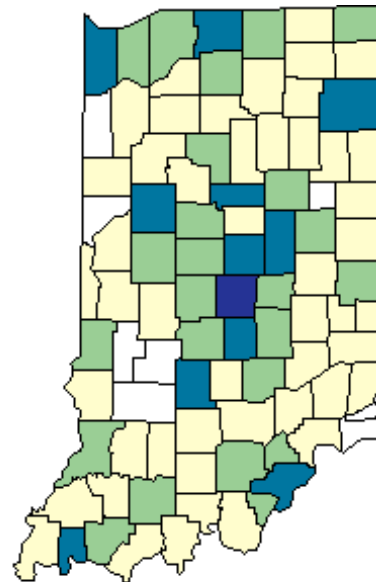


Figure 16. HIP – Psychiatrist Locations



CareSource OB/GYN Network

CareSource HHW

Figure 17. HHW – Female Population

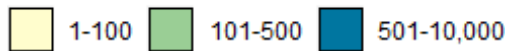
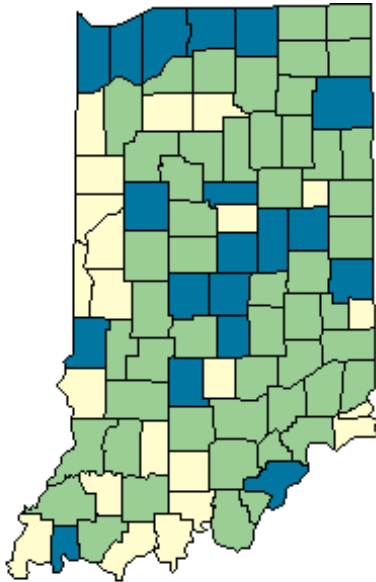
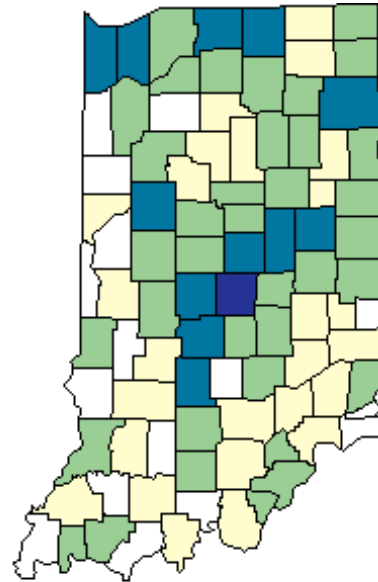


Figure 18. HHW – OB/GYN Locations



CareSource HIP

Figure 19. HIP – Female Population

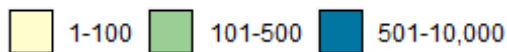
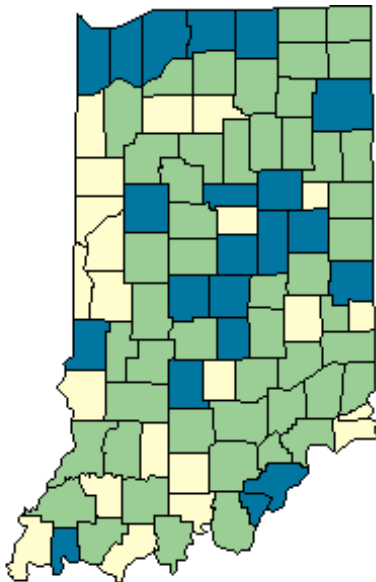
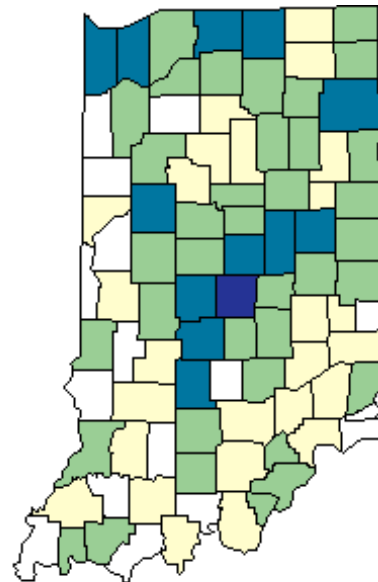


Figure 20. HIP – OB/GYN Locations



MDwise Psychiatrist Network

MDwise HHW

Figure 21. HHW – Enrollee Population

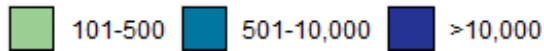
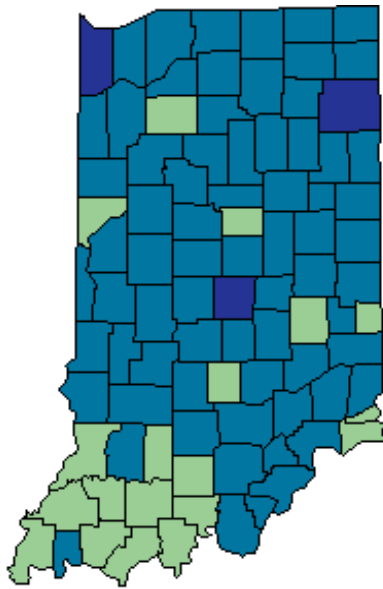
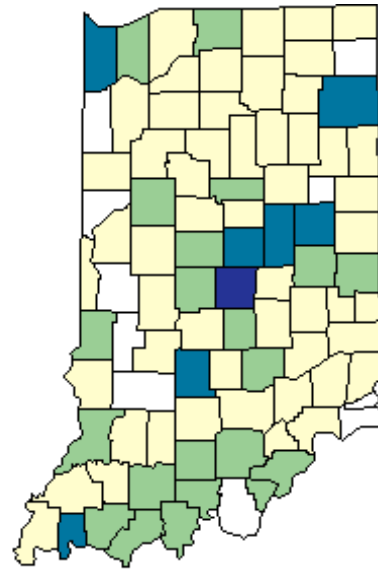


Figure 22. HHW – Psychiatrist Locations



MDwise HIP

Figure 23. HIP – Enrollee Population

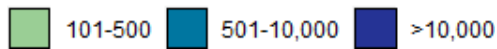
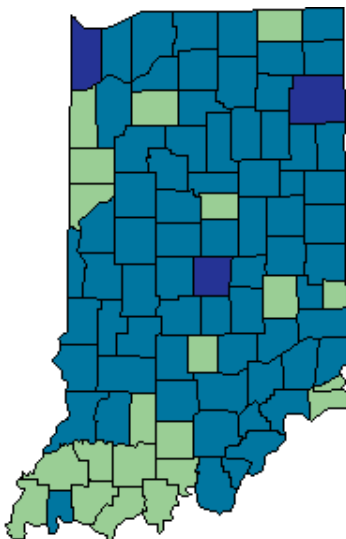
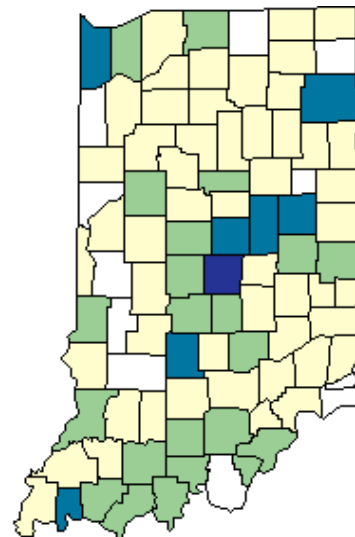


Figure 24. HIP – PMP Service Locations



MDwise OB/GYN Network

MDwise HHW

Figure 25. HHW – Female Population

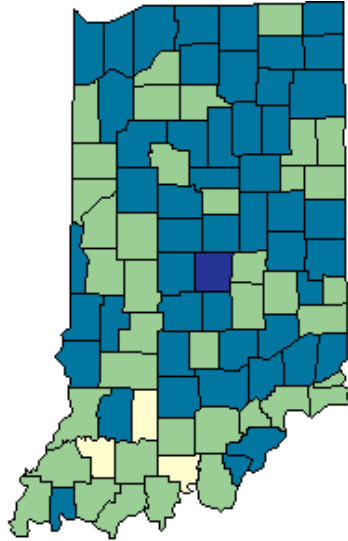
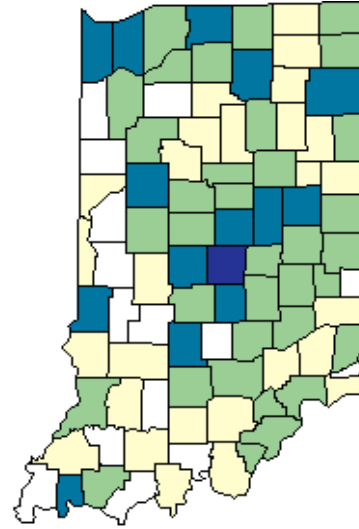


Figure 26. HHW – OB/GYN Locations



MDwise HIP

Figure 27. HIP – Female Population

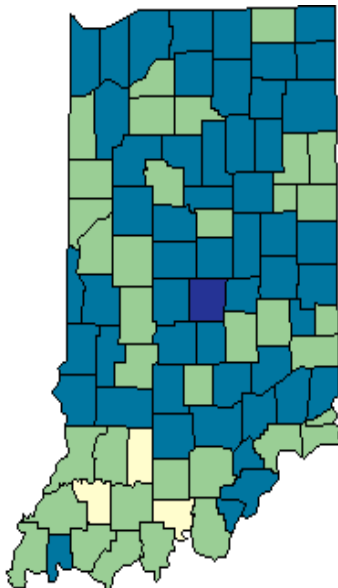
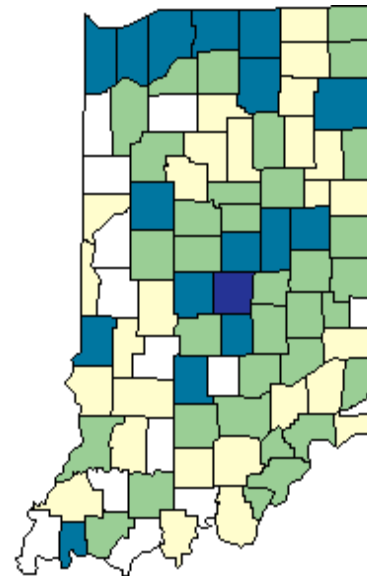


Figure 28. HIP – OB/GYN Locations



MHS Psychiatrist Network

MHS HHW

Figure 29. HHW – Enrollee Population

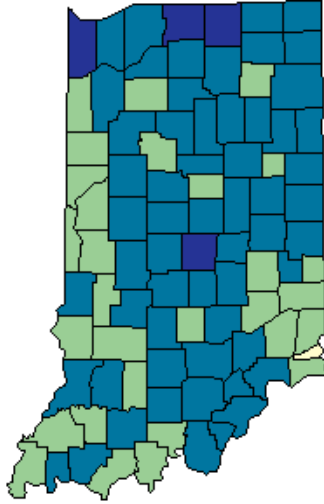
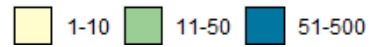
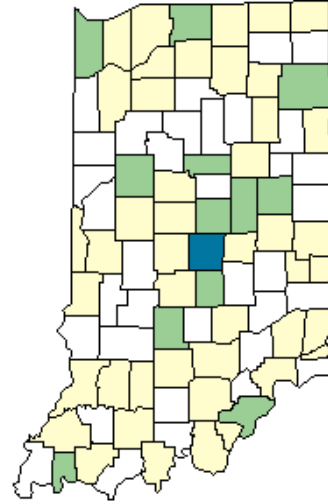


Figure 30. HHW – Psychiatrist Locations



MHS HIP

Figure 31. HIP – Enrollee Population

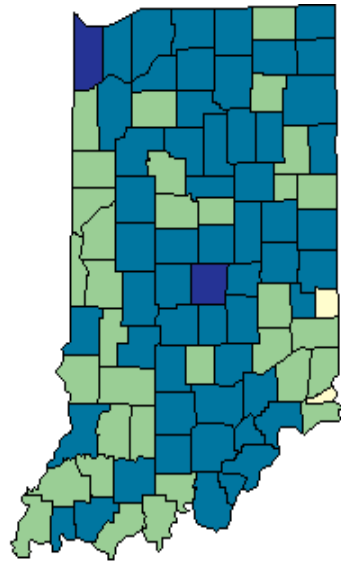
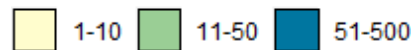
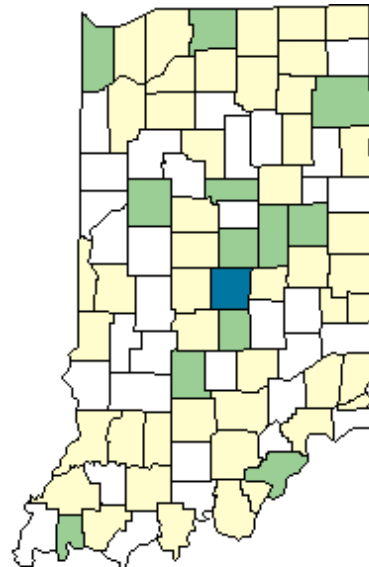


Figure 32. HIP – Psychiatrist Locations



MHS HCC

Figure 33. HCC – Enrollee Population

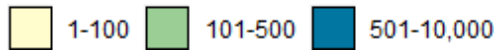
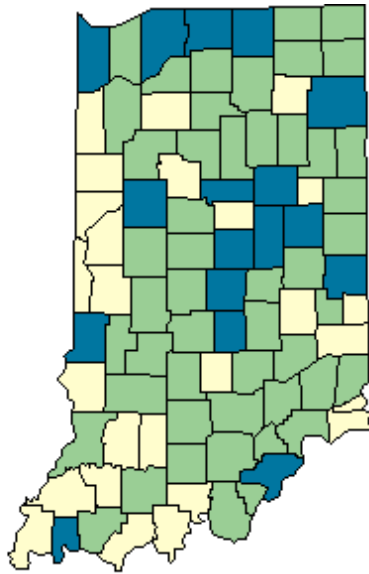
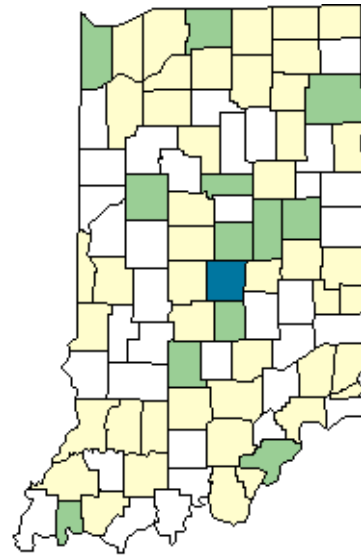


Figure 34. HCC – Psychiatrist Locations



MHS OB/GYN Network

MHS HHW

Figure 35. HHW – Female Population

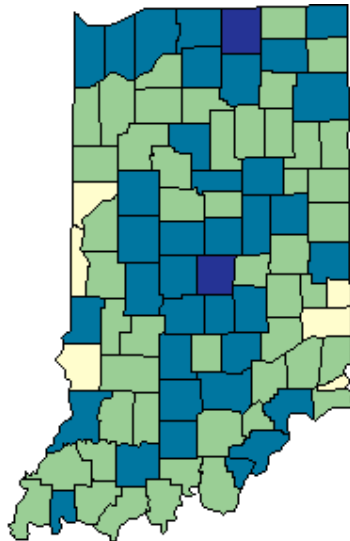
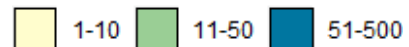
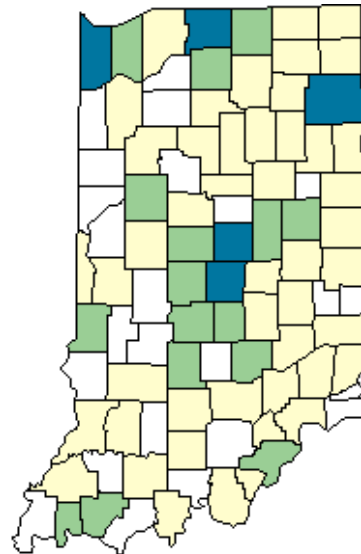


Figure 36. HHW – OB/GYN Locations



MHS HIP

Figure 37. HIP – Female Population

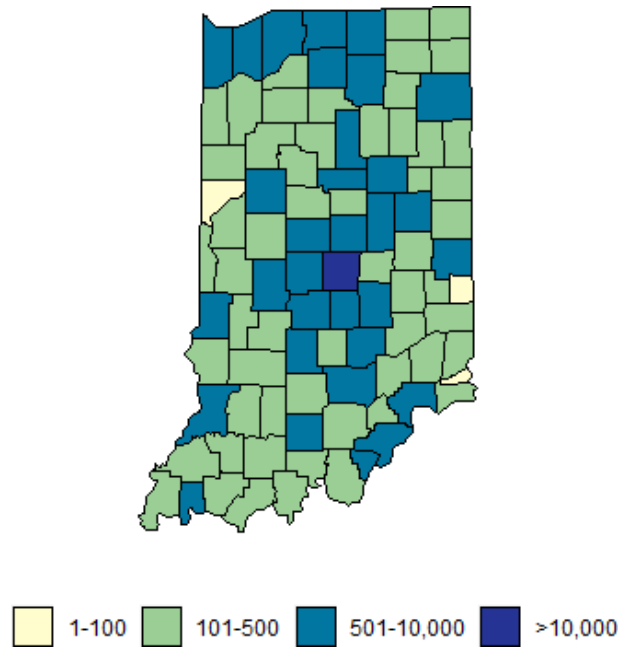
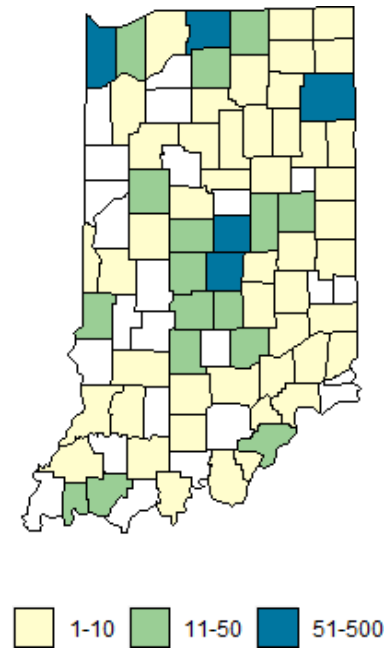


Figure 38. HIP – OB/GYN Locations



MHS HCC

Figure 39. HCC – Female Population

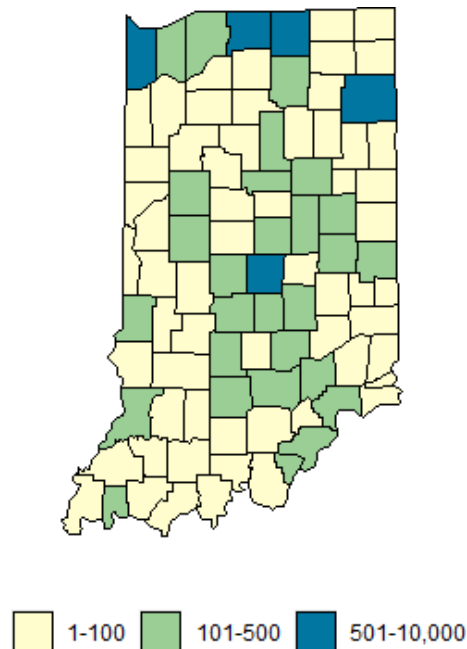
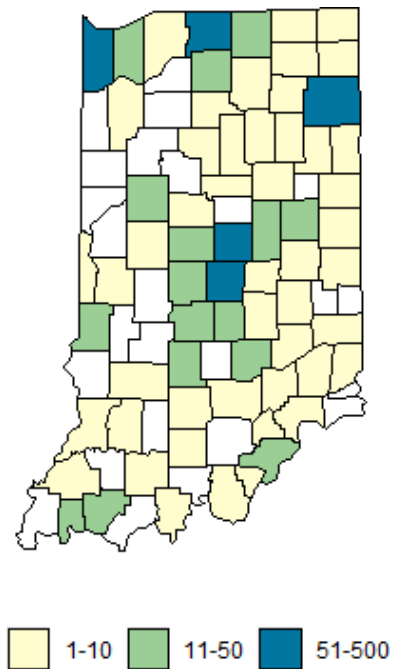


Figure 40. HCC – OB/GYN Locations



UHC Psychiatrist Network

UHC HCC

Figure 41. HCC – Enrollee Population

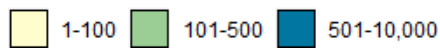
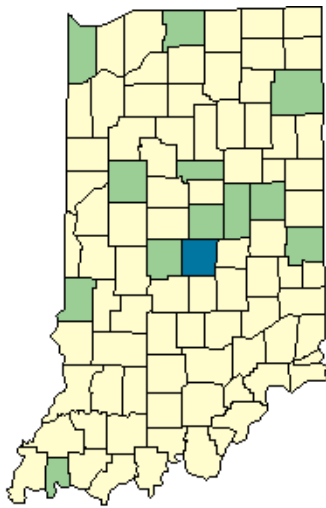
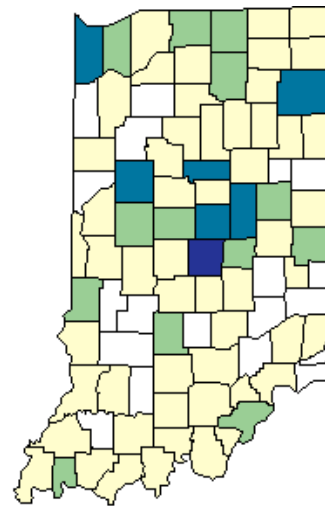


Figure 42. HCC – Psychiatrist Locations



UHC OB/GYN Network

UHC HCC

Figure 43. HCC – Female Population

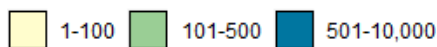
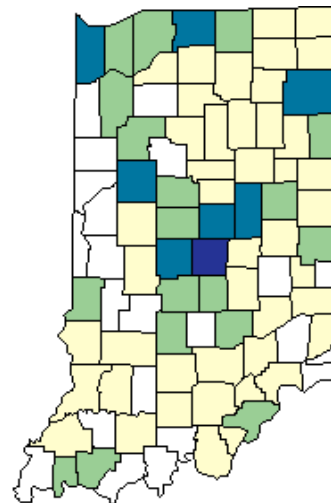


Figure 44. HCC – OB/GYN Locations



Assessment of Annual Reports 0902 and 0903 Issued to the State

The MCE's annual *Report 0902 (Count of Providers)* was compared to the state, comparing provider counts per county to the provider rosters the MCE submitted for analysis (see [Appendix B](#), "Geographic Considerations Regarding the Calculation of Provider-to-Member Ratios.")

Table 20. Count of Providers – Verification of Report 0902

MCE	Program	Psychiatrists			OB/GYN Providers		
		MCE Report 0902	MSLC Calculated	Over (Under) Reported	MCE Report 0902	MSLC Calculated	Over (Under) Reported
Anthem	HHW	663	575	88	1,070	936	134
	HIP	648	574	74	1,066	930	136
	HCC	663	573	90	1,071	936	135
CareSource	HHW	602	592	10	1,078	1,022	56
	HIP	568	564	4	1,058	1,015	43
	HCC						
MDwise	HHW	959	510	449	1,918	1,083	835
	HIP	968	510	458	1,951	1,093	858
	HCC						
MHS	HHW	409	400	9	811	806	5
	HIP	406	394	12	812	808	4
	HCC	401	391	10	783	775	8
UHC	HHW						
	HIP						
	HCC	516	465	51	780	758	22

Counts of providers were higher in Anthem's *Report 0902* than those calculated from Anthem's submitted provider rosters for both psychiatrists and OB/GYNs.

Counts of providers tended to be higher in CareSource's *Report 0902* than those calculated from CareSource's submitted provider rosters.

Counts of providers were significantly higher in MDwise *Report 0902* than those calculated from MDwise's submitted provider rosters. The counties of Marion, Hamilton, and Spencer appeared to have the highest overreporting of psychiatrist and OB/GYN providers.

Counts of providers tended to be slightly higher in MHS' *Report 0902* than those calculated from MHS' submitted provider rosters.

Counts of providers tended to be somewhat higher in UHC's *Report 0902* than those calculated from UHC's submitted provider rosters.

The MCE's *Report 0903 (Member Access to Providers)* was compared to the state's counts of members lacking sufficient access to providers by county to the results of provider network assessments ([Appendix B](#)).

Table 21. Member Access to Providers – Verification of Report 0903

MCE	Program	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
		MCE Report 0903	MSLC Calculated	Over (Under)	MCE Report 0903	MSLC Calculated	Over (Under)	MCE Report 0903	MSLC Calculated	Over (Under)
Anthem	HHW	334,015	334,605	(590)	-	-	-	-	-	-
	HIP	362,097	368,276	(6,179)	-	-	-	-	-	-
	HCC	59,880	59,927	(47)	-	-	-	-	-	-
CareSource	HHW	79,589	79,742	(153)	-	-	-	-	-	-
	HIP	76,467	76,838	(371)	-	-	-	-	-	-
	HCC									
MDwise	HHW	238,091	237,423	668	-	-	-	-	-	-
	HIP	174,324	174,826	(502)	-	-	-	-	-	-

Table 21. Member Access to Providers – Verification of Report 0903

MCE	Program	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
		MCE Report 0903	MSLC Calculated	Over (Under)	MCE Report 0903	MSLC Calculated	Over (Under)	MCE Report 0903	MSLC Calculated	Over (Under)
	HCC									
MHS	HHW	409	400	9	811	806	5	409	400	9
	HIP	406	394	12	812	808	4	406	394	12
	HCC	401	391	10	783	775	8	401	391	10
UHC	HHW									
	HIP									
	HCC	516	465	51	780	758	22	516	465	51

Anthem's *Report 0903 (Member Access to Providers)* was compared to the state's counts of members lacking sufficient access to providers by county and to the results of provider network assessments. There were no differences noted in the counts of members who lacked sufficient access to psychiatrists or OB/GYNs. It was noted that the number of enrollees reported on *Report 0903* were somewhat lower than those calculated using Anthem's submitted provider rosters, particularly for the HIP program.

CareSource's *Report 0903* showed no noted differences in access to either psychiatrists or OB/GYN providers in both programs.

MDwise's *Report 0903* showed no noted differences in access to either psychiatrists or OB/GYN providers in both programs.

MHS' *Report 0903* showed no noted differences in access to either psychiatrists or OB/GYN providers in both programs.

UHC's *Report 0903* showed no noted differences in access to either psychiatrists or OB/GYN providers in both programs.

Assessment of Provider Directories Issued to Members

Each MCE submitted for the assessment a provider directory in Portable Document Format (PDF) format that was issued for either program (HHW, HCC and HIP). The "Restrictions" section of each provider indicated programs accepted.

Two methods were employed to conduct the assessment for each MCE. A limited manual sampling was conducted, followed by an automated address search of all enrolled psychiatrists and OB/GYN providers.

Anthem submitted six provider directories in PDF format, one for each region (Northwest, Northeast, West Central, Central, Southwest, and Southeast). Providers for all three programs (HHW, HIP, and HCC) are listed in all six provider directories.

A random sample of 100 providers was selected from Anthem's submitted roster of psychiatrists and OB/GYN providers. These providers were then searched in the provider directory submitted by Anthem; 85% were found in the directory.

Figure 45. Manual Sampling Results – Anthem

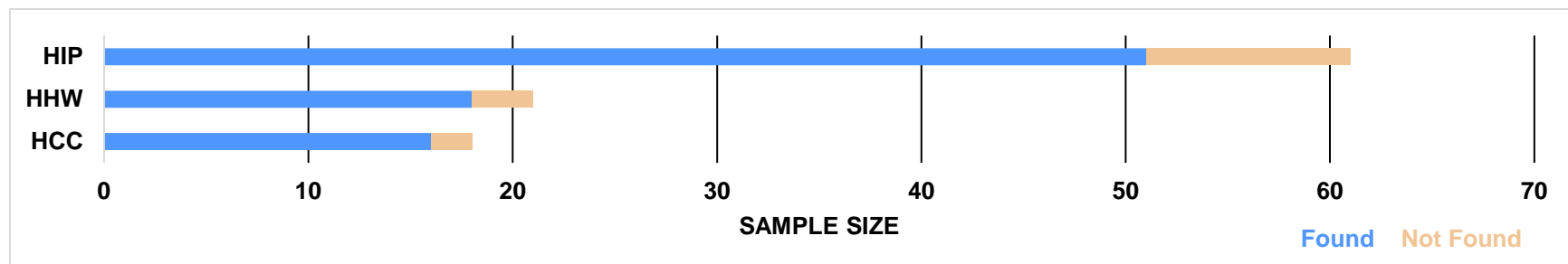
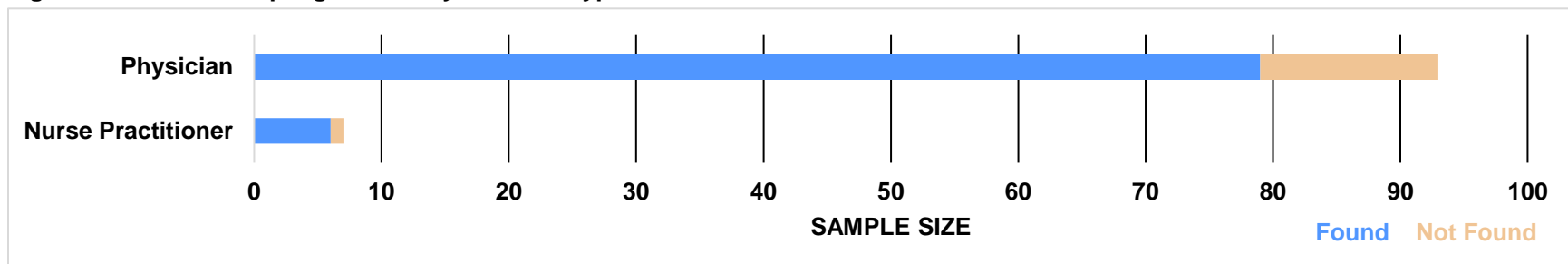


Figure 46. Manual Sampling Results by Provider Type – Anthem



A systematic method was performed to assess the accuracy of the service location addresses of enrolled providers within the enrollees' provider directory as of October 1, 2022. The addresses appearing in the psychiatrist and OB/GYN portions of the provider directory were extracted and geocoded, resulting in a list of standardized address coordinates. These coordinates were compared to the existing

provider address coordinates used in our geographic accessibility analysis. Using this method, Qsource found 71.2% of enrolled psychiatrist addresses and 70.5% of enrolled OB/GYN addresses in the enrollees' provider directories.

Figure 47. Systematic Search of Psychiatrist Service Locations

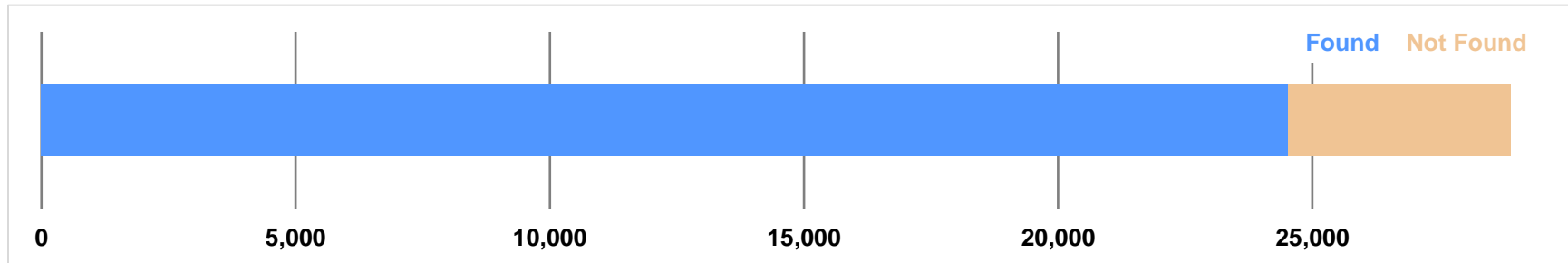
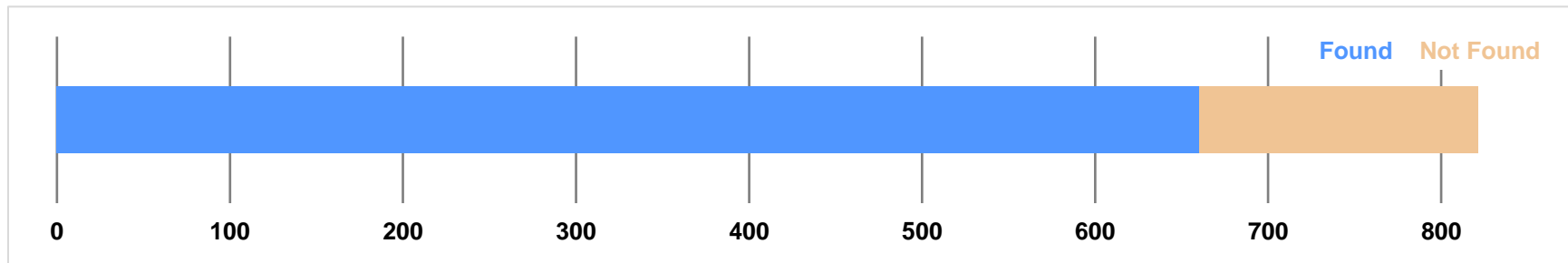


Figure 48. Systematic Search of OB/GYN Service Locations



CareSource submitted for the assessment a single provider directory in PDF format that was issued for either program (HHW and HIP). The “Restrictions” section of each provider indicated programs accepted.

A random sample of 100 providers was selected from CareSource’s submitted roster of psychiatrists and OB/GYN providers. These providers were then looked up in the provider directory submitted by CareSource, and 10% of the 100 sampled providers were found in the directory. CareSource submitted a directory that appears to be one which would be sent to a specific enrollee. As a result, this directory did not contain a complete listing of CareSource HHW and HIP providers in Indiana.

Figure 49. Random Sampling Results – CareSource

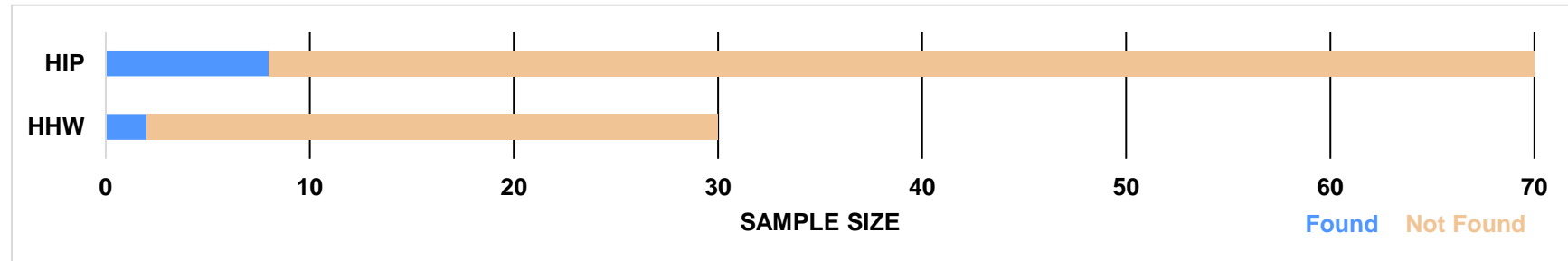
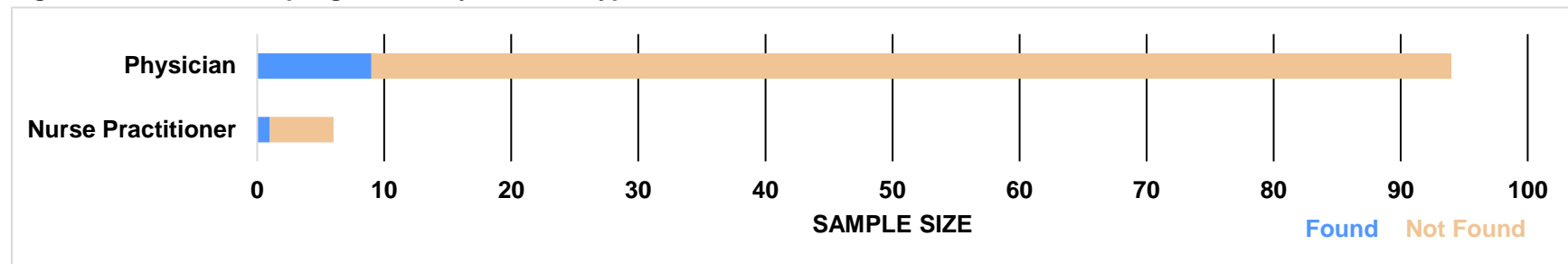
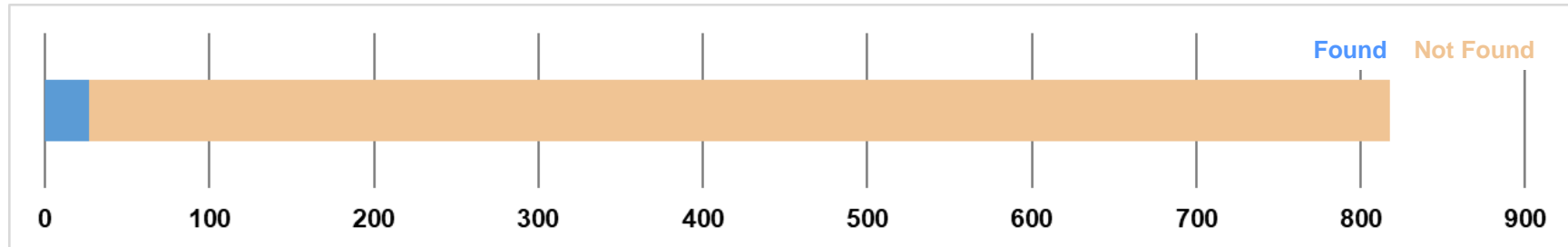
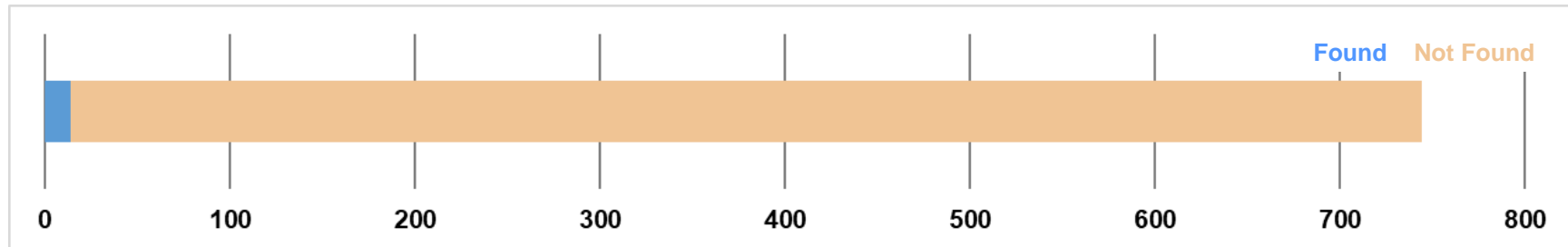


Figure 50. Random Sampling Results by Provider Type – CareSource



A systematic method was performed to assess the accuracy of the service location addresses of enrolled providers within the enrollees' provider directory as of October 1, 2022. The addresses appearing in the psychiatrist and OB/GYN provider sections of the provider directory were extracted and geocoded, resulting in a list of standardized address coordinates. These coordinates were compared to the existing provider address coordinates used in our geographic accessibility analysis. Using this method, Qsource found 3.3% of enrolled OB/GYN provider addresses and 1.9% of enrolled psychiatrist addresses in the enrollees' provider directory.

Figure 51. Systematic Search of OB/GYN Service Locations – CareSource**Figure 52. Systematic Search of Psychiatrist Service Locations – CareSource**

For this assessment, MDwise submitted two provider directories in PDF format that were issued for either program (HHW or HIP). The “Restrictions” section of each provider generally indicated the programs accepted.

A random sample of 100 providers was selected from MDwise’s submitted roster of psychiatrist and OB/GYN providers. These providers were then searched in the provider directory submitted by MDwise; 51% were found in the directory.

Figure 53. Random Sampling Results by Program – MDwise

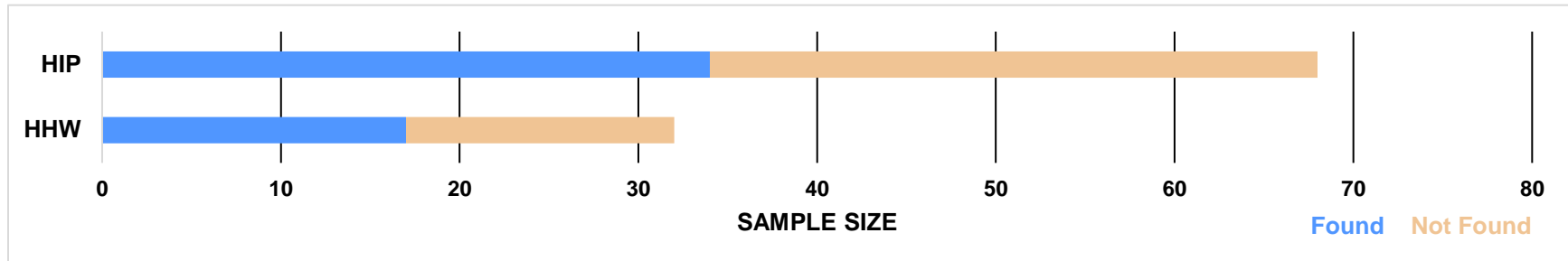
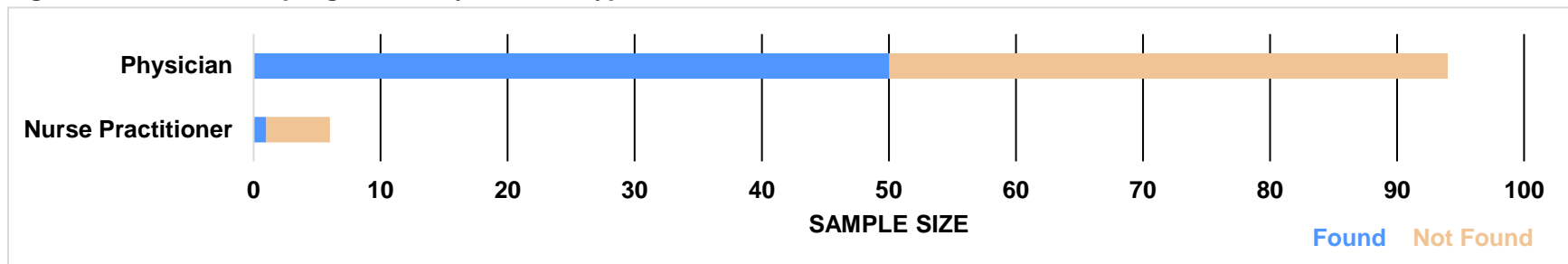


Figure 54. Random Sampling Results by Provider Type – MDwise



For this assessment, MHS submitted three provider directories in PDF for the assessment: one for psychiatrists, and two for OB/GYN providers.

A random sample of 100 providers was selected from MHS' submitted roster of psychiatrists and OB/GYN providers. These providers were then looked up in the provider directory submitted by MHS, and 3% of the 100 providers were found in the directory.

Figure 55. Random Sampling Results by Program – MDwise

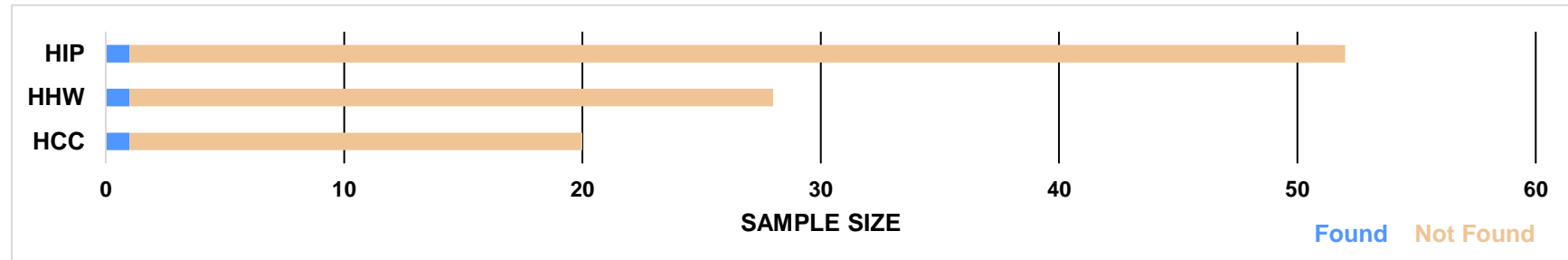
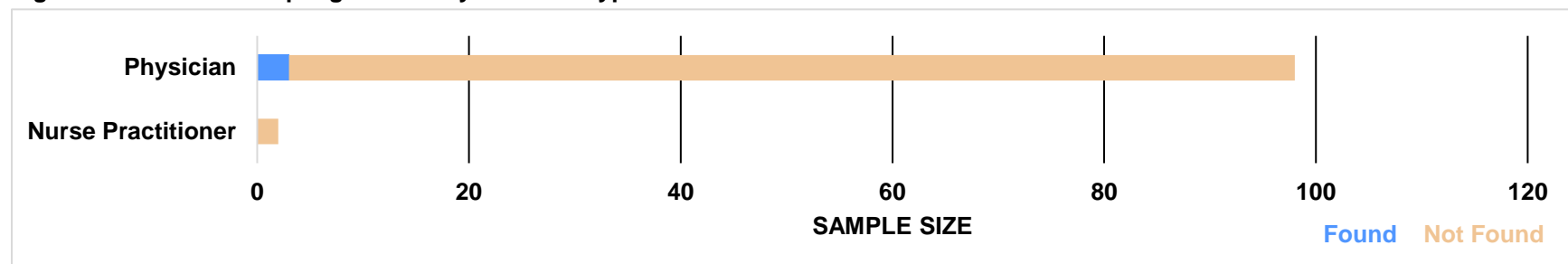


Figure 56. Random Sampling Results by Provider Type – MDwise



A systematic process was performed to assess the completeness and accuracy of the service location addresses of enrolled providers within the enrollees' provider directories as of October 1, 2022. The addresses appearing in the psychiatrist and OB/GYN portions of the provider directory were extracted and geocoded, resulting in a list of standardized address coordinates. These coordinates were compared to the existing provider address coordinates used in our geographic accessibility analysis. Using this method, Qsource found 2.8% of enrolled psychiatrist addresses, and 4.0% of enrolled OB/GYN provider addresses in the enrollees' provider directories.

Figure 57. Programmatic Search of Psychiatrist Service Locations – MHS

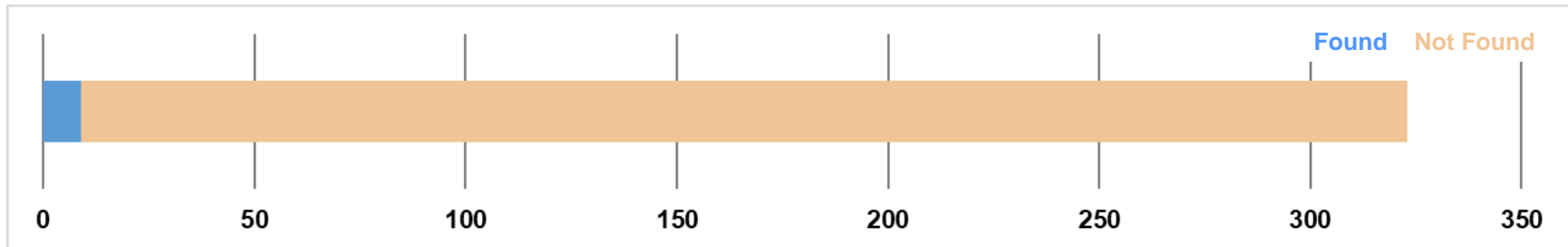
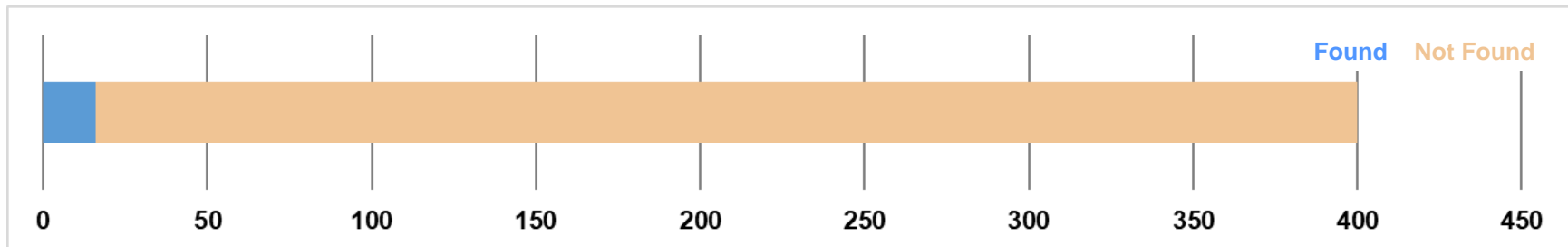


Figure 58. Programmatic Search of OB/GYN Service Locations – MHS



For this assessment, UHC submitted a single provider directory in PDF that was issued to its enrollees in the HCC program.

A random sample of 100 providers was selected from UHC’s submitted roster of psychiatrists and OB/GYN providers. These providers were then looked up in the provider directory submitted by UHC, and 37% of the 100 providers were found in the directory.

Figure 59. Random Sampling Results by Program – UHC

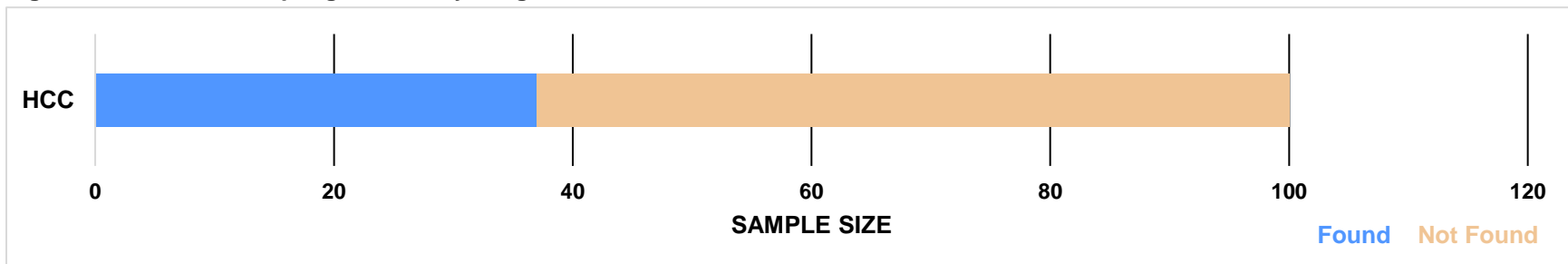
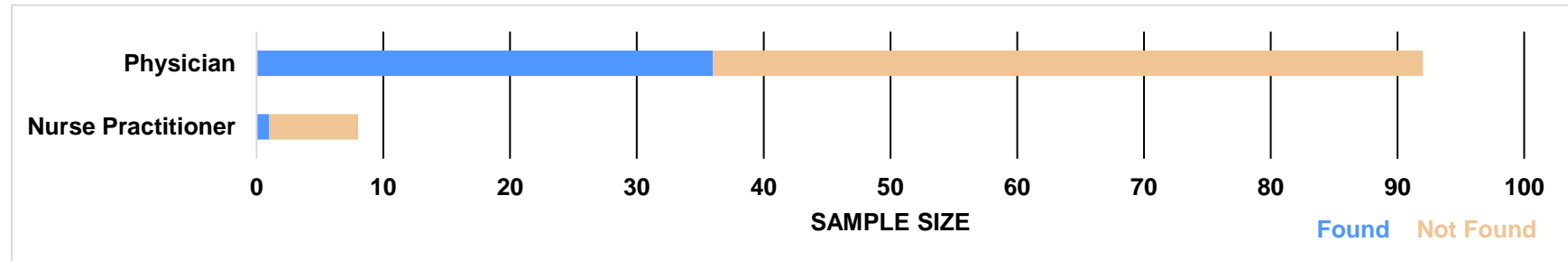


Figure 60. Random Sampling Results by Provider Type – UHC



A systematic process was performed to assess the completeness and accuracy of the service location addresses of enrolled providers within the enrollees' provider directories as of October 1, 2022. The addresses appearing in the psychiatrist and OB/GYN provider portions of the provider directory were extracted and geocoded, resulting in a list of standardized address coordinates. These coordinates were compared to the existing provider address coordinates used in our geographic accessibility analysis. Using this method, Qsource found 28.4% of enrolled psychiatrist addresses and 20.6% of enrolled OB/GYN addresses in the enrollees' provider directories.

Figure 61. Systematic Search of Psychiatrist Service Locations – UHC

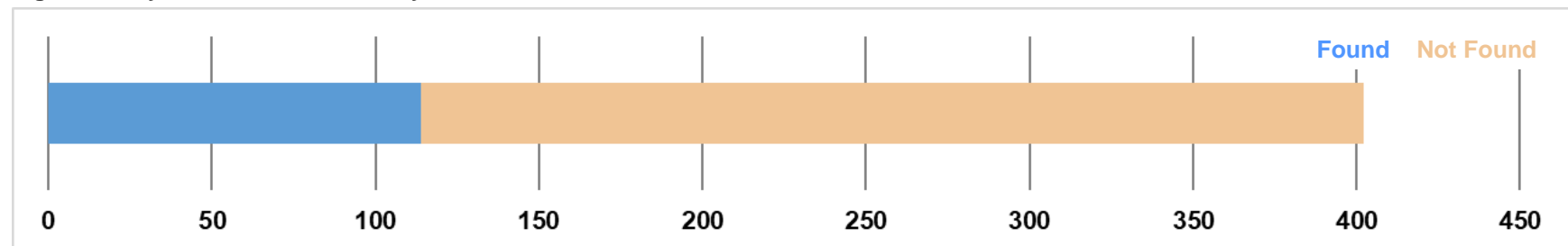
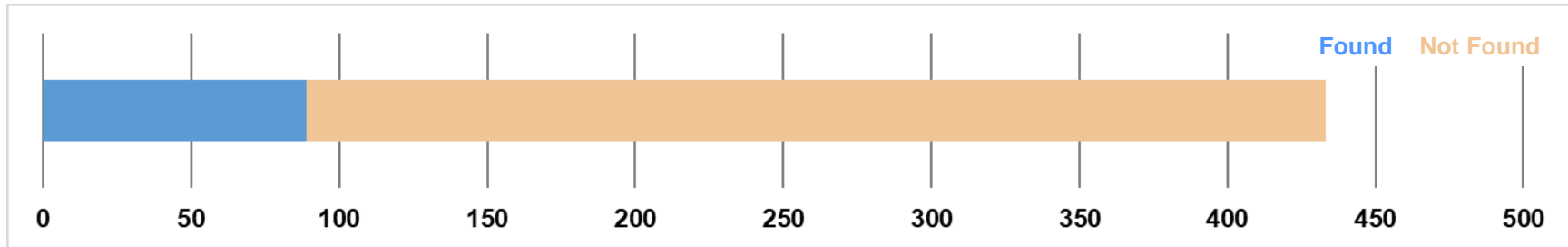


Figure 62. Systematic Search of OB/GYN Service Locations – UHC



Strengths, Suggestions, and AONs

The ANA review assists OMPP, Qsource, and the MCE in identifying strengths, suggestions, and AONs in addition to network adequacy scores. Strengths indicate that the MCE demonstrated proficiency on a given standard and can be identified regardless of compliance score; the lack of an identified strength should not be interpreted as a shortcoming on the part of the MCE. Suggestions are recommendations that are not required to meet compliance but include improvements for the MCE to consider regardless of score. AONs are identified where the MCE achieved less than 100% compliance and reflect what the MCE should do to improve performance.

As shown in **Table 22**, all MCEs were compliant with the geographic accessibility standard.

Table 22. Strengths, Suggestions, and AONs

Anthem	Strengths	
	HHW, HIP, and HCC	<ul style="list-style-type: none"> ◆ Anthem met the requirements for geographic accessibility to psychiatrist providers for 100% of their HHW, HIP, and HCC enrollees. ◆ Anthem met the geographic accessibility standard of two OB/GYN providers within 60 miles for 100% of their HHW, HIP, and HCC enrollees.
	Suggestions	
	HHW, HIP, and HCC	None noted.
	AONs	
HHW, HIP, and HCC	<ul style="list-style-type: none"> ◆ Anthem did not meet the geographic accessibility standard of one OB/GYN provider within 30 miles for 100% of their HHW, HIP, and HCC female enrollees. Anthem should look at improving access for this standard in the following counties: Fountain, Perry, Pulaski, Spencer, Starke, 	

Table 22. Strengths, Suggestions, and AONs

		Vermillion, and Warren.
CareSource	Strengths	
	HHW and HIP	<ul style="list-style-type: none"> ◆ CareSource met the requirements for geographic accessibility to OB/GYN providers for 100% of its HHW and HIP enrollees. ◆ CareSource met the requirement for geographic accessibility to psychiatrists for 100% of its HHW and HIP enrollees.
	Suggestions	
	HHW and HIP	<ul style="list-style-type: none"> ◆ CareSource may want to consider reviewing the provider directories issued to its enrollees for completeness.
	AONs	
HHW and HIP	None noted.	
MDwise	Strengths	
	HHW and HIP	<ul style="list-style-type: none"> ◆ MDwise met the requirements for geographic accessibility to psychiatrist providers for 100% of its HHW and HIP enrollees. ◆ MDwise met the geographic accessibility requirements of one OB/GYN provider within 30 miles and two OB/GYN providers within 60 miles for 100% of their HHW and HIP female enrollees.
	Suggestions	
	HHW and HIP	<ul style="list-style-type: none"> ◆ MDwise may want to consider reviewing its <i>Report 0902 (Count of Providers)</i> to the State against its roster of enrolled providers to ensure the OB/GYN provider and psychiatrist counts are accurate.
	AONs	
HHW and HIP	None noted.	
MHS	Strengths	
	HHW, HIP, and HCC	<ul style="list-style-type: none"> ◆ MHS met the requirements for geographic accessibility to psychiatrists for 100% of its HHW, HIP, and HCC enrollees. ◆ MHS met the geographic accessibility standard of two OB/GYN providers within 60 miles for

Table 22. Strengths, Suggestions, and AONs		
		100% of its HHW, HIP, and HCC female enrollees.
	Suggestions	
	HHW, HIP, and HCC	◆ MHS may want to consider reviewing the provider directories issued to their enrollees for completeness.
	AONs	
	HHW, HIP, and HCC	◆ MHS did not meet the geographic accessibility standard of one OB/GYN provider within 30 miles for 100% of their HHW, HIP, and HCC female enrollees. MHS should look at improving access for this standard in the following counties: Benton, Fountain, Owen, Pulaski, Putnam, Switzerland, Vermillion, and Warren.
UHC	Strengths	
	HCC	<ul style="list-style-type: none"> ◆ UHC met the requirements for geographic accessibility to psychiatrists for 100% of its HCC enrollees. ◆ UHC met the geographic accessibility standard of two OB/GYN providers within 60 miles for 100% of its HCC female enrollees.
	Suggestions	
	HCC	◆ UHC may want to consider reviewing the provider directories issued to its enrollees for completeness.
	AONs	
	HCC	◆ UHC did not meet the geographic accessibility standard of one OB/GYN provider within 30 miles for 100% of its HCC female enrollees. UHC should look at improving access for this standard in the following counties: Fountain, Parke, Perry, Sullivan, and Switzerland.

Conclusions and Recommendations

The MCEs demonstrated a shared strength for providing access to their enrollees to psychiatrist providers within the required travel time standard. Based on the analyses of the MCE's geographical network adequacy, Qsource concluded that all

MCEs met the requirements for geographic accessibility to a psychiatrist. In addition, all MCEs demonstrated a shared strength in providing access to 100% of their female enrollees to

OB/GYN providers in the accessibility standard of 2 providers within 60 miles.

Recommendations

1. The MCEs are encouraged to maintain accurate provider lists in all member materials and ensure service locations are correct, which will improve member accessibility.
2. The MCEs may want to consider incorporating additional data quality validations into both their member records and provider records.
3. Each MCE is encouraged to build relationships to contract with all the providers in the IHCP, to reduce the distance that members must travel for services.
4. Qsource suggests that each MCE use the total count of providers available against the total count of providers contracted within the IHCP for accurate benchmarking.
5. Qsource suggests that MCEs continue to monitor their provider network and implement corrective action for identified deficiencies.
6. Qsource suggests that the MCEs use the same methodology to count providers.

Encounter Data Validation (EDV) and Periodic Report

CMS' *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan (2023)* is a voluntary protocol used to validate encounter data submitted to states by managed care organizations and programs. While the encounter data validation (EDV) protocol is voluntary, CMS strongly encourages states to contract with qualified entities to evaluate its Medicaid encounter data. This validation assesses the completeness and accuracy of the encounter data that has been adjudicated (i.e., paid or denied) by the MCE and submitted to the State's Fiscal Agent Contractor (FAC). States may be at risk for loss of federal financial participation/reimbursement if the encounter data is incomplete and/or inaccurate.

EDV can assist states in reaching the goals of transparency and payment reform to support its efforts in quality measurement

and improvement. The final Medicaid Managed Care Rule strengthens the requirements for State monitoring of managed care programs. Each state Medicaid agency must have a monitoring system that addresses all areas of the State's managed care program, such as the periodic audit requirement.

Additionally, states are required to provide accurate encounter (and financial) data to the actuaries, and to CMS as part of the Transformed Medicaid Statistical Information System project. Protocol 5 enables states to meet these data validation and monitoring requirements. Protocol 5 also evaluates state/departments policies, as well as the policies, procedures, and systems of the MCE, assists states in gauging utilization, identifying potential gaps in services, evaluating program

effectiveness, and identifying strengths and opportunities to enhance oversight.

Methodology

Source Data

Encounter data submitted to the FAC for the period January 1, 2022, through December 31, 2022, was used for the analyses. The MCEs were provided with an initial data and documentation request on July 24, 2023, which included sample claims data and financial data for two months: March 2022 and September 2022. In addition, a questionnaire was sent as part of the initial data and documentation request. The submissions were uploaded to the OMPP SharePoint site. Qsource requested the MCEs provide data for each of their IHCPs. Information provided by the MCEs was assumed to be complete and accurate. Limitations within the data are discussed in [Activity 3](#) of this report.

Analysis

CMS' guidelines for EDV consist of five activities:

1. Review State requirements for collecting and submitting encounter data.
2. Review the MCE's capacity to produce accurate and complete encounter data.
3. Analyze MCE electronic encounter data for accuracy and completeness.
4. Review medical records for confirmation of findings of analysis of encounter data.
5. Submission of findings.

Results are presented in summary form for each activity in the next section, with highlights regarding areas of concern. The appendices contain analysis and detailed results for all MCEs.

Results

Activity 1: Review State Requirements

The purpose of Activity 1 is to review information about the State's requirements for collecting and submitting encounter data. This review determines if additional or updated requirements are needed to ensure encounter data is complete and accurate. OMPP and Qsource provided Myers and Stauffer the State-required items (as listed in Protocol 5).

In addition to reviewing the State requirements, OMPP's contracts with the MCEs were reviewed in detail. Qsource also met with OMPP representatives regularly.

Upon completion of Activity 1's review of State requirements and OMPP's contracts, no findings were noted.

Activity 2: Review Health Plan Capability

The MCEs' ability to collect accurate and complete encounter data is determined by reviewing the MCEs' information system via a HEDIS Roadmap. A third party is engaged to perform the HEDIS Roadmap review, which assesses the systems used to implement programs and changes that occurred over the latest three-year period. Myers and Stauffer pursued questions based on CMS' *Protocol 2. Validation of Performance Measures*

(2023), which ensures measure results are accurately calculated by reviewing the data sources that feed the calculations.

In addition to the performance measure validation questions, a questionnaire was developed, requested documentation was reviewed, and personnel interviews were conducted to gain an understanding of each MCE's structure and processes. The questionnaire and personnel interviews included questions related to claims processing, encounter submissions, enrollment, data systems, and controls and mechanisms.² The requested documentation supported workflows, policies and procedures, and organizational structures. Program integrity reports were reviewed to ensure MCEs proactively identify improper payments, ensure the number of claims identified does not materially impact the encounter completeness, and constantly monitor for potential fraud, waste and abuse.

Upon completion of Activity 2 MCE interviews and review of MCE's documentation, no findings were noted.

Activity 3: Analyze Electronic Encounter Data

The purpose of Activity 3 is to determine the validity of the encounter data submitted to the State, which requires verifying the completeness and accuracy of the encounter data. Encounter data for the period January 2022 through December 2022 was used for analyses. Cash Disbursement Journals (CDJs) and sample claims data were submitted by each MCE for two

selected sample months, March 2022 and September 2022. Both the CDJs and sample claims data were evaluated against the encounter data submitted to the FAC to determine its integrity (i.e., completeness and accuracy).

The submitted CDJs and sample claims data were assumed to be complete and accurate. Unless noted, completeness and accuracy percentages reflect the combined total for the two sample months. A 95% threshold was used for testing.

Encounter Data Extract

Encounters are a record of claims that have been adjudicated by the MCE to providers that have rendered healthcare services to enrollees enrolled with the MCE. These encounters are submitted by the MCEs to OMPP via the FAC and the data warehouse vendor. Gainwell Technologies was the FAC during the validation period and Optum was the data warehouse vendor.

Myers and Stauffer received encounter data from the FAC and data warehouse vendor in a standardized data extract. The extract included encounters received and processed from January 2022 through December 2022. No limitations were identified within the data.

Completion Percentages: Cash Disbursement Journals

Each MCE provided a summary-level reconciliation with its CDJ extract files. The reconciliation included the total paid

² Questions found in Appendix V, Attachment B of Protocol 5 were included in the survey. <https://www.medicaid.gov/sites/default/files/medicaid/quality-of-care/downloads/app5-attachb-isreview.pdf>.

amount as reported in the Medicaid Management Information System (MMIS) encounter data, compared to the total paid amount as reported in the CDJ extract. Descriptions and supporting documentation were to be included for any reconciling items.³ Encounters from the FAC encounter data extract were compared to the CDJs submitted by the MCE for the two sample months. Completion percentages were determined by comparing the total CDJ paid amount to the sum of the encounter paid amounts.

Completion Percentages: Sample Claims

The comparison of the sample claims data to the encounter data sought to ensure that all claims are included in the sample claims and/or encounter data. The sample claims data for the two sample months was traced to encounter data using the MMIS internal control number or the MCE internal control number.

Completion percentages were evaluated on three criteria:

- 1. CDJ Paid Amount: The total encounter paid amount divided

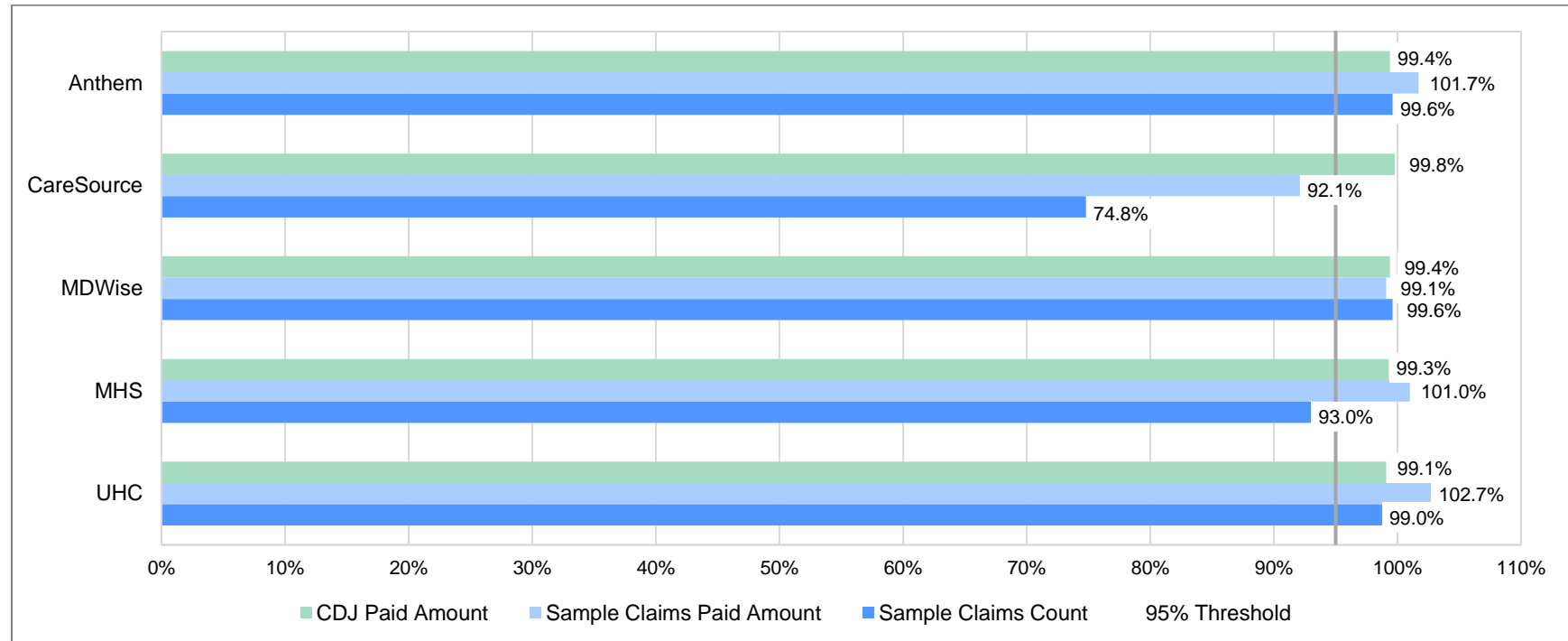
by the total CDJ paid amount.

- 2. Sample Claims Count: The count of claims identified in the encounter data extract divided by the total number of sample claims.
- 3. Sample Claims Paid Amount: The sample claim paid amount identified in the encounter data extract divided by the total CDJ paid amount.

[Figure 63](#) shows the completion percentages obtained after the comparative analysis of the CDJs and the claims sample data to the encounter data for the two sample months. Additional detail on the paid amounts used and encounter matching can be found in [Appendix D](#). Note that not all sample claims or CDJ data identified the program (HHW, HCC, or HIP). When displaying data by program, these records were excluded. Completion percentages greater than 100 percent may be due to incomplete data, timing differences, potential duplicates, or claims, voids, replacements, adjustments and/or other transactions present or absent from the encounter data.

³ Examples of reconciling items include duplicate encounters, capitation payments, and/or administrative payments.

Figure 63. Encounter Completion by MCE



Accuracy

To validate encounter data accuracy, certain key data elements were selected for testing. The key data elements of the encounters traced to the sample claims data were compared to the corresponding key data elements on the sample claim. The key data elements were evaluated on the basis of valid, missing, and erroneous data values. Consistency checks on blank or null data element values were also applied.

- ◆ Valid Values: The encounter key data element value matched the sample claim key data element value. If the encounter key data element was blank (or null) and the data

element in the sample claim was also blank (or null), it was considered valid.

- ◆ Missing Values: The encounter key data element was blank (or null) and the data element in the sample was populated (i.e., had a value).
- ◆ Erroneous Values: The encounter key data element had a value (i.e., was populated) that differed from the sample claim key data element value.

A 95% threshold was used as the accuracy goal for each of the key data elements. The accuracy percentages of non-pharmacy

(non-Rx) encounters are presented in **Table 23** and [Table 24](#). The accuracy percentages of pharmacy (Rx) encounters are

presented in [Table 25](#). The key data elements evaluated, and specific testing results are presented in [Appendix E](#).

Table 23. Accuracy Percentages – Key Data Elements Analysis (Non-Rx)				
Anthem				
Description	HCC	HHW	HIP	Total ¹
Valid Values	90.9%	92.5%	91.4%	91.6%
Missing Values	2.1%	1.0%	1.8%	1.6%
Erroneous Values	7.0%	6.4%	6.8%	6.8%
CareSource				
Description	HCC	HHW	HIP	Total ¹
Valid Values	N/A	95.9%	96.0%	96.0%
Missing Values	N/A	0.9%	1.1%	1.0%
Erroneous Values	N/A	3.2%	2.9%	3.0%
MDwise				
Description	HCC	HHW	HIP	Total ¹
Valid Values	N/A	97.4%	96.8%	97.0%
Missing Values	N/A	0.6%	0.8%	0.7%
Erroneous Values	N/A	2.1%	2.4%	2.3%
MHS				
Description	HCC	HHW	HIP	Total ¹
Valid Values	96.0%	97.7%	97.1%	97.1%
Missing Values	0.7%	0.1%	0.3%	0.3%
Erroneous Values	3.2%	2.2%	2.7%	2.6%
UHC				
Description	HCC	HHW	HIP	Total ¹
Valid Values	84.1%	N/A	N/A	84.1%

Table 23. Accuracy Percentages – Key Data Elements Analysis (Non-Rx)

Missing Values	4.3%	N/A	N/A	4.3%
Erroneous Values	11.6%	N/A	N/A	11.6%

¹Differences are due to rounding.

Table 24. Accuracy Percentages – Key Data Elements Analysis (Non-Rx)

HCC						
Description	Anthem	CareSource	MDwise	MHS	UHC	Total ¹
Valid Values	90.9%	N/A	N/A	96.0%	84.1%	91.8%
Missing Values	2.1%	N/A	N/A	0.7%	4.3%	1.9%
Erroneous Values	7.0%	N/A	N/A	3.2%	11.6%	6.3%
HHW						
Description	Anthem	CareSource	MDwise	MHS	UHC	Total ¹
Valid Values	92.5%	95.9%	97.4%	97.7%	N/A	95.4%
Missing Values	1.0%	0.9%	0.6%	0.1%	N/A	0.7%
Erroneous Values	6.4%	3.2%	2.1%	2.2%	N/A	3.9%
HIP						
Description	Anthem	CareSource	MDwise	MHS	UHC	Total ¹
Valid Values	91.4%	96.0%	96.8%	97.1%	N/A	94.0%
Missing Values	1.8%	1.1%	0.8%	0.3%	N/A	1.2%
Erroneous Values	6.8%	2.9%	2.4%	2.7%	N/A	4.7%

¹Differences are due to rounding.

Table 25. Accuracy Percentages – Key Data Elements Analysis (Rx)

Description	Anthem	CareSource	MDwise	MHS	UHC	Total ¹
Valid Values	93.2%	70.9%	86.9%	93.2%	62.8%	90.7%
Missing Values	0.0%	0.0%	0.0%	0.0%	2.2%	0.0%

Erroneous Values	6.8%	29.1%	13.1%	6.8%	35.0%	9.2%
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¹Differences are due to rounding.

Findings and Recommendations

The findings from the completeness and accuracy analyses of the Non-Rx encounter data are presented in **Table 26**, including recommendations for OMPP, the FAC, and/or the MCE, as appropriate. The findings and recommendations for the Rx encounters are presented in [Table 27](#).

Table 26. Accuracy Findings and Recommendations (Non-Rx)

KDE		Health Plan*	Findings	Recommendations
1	Admission Date	Anthem	Encounter data values are not populated. This data element is required for inpatient claims only.	We recommend that Anthem, CareSource, MDwise, MHS, and UHC work with OMPP and Gainwell to investigate and ensure that the appropriate Admission Date information is submitted on the encounter.
		CareSource		
		MDwise		
		MHS		
		UHC		
2	Bill Type	Anthem	The claim sample data reflect a value, and the encounter data does not or vice versa. This data element is required for inpatient claims only.	We recommend that Anthem, CareSource, MDwise, MHS, and UHC work with OMPP and Gainwell to investigate and ensure that the appropriate Bill Type information is submitted on the encounter.
		CareSource		
		MDwise		
		MHS		
		UHC		
3	Billed Charges		Both the claim sample data and the encounter data reflect valid values and they do not agree.	We recommend that MHS works with OMPP and Gainwell to investigate and ensure that the appropriate payment information is submitted on the encounter.
		MHS		
4	Diagnosis Codes	Anthem	Claim sample values are not populated.	We recommend that Anthem ensure that the requested data template instructions are followed for improved results in future analyses.

Table 26. Accuracy Findings and Recommendations (Non-Rx)

KDE	Health Plan*	Findings	Recommendations
5	Anthem	Both the claim sample data and the encounter data reflect valid values and they do not agree, or encounter data values are not populated.	We recommend that Anthem, CareSource, MDwise, MHS, and UHC work with OMPP and Gainwell to investigate and ensure that the appropriate Health Plan Paid Date is submitted on the encounter.
	CareSource		
	MDwise		
	MHS		
	UHC		
6	MDwise	Claim sample values are not populated.	We recommend that MDwise works with OMPP and Gainwell to investigate and ensure that the appropriate Enrollee Number information is submitted on the encounter.
7	CareSource	Both the claim sample data and the encounter data reflect valid values and they do not agree.	We recommend that CareSource, MDwise, MHS, and UHC work with OMPP and Gainwell to investigate and ensure that the appropriate ICN information is submitted on the encounter.
	MDwise		
	MHS		
	UHC		
8	CareSource	Both the claim sample data and the encounter data reflect valid values and they do not agree.	
	MDwise		
	MHS		
	UHC		
9	Anthem	Both the claim sample data and the encounter data reflect valid values and they do not agree.*	We recommend that Anthem, CareSource, and UHC work with OMPP and Gainwell to investigate and ensure that the appropriate NPI values are submitted on the encounter. We recommend that Anthem ensures that the requested data template instructions are
	CareSource		
	UHC		

Table 26. Accuracy Findings and Recommendations (Non-Rx)

KDE		Health Plan*	Findings	Recommendations
10	NPI - Servicing Provider	Anthem	Both the claim sample data and the encounter data reflect valid values and they do not agree.*	followed for improved results in future analyses.
		CareSource		
		MDwise		
		MHS		
		UHC		
11	Procedure Code		Claim sample values are populated with the revenue code.	We recommend that MHS ensure that the requested data template instructions are followed for improved results in future analyses.
		MHS		
12	Surgical Procedure Code	Anthem	Surgical Procedure Codes: Anthem, CareSource, MHS, and UHC – Encounter data values are not populated.	We recommend that Anthem, CareSource, MHS, and UHC ensure that the requested data template instructions are followed for improved results in future analyses.
		CareSource		
		MHS		
		UHC		

*Anthem – The MCE also appears to have submitted an internal provider identification (ID) in the claim sample data instead of the Billing/Servicing Provider NPI.

Table 27. Accuracy Findings and Recommendations (Rx)

KDE		Health Plan*	Findings	Recommendations
1	Billed Charges	Anthem	The claim sample data reflect \$0.00 billed amounts, and the encounter data reflect values other than \$0.00, or both data reflect valid values and they do not agree.	We recommend that Anthem, MHS and UHC work with OMPP and Gainwell to investigate and ensure that the appropriate payment information is submitted on the encounter.
		MHS		
		UHC		
2	Former Original Claim ICN	Anthem	Claim sample values are not populated, or both the claim sample data and the encounter data reflect valid values and they do not agree.*	We recommend that appropriate audit trails are in place for all adjusted, replaced and void claims. The original ICN should be linked to the replacement, adjustment and/or void claim and the original ICN
		CareSource		
		MDwise		

Table 27. Accuracy Findings and Recommendations (Rx)

KDE		Health Plan*	Findings	Recommendations
		MHS		information is available to trace the replacement/adjustment back to the original claim.
		UHC		
3	Health Plan Paid Amount		Both the claim sample data and the encounter data reflect valid values and they do not agree.	We recommend that UHC works with OMPP and Gainwell to investigate and ensure that the appropriate health plan paid amount is submitted on the encounter.
		UHC		
4	Health Plan Paid Date		Both the claim sample data and the encounter data reflect valid values and they do not agree.	We recommend that CareSource, MDwise, and UHC work with OMPP and Gainwell to investigate and ensure that the health plan paid date information is submitted on the encounter.
		CareSource		
		MDwise		
		UHC		
5	MMIS ICN		Claim sample values are not populated, or both the claim sample data and the encounter data reflect valid values and they do not agree.*	We recommend that CareSource and UHC ensure that the requested data template instructions are followed for improved results in future analyses.
		CareSource		
		UHC		
6	MMIS Enrollee Number		The MCE appears to have submitted an internal enrollee ID in the claim sample data instead of the MMIS Enrollee Number.	We recommend that UHC ensures that the requested data template instructions are followed for improved results in future analyses.
		UHC		
7	Prescriber NPI		The MCE appears to have submitted an internal provider ID in the claim sample data instead of the Prescriber NPI.	We recommend that CareSource ensures that the requested data template instructions are followed for improved results in future analyses.
		CareSource		

Table 27. Accuracy Findings and Recommendations (Rx)

KDE		Health Plan*	Findings	Recommendations
8	Refill Number	CareSource	Both the claim sample data and the encounter data reflect valid values and they do not agree.	We recommend that CareSource works with OMPP and Gainwell to investigate and ensure that the appropriate Refill Number information is submitted on the encounter.

*CareSource appears to have submitted an internal ID in the claim sample data instead of the Former Original Claim ICN and/or MMIS ICN.

Statistics and Distributions

To further support the EDV process, encounters with dates of service during the measurement period were analyzed for consistency among attributes such as enrollee utilization and paid amounts.

Enrollees, Utilization, and Paid Amounts

Capitation data was used to evaluate utilization data on a per enrollee basis. The total number of utilized services (i.e., units) and total paid amounts for MY 2022 were divided by the average number of enrollees for the year to determine per enrollee utilization. The following tables show the resulting utilization and paid amounts per enrollee by plan for each program. Detailed results can be found in [Appendix E](#).

Table 28. HCC Per Enrollee Per Year Utilization and Paid Amounts by Service Type

Service Type	Anthem		MHS		UHC	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Ancillary	15.0	\$1,402	12.6	\$1,951	13.6	\$1,666
Dental	2.0	\$112	2.2	\$114	1.7	\$86
Inpatient	0.2	\$2,387	0.2	\$2,489	0.2	\$2,619
Outpatient	19.3	\$2,836	16.3	\$2,192	17.2	\$2,697
Primary Care	13.5	\$580	11.1	\$486	11.4	\$422
Specialty	7.8	\$586	5.9	\$483	6.8	\$367
Transportation	1.9	\$42	1.0	\$12	0.8	\$17
Vision	1.0	\$30	0.9	\$35	0.7	\$19

Table 28. HCC Per Enrollee Per Year Utilization and Paid Amounts by Service Type

Service Type	Anthem		MHS		UHC	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Rx	26.9	\$4,570	22.8	\$4,693	18.8	\$2,967
Total Health Plan Services	87.6	\$12,545	73.0	\$12,455	71.2	\$10,860

Table 29. HHW Per Enrollee Per Year Utilization and Paid Amounts by Service Type

Service Type	Anthem		CareSource		MDWise		MHS	
	PEPY* Count	PEPY Paid Amount	PEPY Count	PEPY Paid Amount	PEPY Count	PEPY Paid Amount	PEPY Count	PEPY Paid Amount
Ancillary	3.0	\$212	2.6	\$201	2.7	\$250	2.9	\$271
Dental	3.1	\$134	2.7	\$94	3.3	\$147	3.3	\$145
Inpatient	0.1	\$566	0.1	\$700	0.1	\$237	0.1	\$584
Outpatient	4.0	\$420	3.9	\$493	4.3	\$500	3.9	\$458
Primary Care	8.5	\$263	7.9	\$250	7.6	\$249	8.1	\$254
Specialty	1.5	\$100	1.3	\$99	1.5	\$103	1.4	\$104
Transportation	0.0	\$1	0.0	\$1	0.0	\$1	0.0	\$1
Vision	0.6	\$18	0.5	\$16	0.7	\$27	0.7	\$25
Rx	4.4	\$322	3.7	\$275	4.0	\$559	4.4	\$457
Total Health Plan Services	25.2	\$2,036	22.7	\$2,129	24.2	\$2,073	24.8	\$2,299

*Per Enrollee Per Year

Table 30. HIP Per Enrollee Per Year Utilization and Paid Amounts by Service Type

Service Type	Anthem		CareSource		MDWise		MHS	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Ancillary	9.7	\$572	8.0	\$521	8.4	\$532	8.9	\$545
Dental	1.4	\$103	1.1	\$73	1.3	\$106	1.4	\$106
Inpatient	0.2	\$1,297	0.2	\$1,515	0.1	\$44	0.1	\$1,476
Outpatient	13.2	\$1,594	11.2	\$1,505	13.3	\$1,832	12.6	\$1,567
Primary Care	11.5	\$549	8.9	\$442	10.1	\$520	10.0	\$487
Specialty	4.9	\$401	3.7	\$339	4.4	\$402	4.0	\$359
Transportation	0.7	\$18	0.5	\$13	0.3	\$10	0.4	\$7
Vision	0.7	\$35	0.6	\$31	0.6	\$35	0.6	\$37
Rx	16.0	\$2,022	12.2	\$1,717	14.5	\$2,781	15.1	\$2,124
Total Health Plan Services	58.3	\$6,591	46.4	\$6,156	53.0	\$6,262	53.1	\$6,708

Timeliness

This analysis determines compliance with the timeliness requirements of the health plan’s payment of provider claims and its submission of encounters to the FAC after adjudication (i.e., payment or denial).

Timely Payment of Claims

This analysis measures the compliance of the health plan in paying or denying Non-Rx claims submitted by providers for payment. The contract between OMPP and each MCE requires that the MCE pay or deny 98% of electronically filed clean claims within 21 calendar days of receipt. **Table 31** shows the results of the payment rate analysis.

Table 31. Timely Payment of Claims

Description	Anthem	CareSource	MDWise	MHS	UHC	Total
HCC						
Average Days	7	N/A	N/A	11	10	8
7 Days	83.8%	N/A	N/A	48.6%	50.6%	71.1%
14 Days	95.8%	N/A	N/A	92.0%	89.3%	94.3%

Table 31. Timely Payment of Claims						
Description	Anthem	CareSource	MDwise	MHS	UHC	Total
21 Days	98.2%	N/A	N/A	95.6%	95.8%	97.3%
HHW						
Average Days	7	15	6	10	N/A	8
7 Days	88.1%	14.4%	86.6%	54.3%	N/A	74.1%
14 Days	96.6%	95.2%	96.9%	95.6%	N/A	96.3%
21 Days	98.1%	96.3%	98.6%	96.7%	N/A	97.8%
HIP						
Average Days	7	16	18	11	N/A	10
7 Days	84.7%	11.1%	79.2%	50.3%	N/A	71.4%
14 Days	95.9%	92.1%	91.5%	92.5%	N/A	94.2%
21 Days	98.1%	95.6%	93.3%	95.0%	N/A	96.5%

Timely Encounter Submissions

The submission rate calculates how long it takes the MCE to submit the Non-Rx encounters to the FAC after adjudication. The contract between OMPP and each MCE requires that the MCE submit 98% of encounters within 21 days of adjudication. **Table 32** shows the results of the submission rate analysis.

Table 32. Timely Encounter Submissions						
Description	Anthem	CareSource	MDwise	MHS	UHC	Total
HCC						
Average Days	7	N/A	N/A	12	11	8
7 Days	53.2%	N/A	N/A	79.0%	93.0%	63.5%
14 Days	99.3%	N/A	N/A	94.0%	96.0%	97.5%
21 Days	99.6%	N/A	N/A	94.2%	96.3%	97.8%
HHW						
Average Days	8	8	7	11	N/A	9
7 Days	55.8%	92.4%	58.2%	47.8%	N/A	57.3%
14 Days	93.2%	98.2%	98.8%	95.0%	N/A	95.6%
21 Days	94.7%	98.2%	98.9%	96.2%	N/A	96.5%

Table 32. Timely Encounter Submissions						
Description	Anthem	CareSource	MDwise	MHS	UHC	Total
HIP						
Average Days	8	9	8	12	N/A	9
7 Days	58.3%	93.5%	50.7%	64.0%	N/A	60.8%
14 Days	96.9%	95.7%	97.3%	95.0%	N/A	96.5%
21 Days	97.6%	95.7%	98.9%	95.8%	N/A	97.3%

Findings and Recommendations

The findings from the timely payment and submission of encounters are presented in **Table 33**, including recommendations for OMPP, the FAC, and/or the MCE.

Table 33. Activity 3 Timely Payment and Submission of Encounters Findings and Recommendations		
	Findings	Recommendations
1	<p>The percentage of claims paid with 21 days was below the 98% threshold for CareSource HHW and HIP; MDwise HIP; MHS HCC, HHW, and HIP; and UHC HCC.</p> <p>The percentage of encounters submitted within 21 days was below the 98% threshold for Anthem HHW and HIP; CareSource HIP; MHS HCC, HHW, and HIP; and UHC HCC.</p>	<p>We recommend that the health plans review their internal claims processes to identify and address barriers to timely payment of claims and encounter submissions. In addition, the health plans should work with OMPP and Gainwell to investigate and ensure that encounters are able to be submitted timely.</p>

Accuracy of Benefit Application

The application of benefits across the largest categories of service (COS) for encounters with dates of service within MY 2022 were reviewed. Categories of service were used to classify the encounters in the extract. For each COS, we analyzed denials as a percentage of total claims completed by program and MCE. Note that encounters may be denied for a valid reason. This analysis evaluated the overall trend of denials by COS relative to other programs and MCEs. More details on these results can be found in [Appendix E](#).

Table 34. Benefit Testing by Program and MCE												
Category of Service	Anthem		CareSource		MDwise		MHS		UHC		Total	
	Paid	Denied	Paid	Denied	Paid	Denied	Paid	Denied	Paid	Denied	Paid	Denied
HHW												
Chiropractic Services	92%	8%	95%	5%	95%	5%	92%	8%	N/A	N/A	92%	8%
Dental Services - Adult	100%	0%	100%	0%	100%	0%	100%	0%	N/A	N/A	100%	0%
Dental Services - Child	100%	0%	100%	0%	100%	0%	100%	0%	N/A	N/A	100%	0%
EPSDT Services	98%	2%	98%	2%	98%	2%	99%	1%	N/A	N/A	98%	2%
Eye Care and Exams	98%	2%	100%	0%	98%	2%	99%	1%	N/A	N/A	98%	2%
Eyewear	98%	2%	100%	0%	98%	2%	100%	0%	N/A	N/A	98%	2%
Home and Durable Medical Equipment (HME/DME)	93%	7%	95%	5%	89%	11%	94%	6%	N/A	N/A	93%	7%
Inpatient Services	92%	8%	93%	7%	91%	9%	96%	4%	N/A	N/A	92%	8%
Lab Services	88%	12%	84%	16%	92%	8%	90%	10%	N/A	N/A	88%	12%
Mental Health Services	96%	4%	96%	4%	96%	4%	95%	5%	N/A	N/A	96%	4%
Outpatient Services	96%	4%	97%	3%	96%	4%	98%	2%	N/A	N/A	96%	4%
Physician Services	97%	3%	97%	3%	97%	3%	98%	2%	N/A	N/A	97%	3%
Podiatrist Services	91%	9%	83%	17%	94%	6%	90%	10%	N/A	N/A	91%	9%
Therapy Services - Audiology	95%	5%	94%	6%	93%	7%	95%	5%	N/A	N/A	95%	5%
Therapy Services - Occupational	97%	3%	96%	4%	97%	3%	95%	5%	N/A	N/A	97%	3%
Therapy Services - Physical	94%	6%	91%	9%	95%	5%	95%	5%	N/A	N/A	94%	6%
Therapy Services - Respiratory	96%	4%	96%	4%	98%	2%	97%	3%	N/A	N/A	96%	4%
Transportation Services	93%	7%	95%	5%	91%	9%	95%	5%	N/A	N/A	93%	7%
HCC												
Chiropractic Services	88%	12%	N/A	N/A	N/A	N/A	95%	5%	100%	0%	90%	10%
Dental Services - Adult	100%	0%	N/A	N/A	N/A	N/A	100%	0%	100%	0%	100%	0%
Dental Services - Child	100%	0%	N/A	N/A	N/A	N/A	100%	0%	100%	0%	100%	0%
EPSDT Services	97%	3%	N/A	N/A	N/A	N/A	99%	1%	100%	0%	98%	2%
Eye Care and Exams	98%	2%	N/A	N/A	N/A	N/A	99%	1%	100%	0%	98%	2%

Table 34. Benefit Testing by Program and MCE												
Category of Service	Anthem		CareSource		MDwise		MHS		UHC		Total	
	Paid	Denied	Paid	Denied	Paid	Denied	Paid	Denied	Paid	Denied	Paid	Denied
Eyewear	98%	2%	N/A	N/A	N/A	N/A	100%	0%	100%	0%	99%	1%
HME/DME	96%	4%	N/A	N/A	N/A	N/A	95%	5%	100%	0%	96%	4%
Inpatient Services	91%	9%	N/A	N/A	N/A	N/A	97%	3%	100%	0%	93%	7%
Lab Services	89%	11%	N/A	N/A	N/A	N/A	89%	11%	100%	0%	89%	11%
Mental Health Services	96%	4%	N/A	N/A	N/A	N/A	95%	5%	100%	0%	96%	4%
Outpatient Services	96%	4%	N/A	N/A	N/A	N/A	98%	2%	100%	0%	97%	3%
Physician Services	96%	4%	N/A	N/A	N/A	N/A	97%	3%	100%	0%	97%	3%
Podiatrist Services	89%	11%	N/A	N/A	N/A	N/A	91%	9%	100%	0%	90%	10%
Therapy Services - Audiology	95%	5%	N/A	N/A	N/A	N/A	93%	7%	100%	0%	94%	6%
Therapy Services - Occupational	97%	3%	N/A	N/A	N/A	N/A	96%	4%	100%	0%	97%	3%
Therapy Services - Physical	92%	8%	N/A	N/A	N/A	N/A	94%	6%	100%	0%	93%	7%
Therapy Services - Respiratory	93%	7%	N/A	N/A	N/A	N/A	98%	2%	100%	0%	95%	5%
Transportation Services	98%	2%	N/A	N/A	N/A	N/A	99%	1%	100%	0%	98%	2%
HIP												
Chiropractic Services	90%	10%	100%	0%	94%	6%	92%	8%	N/A	N/A	92%	8%
Dental Services - Adult	100%	0%	100%	0%	100%	0%	100%	0%	N/A	N/A	100%	0%
Dental Services - Child	100%	0%	100%	0%	100%	0%	100%	0%	N/A	N/A	100%	0%
EPSDT Services	0%	0%	0%	0%	100%	0%	0%	0%	N/A	N/A	100%	0%
Eye Care and Exams	97%	3%	100%	0%	98%	2%	98%	2%	N/A	N/A	98%	2%
Eyewear	97%	3%	100%	0%	95%	5%	100%	0%	N/A	N/A	97%	3%
HME/DME	92%	8%	100%	0%	93%	7%	95%	5%	N/A	N/A	93%	7%
Inpatient Services	90%	10%	100%	0%	93%	7%	95%	5%	N/A	N/A	92%	8%
Lab Services	86%	14%	100%	0%	90%	10%	84%	16%	N/A	N/A	88%	12%
Mental Health Services	95%	5%	100%	0%	94%	6%	94%	6%	N/A	N/A	95%	5%
Outpatient Services	94%	6%	100%	0%	96%	4%	97%	3%	N/A	N/A	96%	4%

Table 34. Benefit Testing by Program and MCE												
Category of Service	Anthem		CareSource		MDwise		MHS		UHC		Total	
	Paid	Denied	Paid	Denied	Paid	Denied	Paid	Denied	Paid	Denied	Paid	Denied
Physician Services	95%	5%	100%	0%	96%	4%	97%	3%	N/A	N/A	96%	4%
Podiatrist Services	90%	10%	100%	0%	92%	8%	91%	9%	N/A	N/A	91%	9%
Therapy Services - Audiology	95%	5%	100%	0%	95%	5%	96%	4%	N/A	N/A	96%	4%
Therapy Services - Occupational	94%	6%	100%	0%	98%	2%	98%	2%	N/A	N/A	96%	4%
Therapy Services - Physical	90%	10%	100%	0%	96%	4%	94%	6%	N/A	N/A	93%	7%
Therapy Services - Respiratory	90%	10%	100%	0%	93%	7%	97%	3%	N/A	N/A	93%	7%
Transportation Services	99%	1%	100%	0%	95%	5%	98%	2%	N/A	N/A	98%	2%

Application of Service Limitation

An analysis was completed of the MCE’s enrollee handbooks to determine the service limitations for each. Additionally, the MCEs submitted supplemental information on their service limitations. The limitations varied by MCE and program. An analysis was conducted using 2022 dates of service to determine how many recipients received services and if any received more than the stated limit of the MCE and program. Six major COS were evaluated: home health, dental, chiropractic, podiatry, therapy, and vision. For vision, limitations were assessed for both visits and eyewear. Results of this analysis can be seen in [Appendix E](#).

Findings and Recommendations

The findings from benefit testing are presented in **Table 35**, including recommendations for OMPP, the FAC, and/or the MCE.

Table 35. Activity 3 Benefit Testing Findings and Recommendations		
	Findings	Recommendations
1	No health plan denied encounters were received for the categories of service analyzed from UHC HCC and CareSource HIP.	We recommend that UHC and CareSource work with OMPP and Gainwell to investigate and ensure that health plan denied encounters are able to be submitted to the MMIS.

Activity 4: Review of Medical Records

Activity 4 confirms and/or provides supporting information for the findings detailed in the Activity 3 analysis of encounter data.

This is performed by tracing certain key data elements from the encounters to the provider medical record. Encounter data for

the two sample months, March 2022, and September 2022, was used as the population for selection of records for review. A sample size of 100 records for each MCE was specified by OMPP for testing. A non-statistical⁴, random sampling of records was selected from the encounter data for review. The selected encounter records were sent to the MCEs for retrieval of the medical record. The MCEs were instructed to submit each medical record for the indicated enrollee and date of service in its entirety.

The medical records review is dependent on the ability of the provider to locate and submit complete and accurate medical records. MCEs were instructed to submit medical records to

Myers and Stauffer by August 22, 2023. Medical records submitted after the extension due date were considered missing and were not validated. Medical records that were illegible and/or incomplete were considered unusable and were excluded from the validation. Myers and Stauffer requested the MCEs provide a written explanation regarding the records not submitted. In general, MCEs indicated that the missing record had been requested but it had not been received from the provider by the due date.

Table 36 summarizes the number of records requested, received, missing, or unusable, and the net number of medical records tested.

Table 36. Medical Records Summary						
Description	Anthem	CareSource	MHS	MDwise	UHC	Total
HHW						
Requested	21	31	28	32	N/A	112
Missing	2	10	8	6	N/A	26
Received	19	21	20	26	N/A	86
Percentage of Requested Records Tested	90.47%	67.74%	71.43%	81.25%	N/A	76.79%
HCC						
Requested	18	N/A	20	N/A	38	76
Missing	2	N/A	6	N/A	11	19
Received	16	N/A	14	N/A	27	57

⁴ Non-statistical sampling is the selection of a test group, such as sample size, that is based on the examiner’s judgement, rather than a formal statistical method.

<https://www.accountingtools.com/articles/non-statistical-sampling.html>.

Table 36. Medical Records Summary						
Description	Anthem	CareSource	MHS	MDwise	UHC	Total
Percentage of Requested Records Tested	88.89%	N/A	70.00%	N/A	71.05%	75.00%
HIP						
Requested	61	67	52	68	N/A	248
Missing	5	20	14	10	N/A	49
Received	56	47	38	58	N/A	199
Percentage of Requested Records Tested	91.80%	70.15%	73.07%	85.29%	N/A	80.24%
Total						
Requested	100	98	100	100	38	436
Missing	9	30	28	16	11	94
Received	91	68	72	84	27	342
Percentage of Requested Records Tested	91.00%	69.38%	72.00%	84.00%	71.05%	78.44%

Validation

The medical records reviewed and compared to the encounter data, validated that the tested key data elements were supported by the medical record documentation. The validation rates were segregated to reflect the following:

- ◆ Supported Validation Rate: Encounters for which the medical records supported the key data elements as a percentage of the total elements sampled (i.e., all requested records).
- ◆ Supported Validation Rate Excluding Missing/Unusable Records: Encounters for which the medical records supported the key data elements as a percentage of usable medical records (i.e., the total of medical records requested [denominator] minus unusable medical records and requested medical records not submitted [missing] by the provider/MCE).
- ◆ Supported and unsupported determinations were for each key data element evaluated and not a claim level determination.

Both validation rates are reported in [Table 37](#) and highlight questions and concerns whether issues originated from non-supported key data elements in the medical records or from the inability of the MCE/provider to submit medical record documentation.

Table 37. Medical Records Validation Rates						
Description	Anthem	CareSource	MHS	MDwise	UHC	Total
HHW						
Elements Reviewed	245	222	217	309	N/A	993
Supported	233	218	205	303	N/A	959
Unsupported	12	4	12	6	N/A	34
Percentage of Elements Supported	95.10%	98.20%	94.47%	98.05%	N/A	96.57%
HCC						
Elements Reviewed	182	N/A	140	N/A	757	322
Supported	155	N/A	125	N/A	704	280
Unsupported	27	N/A	15	N/A	53	42
Percentage of Elements Supported	85.16%	N/A	89.28%	N/A	93.00%	86.95%
HIP						
Elements Reviewed	599	462	544	663	N/A	2,268
Supported	543	442	507	649	N/A	2,141
Unsupported	56	20	37	14	N/A	127
Percentage of Elements Supported	90.65%	95.67%	93.19%	97.88%	N/A	94.40%

Findings and Recommendations

The findings from the encounter data testing against medical records are presented in [Table 38](#), including recommendations for OMPP, the FAC, and/or the MCE, as appropriate.

Table 38. Activity 4 Findings and Recommendations

Findings		Recommendations
1	Four of the five MCEs submitted less than 90% of the requested medical records. The low number of records submitted may impact the percentages of supported key data elements.	The health plans should collaborate with their providers to ensure it receives medical records for the services requested.

Activity 5

Activity 5 summarizes the findings and recommendations identified in [Activity 1](#) through [Activity 4](#). **Table 39** contains finding numbers corresponding to the activity and sequential finding within each section of the report.

Table 39. Activity 5 Findings and Recommendations

Findings and Observations		Recommendations	
Activity 1 – Review State Requirements			
1	No findings were noted.		
Activity 2 – Review Health Plan System Capability			
2	No findings were noted.		
Activity 3 – Analyze Electronic Encounter Data Accuracy Findings and Recommendations (Non-Rx)			
KDE	Health Plan	Findings	Recommendations
1	Anthem	Encounter data values are not populated. This data element is required for inpatient claims only.	We recommend that Anthem, CareSource, MDwise, MHS, and UHC work with OMPP and Gainwell to investigate and ensure that the appropriate Admission Date information is submitted on the encounter.
	CareSource		
	MDwise		
	MHS		
	UHC		
2	Anthem	The claim sample data reflect a value, and the encounter data does not or vice versa. This data element is required for inpatient claims only.	We recommend that Anthem, CareSource, MDwise, MHS, and UHC work with OMPP and Gainwell to investigate and ensure that the appropriate Bill Type information is submitted on the encounter.
	CareSource		
	MDwise		
	MHS		
	UHC		

Table 39. Activity 5 Findings and Recommendations

Findings and Observations			Recommendations	
3	Billed Charges	MHS	Both the claim sample data and the encounter data reflect valid values and they do not agree.	We recommend that MHS works with OMPP and Gainwell to investigate and ensure that the appropriate payment information is submitted on the encounter.
4	Diagnosis Codes	Anthem	Claim sample values are not populated.	We recommend that Anthem ensure that the requested data template instructions are followed for improved results in future analyses.
5	Health Plan Paid Date	Anthem	Both the claim sample data and the encounter data reflect valid values and they do not agree, or encounter data values are not populated.	We recommend that Anthem, CareSource, MDwise, MHS, and UHC work with OMPP and Gainwell to investigate and ensure that the appropriate Health Plan Paid Date is submitted on the encounter.
		CareSource		
		MDwise		
		MHS		
		UHC		
6	MMIS Enrollee Number		Claim sample values are not populated.	We recommend that MDwise work with OMPP and Gainwell to investigate and ensure that the appropriate Enrollee Number information is submitted on the encounter.
		MDwise		
7	Former Original Claim ICN	CareSource	Both the claim sample data and the encounter data reflect valid values and they do not agree.	We recommend that CareSource, MDwise, MHS, and UHC work with OMPP and Gainwell to investigate and ensure that the appropriate ICN information is submitted on the encounter.
		MDwise		
		MHS		
		UHC		

Table 39. Activity 5 Findings and Recommendations

Findings and Observations			Recommendations						
8	MMIS ICN	<table border="1"> <tr><td>CareSource</td></tr> <tr><td>MDwise</td></tr> <tr><td>MHS</td></tr> <tr><td>UHC</td></tr> </table>	CareSource	MDwise	MHS	UHC	Both the claim sample data and the encounter data reflect valid values and they do not agree.	We recommend that CareSource, MDwise, MHS, and UHC work with OMPP and Gainwell to investigate and ensure that the appropriate ICN information is submitted on the encounter.	
CareSource									
MDwise									
MHS									
UHC									
9	NPI - Billing Provider	<table border="1"> <tr><td>Anthem</td></tr> <tr><td>CareSource</td></tr> <tr><td> </td></tr> <tr><td>UHC</td></tr> </table>	Anthem	CareSource		UHC	Both the claim sample data and the encounter data reflect valid values and they do not agree.	We recommend that Anthem, CareSource, and UHC work with OMPP and Gainwell to investigate and ensure that the appropriate NPI values are submitted on the encounter.	
Anthem									
CareSource									
UHC									
10	NPI - Servicing Provider	<table border="1"> <tr><td>Anthem</td></tr> <tr><td>CareSource</td></tr> <tr><td> </td></tr> <tr><td>UHC</td></tr> </table>	Anthem	CareSource		UHC	Both the claim sample data and the encounter data reflect valid values and they do not agree.	We recommend that Anthem, CareSource, and UHC ensure that the requested data template instructions are followed for improved results in future analyses.	
Anthem									
CareSource									
UHC									
11	Procedure Code	<table border="1"> <tr><td> </td></tr> <tr><td>MHS</td></tr> <tr><td> </td></tr> </table>		MHS		Claim sample values are populated with the revenue code.	We recommend that MHS ensure that the requested data template instructions are followed for improved results in future analyses.		
MHS									
12	Surgical Procedure Code	<table border="1"> <tr><td>Anthem</td></tr> <tr><td>CareSource</td></tr> <tr><td> </td></tr> <tr><td>MHS</td></tr> <tr><td>UHC</td></tr> </table>	Anthem	CareSource		MHS	UHC	Surgical Procedure Codes: Anthem, CareSource, MHS, and UHC – Encounter data values are not populated.	We recommend that Anthem, CareSource, MHS, and UHC ensure that the requested data template instructions are followed for improved results in future analyses.
Anthem									
CareSource									
MHS									
UHC									

Table 39. Activity 5 Findings and Recommendations

Findings and Observations		Recommendations		
Accuracy Findings and Recommendations (Rx)				
KDE	Health Plan	Findings	Recommendations	
1	Billed Charges	Anthem	The claim sample data reflect \$0.00 billed amounts, and the encounter data reflect values other than \$0.00, or both data reflect valid values and they do not agree.	We recommend that Anthem, MHS, and UHC work with OMPP and Gainwell to investigate and ensure that the appropriate payment information is submitted on the encounter.
		MHS		
		UHC		
2	Former Original Claim ICN	Anthem	Claim sample values are not populated, or both the claim sample data and the encounter data reflect valid values and they do not agree.	We recommend that appropriate audit trails are in place for all adjusted, replaced, and void claims. The original ICN should be linked to the replacement, adjustment and/or void claim and the original ICN information is available to trace the replacement/adjustment back to the original claim.
		CareSource		
		MDwise		
		MHS		
3	Health Plan Paid Amount		Both the claim sample data and the encounter data reflect valid values and they do not agree.	We recommend that UHC works with OMPP and Gainwell to investigate and ensure that the appropriate health plan paid amount is submitted on the encounter.
		UHC		
4	Health Plan Paid Date	CareSource	Both the claim sample data and the encounter data reflect valid values and they do not agree.	We recommend that CareSource, MDwise, and UHC work with OMPP and Gainwell to investigate and ensure that the health plan paid date information is submitted on the encounter.
		MDwise		
		UHC		
5	MMIS ICN	CareSource	Claim sample values are not populated, or both the claim sample data and the encounter data reflect valid values and they do not agree.	We recommend that CareSource and UHC ensure that the requested data template instructions are followed for improved results in future analyses.
		UHC		

Table 39. Activity 5 Findings and Recommendations

Findings and Observations		Recommendations
6	MMIS Enrollee Number UHC	The MCE appears to have submitted an internal enrollee ID in the claim sample data instead of the MMIS Enrollee Number. We recommend that UHC ensures that the requested data template instructions are followed for improved results in future analyses.
7	Prescriber NPI CareSource	The MCE appears to have submitted an internal provider ID in the claim sample data instead of the Prescriber NPI. We recommend that CareSource ensures that the requested data template instructions are followed for improved results in future analyses.
8	Refill Number CareSource	Both the claim sample data and the encounter data reflect valid values and they do not agree. We recommend that CareSource works with OMPP and Gainwell to investigate and ensure that the appropriate Refill Number information is submitted on the encounter.

Timely Payment and Submission of Encounters Findings and Recommendations

Findings	Recommendations
1 The percentage of claims paid within 21 days was below the 98% threshold for CareSource HHW and HIP; MDwise HIP; MHS HCC, HHW, and HIP; and UHC HCC. The percentage of encounters submitted within 21 days was below the 98% threshold for Anthem HHW and HIP; CareSource HIP; MHS HCC, HHW, and HIP; and UHC HCC.	We recommend that the health plans review their internal claims processes to identify and address barriers to timely payment of claims and encounter submissions. In addition, the health plans should work with OMPP and Gainwell to investigate and ensure that encounters are able to be submitted timely.

Benefit Testing Findings and Recommendations

Findings	Recommendations
1 No health plan denied encounters were received for the categories of service analyzed from UHC HCC and CareSource HIP.	We recommend that UHC and CareSource work with OMPP and Gainwell to investigate and ensure that health plan denied encounters are able to be submitted to the MMIS.

Activity 4 – Review of Medical Records

1 Four of the five MCEs submitted less than 90% of the requested medical records. The low number of records submitted may impact the percentages of supported key data elements.	The health plans should collaborate with their providers to ensure it receives medical records for the services requested.
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Conducting Focus Studies of Health Care Quality

Background

Office of Medicaid Policy and Planning

In Indiana, FSSA administers programs that promote the emotional, mental, and physical well-being to over 1.5 million residents.⁵ Within FSSA, the Office of Medicaid Policy and Planning is the division responsible for the administration of Medicaid programs for the state, including traditional Medicaid (i.e., Fee-for-Service [FFS]), the managed care system, and waiver programs for specific populations. The managed care system is currently comprised of three programs serving over a million members— (1) HIP, (2) HCC, and (3) HHW⁶—with five managed care entities contracted to serve members in one or more of these managed care programs. In addition to promoting physical and mental well-being, the agency and division aim to dismantle inequity impacting the diverse population served and to provide a crucial safety net to residents.

In an effort to continue to support Medicaid members over 60 years of age, the Indiana Pathways for Aging program will be implemented beginning in the summer of 2024, building

greater coordination for members through managed long-term services and supports.⁷

External Quality Review

The Centers for Medicare & Medicaid Services play a leading role in promoting the quality and performance of Medicaid managed care programs. One of the mechanisms employed for this purpose is the EQR process. The purpose of an EQR is to “analyze and evaluate aggregated information on quality, timeliness, and access to the health care services that a managed care plan, or its contractors, furnish to Medicaid beneficiaries.”⁸ CMS requires states delivering Medicaid and CHIP services through managed care to contract with at least one EQRO to conduct an EQR of their health plans.⁹ In accordance with Title 42 CFR § 438.364, OMPP contracted with Qsource—a nonprofit health care-related quality improvement organization—to perform mandatory and optional EQR activities. Myers and Stauffer is subcontracted

⁵ Indiana Family and Social Services Administration. (n.d.). *History and Overview*. Retrieved from <https://www.in.gov/fssa/about-fssa/historyoverview/>.

⁶ *Ibid.*

⁷ Indiana Family and Social Services Administration. (n.d.). *Why Indiana Pathways for Aging*. Retrieved from <https://www.in.gov/fssa/indiana-pathways-for-aging/about-indiana-pathways-for-aging/>.

⁸ Centers for Medicare & Medicaid Services. (n.d.). *Quality of Care External Quality Review*. Retrieved from <https://www.medicare.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html#:~:text=EOR%2Drelated%20activities%20are%20intended,timeliness%2C%20and%20access%20to%20care.>

⁹ *Ibid.*

by Qsource to assist in the EQR, which included designing and conducting Indiana's Protocol 9 activities.

EQR Protocol 9

Protocol 9 is among a series of protocols within the EQR framework and addresses critical aspects of data use, performance measurement, and quality improvement within the

Medicaid managed care realm. Many states choose to contract with an EQRO to conduct focus studies for legislative or administrative purposes, or to improve the quality of health care provided by their contracted managed care plans (MCPs). Protocol 9 is a voluntary protocol used to conduct health care quality-related focus studies that typically evaluate a specific service area (clinical or nonclinical) during a single year.¹⁰

Study Design

Protocol 9 is comprised of seven activities that take the EQRO through a specific process from selecting the study topic and defining the study question to developing the study methods, collecting the data, and reporting the results back to the state. A summary of CMS general guidance¹¹ for each activity is provided in the table below.

¹⁰ Centers for Medicare & Medicaid Services. (n.d.). *Quality of Care External Quality Review*. Retrieved from <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality->

[review/index.html#:~:text=EOR%2Drelated%20activities%20are%20intended,timeliness%2C%20and%20access%20to%20care.](#)

¹¹ *Ibid.*

Table 40. Protocol 9 Activity Steps**Activity 1: Select the Study Topic(s)**

Selected focus studies should target relevant areas of clinical or nonclinical service areas that have been identified as needing improvement. When selecting focus study topics, a variety of factors related to member characteristics, health risks, experience of care, and special population or service needs should be considered.

Activity 2: Define the Study Question(s)

The study questions should identify the focus of the studies, establish a framework for data collection and analysis, and be clear, concise, and answerable. The study questions should specify measurable indicators for the study population and appropriate reporting period.

Activity 3: Select the Study Variable(s)

The selected study variables should use clearly defined measurable indicators of performance, as to allow the EQRO to measure the MCPs performance in an objective and reliable manner. When selecting study variables, measures that currently exist within the managed care/health care industry, are collected by MCPs, and include already established benchmarks should be considered.

Activity 4: Develop a Plan to Study the Population

When selecting a study population, all members of the population that meet measure-specific eligibility criteria should be included. After the study population is selected, the EQRO can decide if it is necessary to review a representative sample of the population. If this is the case, the sample should reflect the total study population.

Activity 5: Collect Data

A data collection plan should be developed to specify data sources, data to be collected, how and when the data will be collected, the frequency of data collection, who will collect the data, and instruments used to collect the data. The plan must clearly define the data sources and specify steps that will be taken to ensure complete and reliable data collection. Both qualitative and quantitative data should be considered.

Activity 6: Analyze and Interpret Study Results

A data analysis plan should be developed to specify how data will be analyzed and interpreted. The EQRO should develop hypotheses about the root causes of MCP performance, and data collection should aim to validate these hypotheses.

Activity 7: Report Results to the State

After completion of the focus studies, results should be reported to the state by way of an EQR technical report. The EQRO should submit an outline to the state before drafting the report to ensure appropriate information is included in the desired format.¹²

For Protocol 9, OMPP selected two focus study topic areas:

- ◆ Assessing the Managed Care Entities (MCEs) Approach to Addressing Health-related Social Needs (HRSNs); and
- ◆ Transitions of Care Post-Discharge for the Hoosier Care Connect (HCC) Population.

¹² Centers for Medicare & Medicaid Services. (n.d.). *Quality of Care External Quality Review*. Retrieved from <https://www.medicare.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html#:~:text=EOR%2Drelated%20activities%20are%20intended,timeliness%2C%20and%20access%20to%20care>.

Myers and Stauffer ensured addressing each of the seven activities when performing each of the Indiana focus studies. Specific study design details can be found later in the report.

Focus Study 1: Health-Related Social Needs (HRSN)

Introduction

The U.S. Department of Health and Human Services’ Healthy People 2030 Framework states that “the health and well-being of all people and communities is essential to a thriving, equitable society.”¹³

Health equity is defined by the Centers for Disease Control and Prevention (CDC) as “the state in which everyone has a fair and just opportunity to attain their highest level of health.”¹⁴ Addressing health equity requires understanding and mitigating factors disproportionately and adversely impacting an individual’s and community’s health and well-being. Social determinants of health (SDOH)— “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life (e.g., economic, social, and political policies, norms, and systems)¹⁵— are the non-medical factors profoundly influencing an

individual’s health outcomes, access to health care resources, and well-being.¹⁶

While SDOHs can be thought of as community and social level systems influencing health, health-related social needs refer to individual-level, adverse social conditions that significantly impact health outcomes and may result from social determinants of health. Factors such as employment, education level, housing stability and affordable utilities, access to nutritional food, personal safety, and lack of transportation collectively affect an individual’s health trajectory.¹⁷ Notably, while the terms SDOH and HRSN reflect different social ecological levels, they are often used interchangeably.

Table 41. Social Determinants of Health Z Codes	
Z Code	Social Determinants of Health
Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z58	Problems related to physical environment

¹³ U.S. Department of Health and Human Services. (n.d.). Healthy People 2030 Framework: A Guiding Vision. Retrieved from <https://health.gov/healthypeople/about/healthy-people-2030-framework#:~:text=Healthy%20People%202030%27s%20overarching%20goals,and%20well%2Dbeing%20of%20all>.

¹⁴ Centers for Disease Control and Prevention. (December 16, 2022) Health Equity. Retrieved from <https://www.cdc.gov/nchhstp/healthequity/index.html>.

¹⁵ World Health Organization (2023) Social Determinants of Health. Retrieved from: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

¹⁶ Oregon Health Authority (n.d.). Patient-Centered Primary Care Home Program. Retrieved from <https://www.oregon.gov/oha/HPA/dsi-pcpc/AdditionalResources/Health-related%20Social%20Needs%20vs%20the%20Social%20Determinants%20of%20Health.pdf>.

¹⁷ Centers for Medicare & Medicaid Services. (September 2021). Z codes data highlight [PDF]. Retrieved from <https://www.cms.gov/files/document/z-codes-data-highlight.pdf>.

Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

Achieving health equity requires collaborative, ongoing efforts to address social determinants of health and health-related social needs. By recognizing the interconnections between these factors, health care systems can develop strategies to promote fair access to health care, reduce health disparities among diverse populations, and improve overall patient well-being.

Study Purpose and Objectives

The purpose of Focus Study 1 was to evaluate how contracted MCEs compared during CY 2022 regarding expectations of their providers’ use of Z codes to assess for HRSNs, providers use of Z codes via claims, and how MCEs are closing the loop on HRSN referrals. A closed-loop referral is one that identifies a health-related social need, and “securely and efficiently delivers

and tracks the referral in an actionable way for the sending and receiving organization.”¹⁸

Specifically, the objectives of the study were to address the following questions for CY 2022:

- ◆ How does the volume of Z code claims compare across the Medicaid program, across all MCEs, stratified by Indiana managed care programs as well as by member demographics?
- ◆ How do MCEs expectations of their providers’ use of Z codes to assess for HRSNs compare?
- ◆ How do MCEs compare in their approach to address HRSNs and/or SDOHs of their members?
- ◆ What process and supports, if any, are MCEs using to close the loop on any HRSN-related referrals?

Background

National Landscape

Nationally, the use of Z codes to document social determinant of health data remains relatively low.¹⁹ In a national assessment done by the University of Chicago, it was discovered that only 1.42% of Medicaid enrollees in 2018 had at least one health-related social need documented on their claims or encounter data.²⁰ However, the importance of considering the broader social context in which patients live has become increasingly

¹⁸ Michigan Health Information Network Shared Services. (n.d.). ReferralsPlus Use Case. Retrieved from <https://mihin.org/referralsplus-use-case/#:~:text=When%20a%20person%20is%20identified,care%20to%20meet%20that%20need.>

¹⁹ Centers for Medicare & Medicaid Services. (September 2021). Z codes Data Highlight [PDF]. Retrieved from <https://www.cms.gov/files/document/z-codes-data-highlight.pdf>.

²⁰ NORC at the University of Chicago. (2022). Documentation of Social Determinants of Health in Medicaid Claims [PDF]. Retrieved from https://www.norc.org/content/dam/norc-org/pdfs/Documentation%20of%20SDOH%20in%20Medicaid%20Claims_032422.pdf.

recognized.²¹ There is strong evidence to suggest that social determinants of health are important predictors of patient health outcomes, utilization, and health care costs.²² Addressing social determinants of health and health-related social needs requires a collaborative, community-wide approach that involves the support of diverse stakeholders to address health inequities.²³ Healthy People 2030 notes that promoting and achieving health and well-being nationwide is a shared responsibility that is distributed across the national, state, tribal, and community levels, including the public, private, and not-for-profit sectors.²⁴ Health care organizations are uniquely positioned to identify and address unmet health-related social needs for their patient populations. However, many barriers exist to the identification and documentation of social determinant of health data.

In addition to identifying and documenting health-related social needs, health care organizations must address unmet needs by providing referrals to community services. Without a formal and accountable process for tracking these referrals, it can be difficult to ensure patients attend their referral appointments,

and even more challenging to alert referring physicians when the visit was completed. This can be addressed by securely and efficiently delivering and tracking the referral in an actionable way for the receiving organization, also known as closing the loop on the referral.

Increasing the documentation and use of Z codes in healthcare is crucial for capturing important contextual information that plays a critical role in treatment decisions, resource allocation, and overall patient care.²⁵ In addition, documenting health-related social needs through the use of Z codes informs policy and payment reform efforts, and helps state Medicaid agencies tailor programs and policy to meet their populations' needs.²⁶ Lastly, closing the loop of health-related social needs referrals can significantly improve patient safety and satisfaction, and positively impact care coordination.

State Landscape

OMPP updates and submits a Quality Strategy to CMS at least once every three years. The Quality Strategy is a key document

²¹ Rajabi, A., Dehghan Nayeri, N., Zare, M., & Bahrani, N. (2016). *The Challenges of Nursing Students in the Clinical Learning Environment: A Qualitative Study*. *Journal of Education and Health Promotion*, 5, 16. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5135524/>. Accessed October 21, 2023.

²² Centers for Medicare & Medicaid Services. (2022). *State Medicaid & CHIP COVID-19 Performance Improvement Project (PIP) Fact Sheet [PDF]*. Medicaid.gov. https://www.medicaid.gov/sites/default/files/2022-01/sho21001_0.pdf.

²³ Health Affairs. (n.d.). *Talking Social Determinants: Precision Matters*. Health Affairs. Retrieved from <https://www.healthaffairs.org/content/forefront/talking-social-determinants-precision-matters>.

²⁴ U.S. Department of Health and Human Services. (n.d.). *Healthy People 2030's Overarching Goals*. *Healthy People 2030 Framework*. Retrieved from <https://health.gov/healthypeople/about/healthy-people-2030-framework#:~:text=Healthy%20People%202030%27s%20overarching%20goals,an%20well%20being%20of%20all>.

²⁵ *Guide to ICD-10-CM Z Codes*. (n.d.). Wolters Kluwer. Retrieved from <https://www.wolterskluwer.com/en/expert-insights/guide-to-icd-10-cm-z-codes>.

²⁶ NORC at the University of Chicago. (2022). *Documentation of Social Determinants of Health in Medicaid Claims [PDF]*. NORC. Retrieved from https://www.norc.org/content/dam/norc-org/pdfs/Documentation%20of%20SDOH%20in%20Medicaid%20Claims_032422.pdf.

that describes the aims, objectives, and high-level oversight processes of OMPP. Approaches for addressing health inequities are notably discussed throughout the [OMPP Quality Strategy Overview](#).

The Quality Strategy describes FSSA's Office of Healthy Opportunities which prioritizes identifying and reducing the impact of social determinants of health on Indiana's citizens. The Quality Strategy goes on to point out that contracted MCEs play an integral role in the identification of health-related social needs to address risk factors and support the advancement of health equity. OMPP required MCEs to provide presentations outlining health equity efforts and encouraged MCEs to develop data collection methods to guide future health equity efforts. In addition, each MCE was required to appoint a Health Equity Officer as key staff by 2023 and must continue to showcase efforts by submitting an annual Health Equity Plan for OMPP approval. Lastly, OMPP required all MCEs to develop a QIP with a goal to increase the rates of completion for the HNS.

During the reporting period, five MCEs were contracted to provide health care services to Indiana's member population and were included in this focus study: (1) Anthem, (2) CareSource, (3) MDwise, (4) MHS, and (5) UHC. The health program(s) each MCE serves is provided in **Table 42** below.

Table 42. Protocol 9 MCEs Studied			
MCE	HCC	HIP	HHW
Anthem	✓	✓	✓

Table 42. Protocol 9 MCEs Studied

MCE	HCC	HIP	HHW
CareSource		✓	✓
MDwise		✓	✓
MHS	✓	✓	✓
UHC	✓		

Methods

Study Design

The study evaluated the five MCEs approach to addressing member's health-related social needs across the Indiana Medicaid program during CY 2022. A mixed method study design was used to collect quantitative and qualitative data to address the study objectives. Details about each study component are provided below. This study was conducted in accordance with the 2023 CMS External Quality Review Protocols Guide.

There were no exclusion criteria; any member enrolled in Hoosier Care Connect, Healthy Indiana Plan, or Hoosier Healthwise during CY 2022 was included in the quantitative analysis and all MCEs were included in the qualitative components and analyses. A description of the subpopulations for each health program is provided in **Table 43** below.

Table 43. Protocol 9 Subpopulations of Each MCE

Program	Approximate Number of Members	Types of Members Served
Hoosier Care Connect	100,000	Aged, blind, and disabled individuals who are not

Table 43. Protocol 9 Subpopulations of Each MCE

Program	Approximate Number of Members	Types of Members Served
Healthy Indiana Plan	800,000	dually eligible for Medicare, and foster children. Low-income and working adults ages 19-64 who may not be eligible for Medicare or Medicaid.
Hoosier Healthwise	800,000	Children and pregnant women, including Indiana’s CHIP population.

For each study component and objective, different information was collected and used, including claims data, MCE-provided policy and procedure documents and reports, and key informant interviews. The data sources available for each study component as well as the study objective they address are provided in **Table 44** below.

Table 44. Protocol 9 Data Sources

Data Sources	Study Component	Study Objective
CY 2022 MCE Claims Data	Quantitative: Claims Analysis	Objective 1
CY 2022 Indiana CPT Data Dictionary	Quantitative: Claims Analysis	Objective 1
MCE Policies and Procedures	Qualitative: Document Review	Objectives 2, 3, and 4
Key Informant Interviews	Qualitative: MCE Interviews	Objectives 2, 3, and 4

Quantitative Methods

To evaluate how the volume of Z code claims compared across the Medicaid program (study objective 1), primary and secondary variables were first identified. The primary variable for analysis was Z code use. Secondary variables available and included in the claims analysis were: age in years, gender (male or female), race/ethnicity, and health program.

The dataset included MCE-submitted encounters, for the period of January 1, 2022, through December 31, 2022, contained in the state’s Medicaid Management Information System (MMIS) and provided to Myers and Stauffer by OMPP as part of a standard data extract process. Diagnosis codes for social determinants of health were identified within the professional claim dataset. The dataset was further limited to claims with at least one Z code within the broad categories of Z codes (i.e., Z55-Z65). Each of these broad categories have multiple sub-codes that describe more specific conditions under the broad category of the code, such as Z55.0 (illiteracy and low-level literacy) and Z56.89 (other problems related to employment). A list of these sub codes and counts of use can be found in Appendix D.

Qualitative Methods

The two processes described below (documentation request and key informant interviews) were used to evaluate study objectives 2, 3, and 4—how MCEs expectations of their providers’ use of Z codes compared, how MCEs approach to address member’s

HRSNs compared, and what process or supports MCEs use to close the loop on HRSN referrals, respectively.

Documentation Request

First, a document review of MCE-provided policy and procedures and reports was performed to determine whether/how MCEs support the use of Z codes to address health-related social needs. Documents requested included materials relevant to requirements related to HRSN and/or SDOH and Z code use, systems or software used to support closed loop referrals, copies of relevant training materials, specific health needs screening data, and any relevant initiative information. A full list of requested documents can be found in Appendix C.

The data request process was standardized throughout the data collection process. Each MCE (N=5) was contacted and provided with a list of requested data and submission instructions.

Following document receipt, a minimum submission review (MSR) was performed to ensure all requested information was accessible, received, and relevant. When issues occurred, the MCE was contacted to submit updated information. Once the MSR was completed, an assigned reviewer conducted a primary review of all documentation, identified key components from each document, and outlined notable context to include during the key informant interviews. A secondary reviewer also completed a validation check. Once all MCE documents were

reviewed, data were organized by relevance and emerging themes and patterns were identified.

Key Informant Interviews

Second, key informant interviews were conducted with subject-matter staff from each MCE (N=5) to discuss each plan's processes and perspectives to support the use of Z codes to address health-related social needs, identify what SDOH data the plans currently collect and analyze, and obtain detail regarding SDOH initiatives the plans are implementing, among others.

MCEs were provided with a full list of interview questions to ensure the necessary staff were available to participate. Interviews were conducted virtually using a semi-structured approach. Participants were given the opportunity to send additional information via email within one week of their completed interview. With participants' consent, interviews were recorded to capture detailed responses accurately.

Following interview completion, transcribed interviews and recordings were reviewed and data were organized by emerging themes and patterns. Information collected during the interviews was also compared to information submitted in the document request and used to supplement those data, as appropriate.

Data Analysis and Findings

The data analysis and findings are structured to evaluate MCE use of Z codes systematically. First, MCE Z code expectations and use and factors that are likely to preemptively impact Z code

claims use (e.g., HRSN screening; provider expectations, training, and incentives; and data analysis software) are assessed. Second, Z code claims data are analyzed. Third, the MCEs' processes for closing the loop on HRSN referrals—which follows documenting a member's social need—are evaluated. Finally, HRSN/SDOH initiatives and strategies MCEs use are outlined. Initiatives close the loop on the analysis and findings section as they wrap up what MCEs may be doing that could enhance and improve addressing member HRSNs and provider Z code use.

Z code Expectations and Use

To understand the scope of expectations MCEs, maintain related to SDOH, HRSN, and/or Z codes, including closed loop referrals, the following documentation was requested:

- ◆ Policies, procedures, and contract requirements, regarding health-related social needs and/or social determinants of health;
- ◆ A list, if any, of MCE-supported systems and/or software utilized to support closed loop HRSN referrals (e.g., 211, Aunt Bertha, UniteUs, etc.);
- ◆ A copy of any relevant HRSN, SDOH, and/or Z-codes training materials (in-house staff training and/or provider materials);
- ◆ All written MCE protocols, if any, for activities when members select “yes” on Question 10 of the New Member Health Needs Screen; and

- ◆ Documentation regarding any initiatives in place to support collection, utilization, improvement, and/or reporting of HRSN, SDOH, and/or Z codes.

In response to the document request, MCEs submitted policies and procedures that described expectations related to such topics as cultural competency; health needs screening; member identification and stratification; population health, care management, case management and disease management; post-acute care facility care management; and high-touch, face-to-face visits.

Screening for Health-related Social Needs

The identification of needs is an essential step in the process for documenting and addressing health-related social needs. A screening tool aiming to identify a member's immediate physical, behavioral, and/or social needs is used to complete an initial assessment.

MCEs are required to conduct an initial HNS within 90 calendar days of a member's effective date of enrollment. MCEs are expected to use an FSSA-approved screening tool; the initial screening may be conducted in-person, by phone, electronically, or by mail. MCEs are also expected to develop strategies to encourage contracted providers to use FSSA-approved

screening tools.²⁷ All five MCEs verified screening for social determinants of health using an FSSA-approved assessment tool to screen, as documented by submitted policies and procedures, utilization management reports, and context provided during interviews.

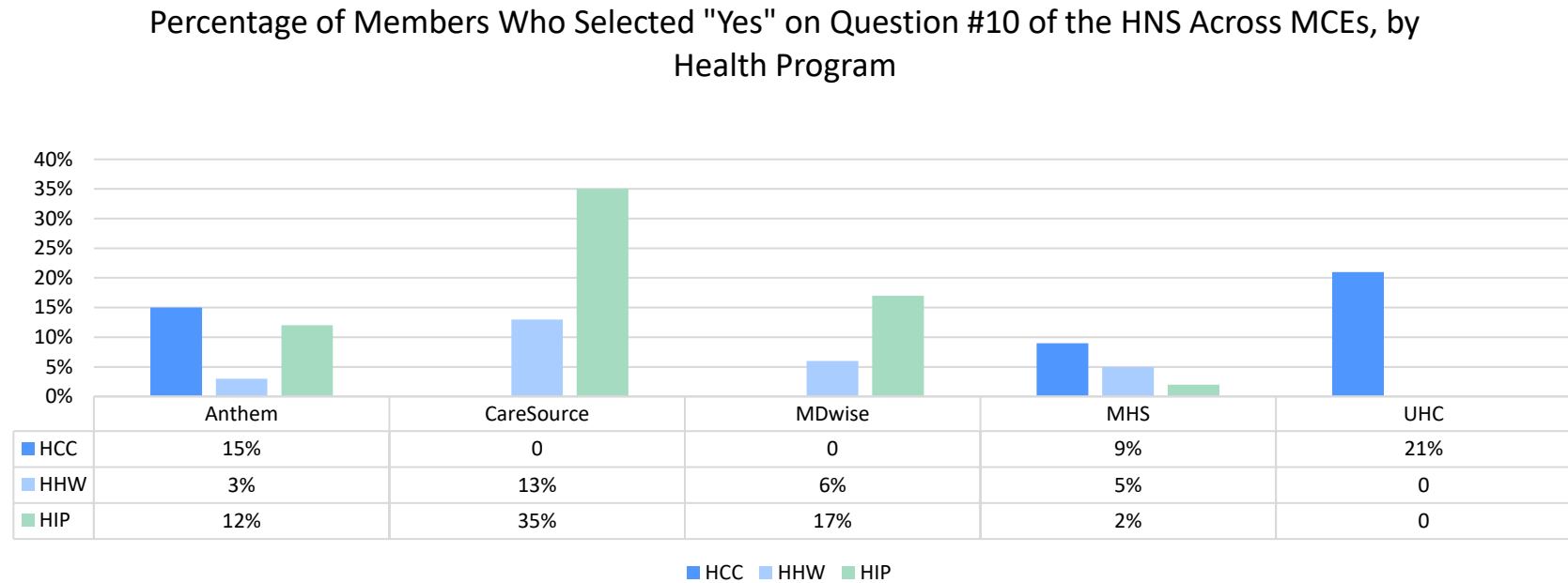
Screening Rates

The HNS is comprised of thirteen questions, with question ten specifically screening for information about health-related social needs by asking: “Do you worry about things like where you live? Getting food every day? Getting to the grocery or doctor’s appointments? Feeling safe?”

The percentage of members who selected “yes” on question ten across all MCEs in CY 2022, was assessed by health program (HCC, HHW, HIP). Of the three MCEs participating in HCC, UHC had the highest percentage (21%) of members who selected “yes” on Question 10. Of the four MCEs participating in HIP and HHW, CareSource had the highest percentage (13% for HHW, 35% for HIP) of members who selected “yes” on Question 10. The percentage of members selecting yes for each MCE by the respective health program is provided in [Figure 64](#) below.

²⁷ Indiana Family and Social Services Administration. (n.d.). *Quality and Outcomes Reporting*. Retrieved from <https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/>.

Figure 64. Percentage of Members who Selected “Yes” on Question #10 of the HNS Across MCEs, by Health Program



Note: A value of 0 indicates that this MCE did not offer the designated IHCP and should be considered Not Applicable (NA).

The proportion of members that selected “yes” on Question 10 was also compared to the total number of members who completed the HNS in CY 2022, by health program. Of the three MCEs participating in HCC, UHC had the largest proportion (N = 493) of members who selected “yes” on Question 10 compared to the total number of members (N = 1,825) who completed the HNS. Of the four MCEs participating in HHW and HIP, CareSource had the largest proportion (N = 1,276 for HHW, N

= 3,212 for HIP) of members who selected “yes” on Question 10 compared to the total number of members (N = 8,813 for HHW, N = 5,927 for HIP) who completed the HNS.

Detailed results for each MCE by health program are provided in **Figure 65**, **Figure 66**, and [Figure 67](#) below. Each figure is a graph in which the proportion of members selecting “yes” as part of the total completing the HNS for each MCE is depicted.

Figure 65. Total Number of HCC Members Who Completed the HNS Compared to Those Who Selected “Yes” on Question 10

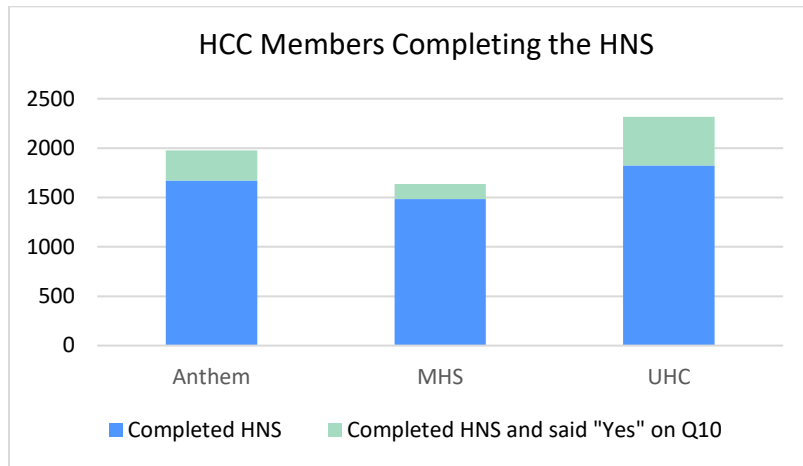


Figure 67. Total Number of HIP Members Who Completed the HNS Compared to Those Who Selected “Yes” on Question 10

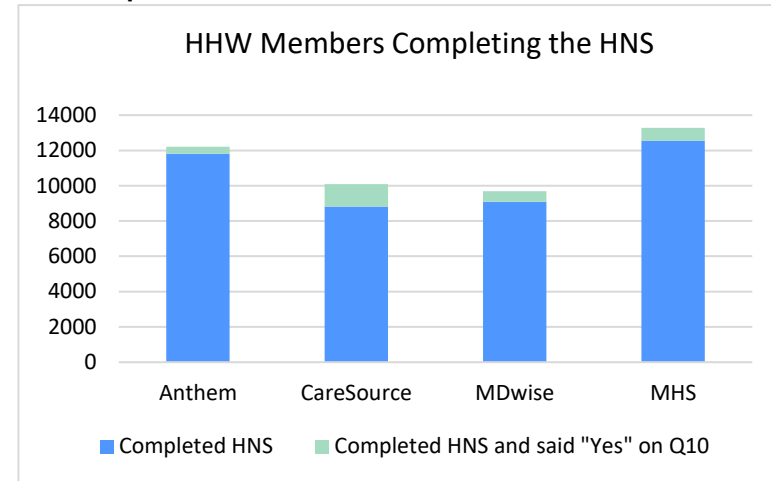
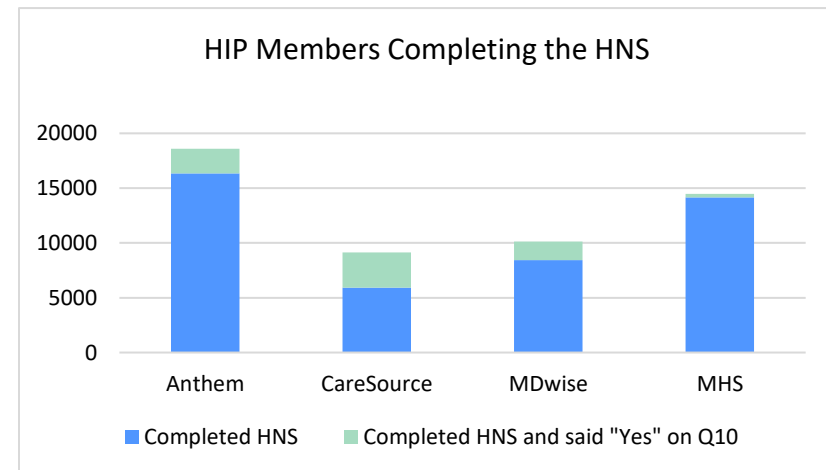


Figure 66. Total Number of HHW Members Who Completed the HNS Compared to Those Who Selected “Yes” on Question 10



Identification and resolution of member needs requires the HNS first be completed. Four of the MCEs offer an incentive for completion of the HNS. One MCE offers an incentive to members, while three MCEs offer incentives to providers. The incentive ranged between \$10-30 per completed assessment. The proportion of MCEs offering incentives to improve completion rates of the HNS is presented in **Table 45** below.

Provider Expectations and Training

None of the MCEs had written policies and procedures, nor contractual requirements for providers to document HRSN using Z codes. However, all five MCEs had written policies and procedures related to social determinants of health. UnitedHealthcare submitted a written policy and procedure for locating SDOH resources, as well as for screening and documenting SDOH data. CareSource had a procedure that highlights their “no wrong door” to providing health-related social needs referrals. MHS has a SDOH referral workflow that provides step-by-step guidance on how to identify unmet needs and provide immediate support by connecting members with available resources. Anthem had a procedure guide that outlined the process for case managers to identify high-risk members and refer them to their Quality Member Outreach Recovery Engagement (QMORE) team which is staffed with frontline community health workers.

The majority of the MCEs did not offer training on Z code use and documentation for their provider network. However, all MCEs did offer some form of general social determinant of

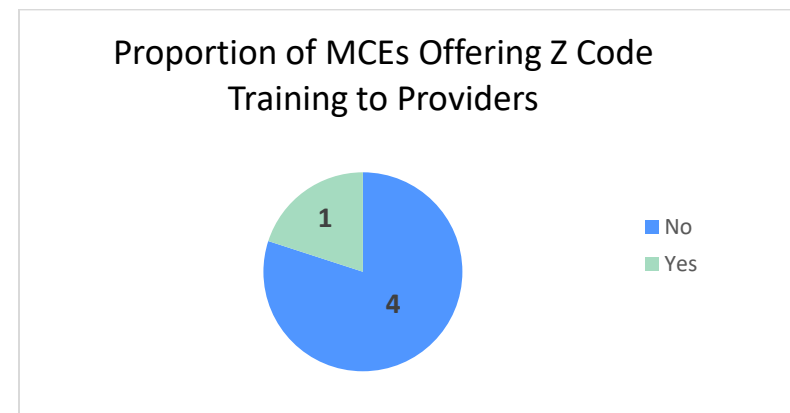
health or health equity training. MCEs recognize the increasing importance of Z code use to address social determinants of health and have begun to understand the benefits of offering training to provide guidance to their providers on how to document Z codes in patient records. Some MCEs not currently offering Z code specific training, plan to implement a training program in 2024. The proportion of MCEs offering Z code

Table 45. Proportion of MCEs Offering Incentives for the Completion of the HNS

MCE	Provider Incentive	Member Incentive
Anthem	✓	✓
CareSource		✓
MDwise	✓	✓
MHS	✓	✓
UHC	✓	✓

training to improve the use of Z codes is provided in **Figure 68**.

Figure 68. Proportion of MCEs Offering Z Code Training to Providers

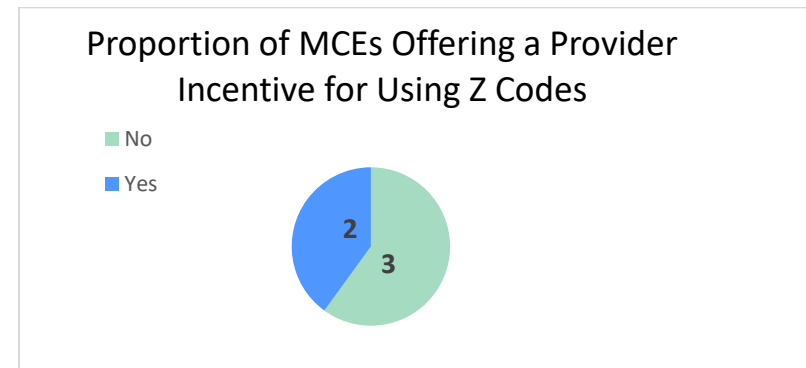


Provider Incentives to Increase Z Code Usage Rates

After social determinant of health data is collected, a member of the care team should document the data in the member's official medical record, and assign a Z code, if appropriate.²⁸ Ensuring documentation in the electronic health record enables health information exchange across providers, critical population health analytics, and timely and effective responses to individual-specific needs. However, Z codes are not directly reimbursable and, often, not tied to quality measures, contributing to low uptake across the nation.

The majority of Indiana MCEs did not offer an incentive to their provider network for including a Z code on claims. The MCEs mentioned several barriers to implementing Z code incentive programs such as administrative burden and difficulty proving return on investment when offering incentives. Despite these challenges, two of the three MCEs not currently offering incentives plan to implement an incentive program in 2024. The proportion of MCEs offering incentives to improve the use of Z codes is provided in **Figure 69**.

Figure 69. Proportion of MCEs Offering Provider Incentives for Z Code Use



Software and Systems for Data Analysis

MCEs must operate and maintain information systems to accurately and consistently collect and analyze data to support Indiana health program requirements. MCEs are required to collect and transmit relevant aggregated member data and reports (e.g., utilization management reports, clinical reports, and member service reports) to OMPP, including data for the HNS. This data is used to understand member utilization, care management, case management, and disease management activities, among other things.

Importantly, all five MCEs were found to be using data dashboards in some capacity to collect, track, or monitor SDOH data. MCEs indicated using dashboards to risk stratify populations, understand how best to target care management

²⁸ Centers for Medicare and Medicaid Services. (June 2023). *Using Z codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes [PDF]*. Retrieved from <https://www.cms.gov/files/document/zcodes-infographic.pdf>.

efforts, and evaluate hot-spots, resource deserts, common referral types, and community-based referral trends. Dashboards being used by MCEs include such information as:

- ◆ Summary of needs by county, age, sex, race, ethnicity, and language;
- ◆ Summary of needs compared to clinical conditions;
- ◆ Summary of members wanting program assistance;
- ◆ Summary of community-based organization referrals; and
- ◆ Summary of members with needs met.

One MCE dashboard observed was able to demonstrate that the top five areas of concern across the state include: (1) nutrition, (2) family circumstances, (3) psychosocial, (4) financial, and (5) housing, while the top five counties with needs include Marion, Lake, Allen, Vanderburgh, and Tippecanoe counties.

Z Codes Claims Data

In total, there were 13,725 Z codes attached to claims among the HIP, HHW, and HCC member populations in CY 2022. The top three most common Z codes documented were:

- ◆ Z62, problems related to upbringing (N = 4,479);
- ◆ Z63, other problems related to primary support group including family circumstances (N = 4,090); and
- ◆ Z59, problems related to housing and economic circumstances (N = 2,359).

The number of claims counted for each broad Z code are provided in **Table 46**.

Table 46. Total Number of Broad Z Code Claims for CY 2022

Code	Description	Count
Z55	Problems related to education and literacy	890
Z56	Problems related to employment and unemployment	482
Z57	Occupational exposure to risk factors	8
Z58	Problems related to physical environment	0
Z59	Problems related to housing and economic circumstances	2,359
Z60	Problems related to social environment	443
Z62	Problems related to upbringing	4,479
Z63	Other problems related to primary support group, including family circumstances	4,090
Z64	Problems related to certain psychosocial circumstances	105
Z65	Problems related to other psychosocial circumstances	847
Total		13,703

To better understand the top three utilized Z codes, sub codes for Z59, Z62, and Z63 were reviewed. Of these, the sub codes most frequently reported are provided in [Table 47](#).

Table 47. Summary of Most Frequently Report Z59, Z62, and Z63 Sub Code Use

Z59 – Housing/Economic	Z62 – Upbringing	Z63 – Primary Support
◆ 34.9% reported homelessness.	◆ 44.5% reported parent-biological child conflict.	◆ 33.5% reported problems related to the disappearance or death of a family member.
◆ 24.7% reported food insecurity.	◆ 22.4% reported physical, psychological, or sexual abuse in childhood.	◆ 24.2% reported problems related to the primary support group.
◆ 20.4% reported housing instability.	◆ 12.2% reported child in welfare custody.	◆ 20% reported problems in
◆ 13.1% reported problems with housing and economic		

Table 47. Summary of Most Frequently Report Z59, Z62, and Z63 Sub Code Use		
Z59 – Housing/Economic circumstances.	Z62 – Upbringing	Z63 – Primary Support relationship with spouse or partner.

Demographics

Of the 13,725 Z codes documented, the 0-18 years of age group had the highest proportion (44%) of members with a Z code documented on their claim. Caucasian members represented the largest proportion (79%) of members and Black members represented the next largest proportion (18%) with a Z code attached to their claim. When the data were stratified by gender, females (59%) represented a larger percentage of total Z code claims compared to males (41%). Demographic results are presented in **Figure 70**, **Figure 71**, and [Figure 72](#).

Figure 70. Z Codes by Gender

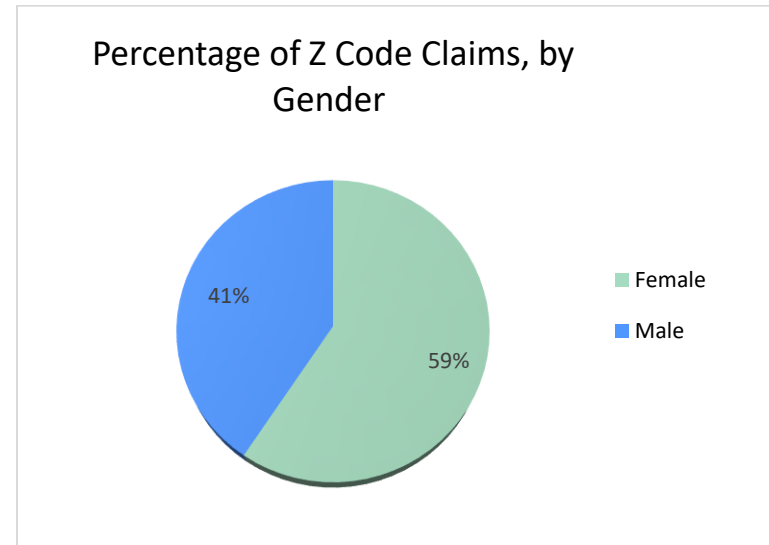


Figure 71. Z Codes by Race/Ethnicity

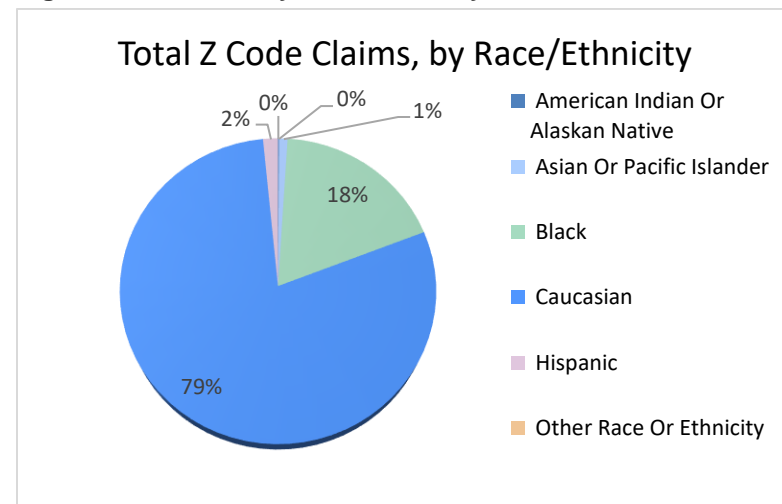
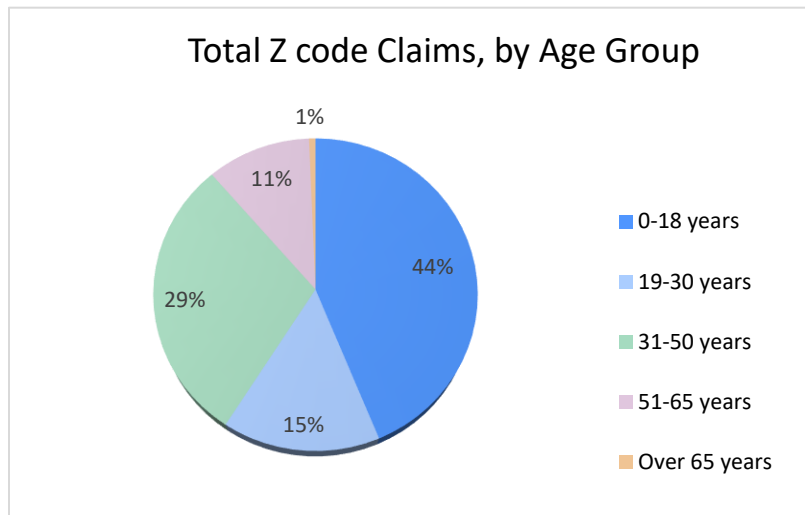


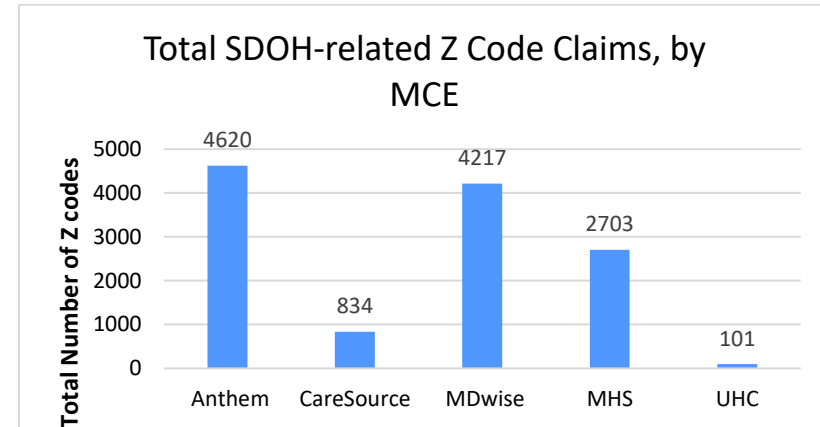
Figure 72. Z Codes by Age Groups



Managed Care Entities

When evaluating the MCEs individually, Anthem had the highest number (N = 4,620) of Z codes documented, followed by MDwise (N = 4,217), and MHS (N = 2,703). MCE results are presented in **Figure 73**.

Figure 73. Total Z Code Claims, by MCE



Closing the Loop on Health-Related Social Needs Referrals

Once social determinant of health data is collected and a Z code is documented on a member's health record, contracted providers are encouraged to address the member's health-related social needs by providing referrals to appropriate resources. This may include referrals to internal programs or referrals to external community-based organizations (CBOs). Once a referral has been made, it should be documented and tracked to ensure the referral loop is closed and the member receives the care they need. A closed-loop referral is one that identifies a health-related social need, and "securely and efficiently delivers and tracks the referral in an actionable way for the sending and receiving organization,"²⁹ sending confirmation of referral completion and results to the referring provider.

²⁹ Michigan Health Information Network Shared Services. (n.d.). ReferralsPlus use case. Retrieved from <https://mihin.org/referralsplus-use>

[case/#:~:text=When%20a%20person%20is%20identified,care%20to%20meet%20that%20need.](#)

None of the MCEs were found to have written policies and procedures, nor contractual expectations for providers to make health-related social needs referrals. However, MCEs indicated that providers were educated and encouraged to make referrals on behalf of their members. Three of the five MCEs lacked a system that automatically notified providers and/or the MCE when a member used the referral. Instead, these MCEs relied on staff to follow up with members via email or phone to close the referral loop, in some instances using systems and software that reminded staff to follow up.

Finally, all five MCEs mentioned the use of FindHelp in some capacity for referrals. FindHelp (formerly Aunt Bertha) is a free web-based search tool that allows members to quickly and easily connect to community programs and resources that serve their area. Members have access to thousands of resources across the nation, can browse social services and programs, and can contact the programs directly.³⁰ All five MCEs used FindHelp as the main platform for connecting members with community resources to address health-related social needs. Once members are screened and unmet needs are identified, case management staff conduct member outreach to connect members with community resources.

MCEs can adjust FindHelp to include MCE branding to build recognition and include links within their member portals. MCEs can pull reports to review areas of need and identify opportunities to offer further support to their members. FindHelp has the ability to support closed loop referrals by tracking referrals electronically; however, this feature is limited based on CBO participation and engagement.³¹ In key informant interviews, two MCEs mentioned that although CBOs in their area were participating in the closed loop referral process, efforts to further improve engagement should be prioritized. While FindHelp plays a role in developing connections between patients and community-based organizations, health care organizations are ultimately responsible for encouraging CBO participation and engagement with the platform.³² MCEs also mentioned using other platforms, primarily the telephone number, 211, to support connecting members to community-based services.

The MCEs mentioned several barriers to closing the loop on HRSN referrals such as high costs associated with custom electronic medical record systems—which allow MCEs to receive automatic notifications—and low participation rates from CBOs to enroll in these systems. The proportion of MCEs using systems and software that provide an automatic

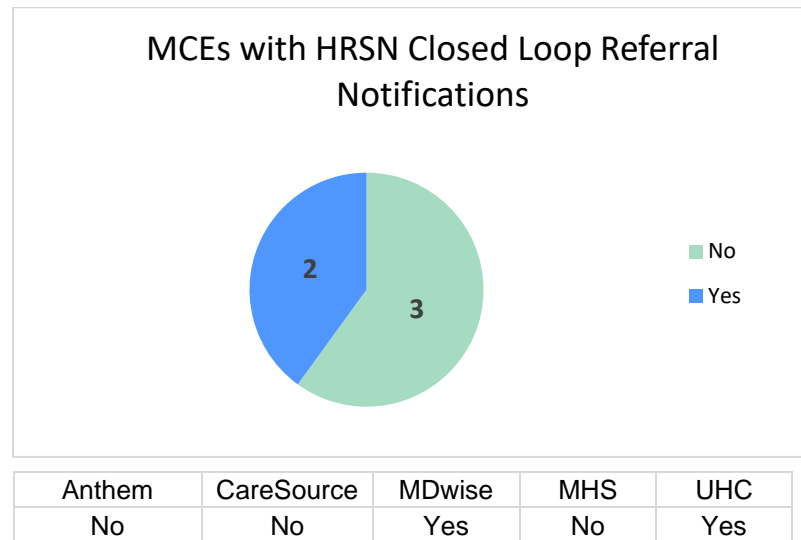
³⁰ FindHelp. (n.d.) FAQ. Retrieved from <https://company.findhelp.org/faq/#findhelp-faq>.

³¹ FindHelp. (n.d.) Closed Loop Referrals. Retrieved from <https://company.findhelp.com/closing-the-loop/#:~:text=Our%20Outcomes,study%20health%20and%20other%20outcomes>.

³² FindHelp. (n.d.) Closed Loop Referrals. Retrieved from <https://company.findhelp.com/closing-the-loop/#:~:text=Our%20Outcomes,study%20health%20and%20other%20outcomes>.

notification when a HRSN referral loop has been closed is provided in **Figure 74**.

Figure 74. Proportion of MCEs with Closed Loop Referral Notifications



Initiatives and Strategies to Address Health-related Social Needs

All MCEs have implemented strategies, interventions, or programs to identify and address health-related social needs. Three MCEs, CareSource, MDwise, and MHS, offer programs providing a stipend to members that can be used for expenses related to social risk factors. For example, stipends may be used to pay fees related to driver’s license reinstatement, expungement, or other barriers related to social determinants of health. UHC incentivizes members to attend follow-up appointments by offering a gift card once the member attends the appointment. Initiatives spanned the social determinants of

health, including housing, food, and transportation, among others, as noted in **Table 48**.

Table 48. Initiatives to Address SDOH		
Housing	Food	Transportation
CareSource utilizes the PRAPARE assessment to better understand and act using multiple strategies to positively increase housing stability. Members can work with a Life Coach to increase employment opportunities, at the same time delaying housing subsidy changes and rent increases. CareSource partners with national housing groups for expertise and support.	UHC trains member services to address HRSN in real-time using pop-up prompts. Member services identify resources and make community-based referrals, such as Mom's Meals that provides 14 home-delivered meals, and Essential Boxes that provide shelf stable foods for short term food insecurity issues while seeking long term solutions.	Anthem utilizes a Community Paramedicine Program to allow qualified paramedics associated with local emergency medical services (EMS) to go into the homes of Medicaid members who are identified through Anthem as frequent users in the EMS system and brings their care to their door. Follow-up visits are no longer missed due to transportation issues.

The following initiatives were identified in use by the MCEs.

- ◆ Care Grants, Employment Grants;
- ◆ Community Paramedicine Program;
- ◆ Essential Boxes;
- ◆ Grocery Trips;

- ◆ High School Equivalency Vouchers;
- ◆ HousingConnect Pathways Towards Housing Stability;
- ◆ I2A Referrals;
- ◆ License Reinstatement Program;
- ◆ LifeServices;
- ◆ Live Great Program;
- ◆ Maternal Child Health Community Health Worker Program;
- ◆ Medical Legal Partnership;
- ◆ Medically Tailored Food Boxes;
- ◆ Member Assistance Fund; and
- ◆ Re-entry Member Expungement Fund.

Conclusions and Recommendations

While the overall use of Z codes remains low, younger members (0-18 years of age), Caucasian members, and female members were represented most among those with Z codes documented on their claims. Problems related to upbringing (Z62) was the most frequently used Z code, followed by other problems related to primary support group including family circumstances (Z63), and problems related to housing and economic circumstances (Z59). Additionally, Z59, Z62, and Z63 were among the top three most documented Z codes across all MCEs, indicating that providers across MCEs appear to be coding similarly.

Upon review of the sub codes for Z59, Z62, and Z63, the most frequently documented SDOH/HRSN issues related to homelessness/inadequate housing, food insecurity, and psychosocial issues including parent-biological child conflict, a

history of abuse in childhood, loss of a family member, and problems with the primary support group or relationship with a spouse or partner. This data supports what several MCEs shared during key informant interviews, including that homelessness is one of the most difficult HRSN to address. MCEs are encouraged to prioritize and strengthen supports, including preventive efforts, for members across the lifespan and particularly younger members whose social environment may impact their lifelong health trajectory.

Overall, these findings demonstrate that health-related social needs are beginning to be documented among Indiana's Medicaid population, and more can be done to consistently identify and address these needs. However, barriers still exist to consistent documentation and use of Z codes:

- ◆ Z codes are not directly tied to quality measures, therefore lacking financial incentive; and
- ◆ Providers may feel restricted in their ability to address non-medical needs.

The documentation and use of Z codes marks a significant advancement towards patient-centered care. However, improving the use of Z codes in health care requires a cooperative effort across the health care system. A summary of recommendations to improve the use of Z codes and address health-related social needs are provided in [Table 49](#). These recommendations may be collaboratively addressed by OMPP and MCE via contract, policies, procedures, program and system

investments, quality improvement efforts, and training mechanisms, among others.

Table 49. Recommendations for Focus Study	
Area of Focus	Recommendation
Education and Training	Provide comprehensive training to provider networks regarding the significance and proper use of Z codes, and the availability of incentives, if any.
Standardized Policies and Procedures	Develop standardized guidelines for the consistent use of Z codes. Establish clear protocols on when and how to document social determinants, ensuring uniformity in coding practices.
EHR Integration	Integrate Z codes seamlessly into electronic health record systems in user-friendly formats. This integration may include automatic prompts for members of the care team to screen for and document relevant social determinants of health during patient encounters, and notifications when a referral loop has been closed.
Investments in Youth	Younger members make up the largest percentage of members with health-related social needs. Therefore, investments in programs and initiatives that address unmet needs for youth would have far reaching impact.
Community Engagement	Build strong partnerships with community-based organizations and involve them in the process of tracking health-related social needs referrals.
Patient Empowerment	Empower patients to actively participate in their health care and educate them about the importance of sharing social and economic information with health care providers.

³³ *Transitions of Care. (n.d.). Transitions of Care Standards. Retrieved from <https://transitionsofcare.org/#:~:text=The%20phrase%20Transitions%20of%20Care,points%20in%20the%20healthcare%20continuum.>*

Table 49. Recommendations for Focus Study

Area of Focus	Recommendation
Regular Evaluation and Feedback	Establish mechanisms for regular evaluation of the use and impact of Z codes. Collect feedback from providers and patients to identify challenges and areas for improvement. Use this feedback to refine coding practices and training programs.
Data Analysis	Conduct a more in-depth analysis of Z code use by primary diagnosis code and provider type. This data can be used to enhance current initiatives or support the creation of new ones.

Focus Study 2: Transitions of Care (TOC)

Introduction

Effective healthcare delivery involves a complex network of interactions among various providers, patients, and healthcare settings. Transitions of care, the movement of a patient from one setting of care to another,³³ play a pivotal role in the quality and continuity of healthcare services. These transitions may occur within a single healthcare facility, between different facilities, or across different levels of care. Transitions of care are critical junctures in a patient's healthcare journey where the potential for miscommunication, medication errors, and fragmented care is heightened. Inadequate or poorly managed transitions can result in adverse events and readmissions, which can be costly to a health care organization and negatively impact patient satisfaction.³⁴ According to CMS, effective care transitions must (1) prevent medical errors, (2) identify issues for early

³⁴ *Health Affairs. (September 12, 2012). Improving Care Transitions. Health Affairs. Retrieved from [https://www.healthaffairs.org/doi/10.1377/hpb20120913.327236/.](https://www.healthaffairs.org/doi/10.1377/hpb20120913.327236/)*

intervention, (3) prevent unnecessary hospitalization, (4) support consumer preferences and choices, and (5) avoid duplication of processes and efforts to more effectively utilize resources.³⁵ As healthcare organizations continue to prioritize patient-centered care, ensuring seamless transitions of care remains a crucial priority. By identifying and addressing the root causes of poor care transitions, managed care plans can potentially reduce healthcare costs, improve patient satisfaction, and ultimately improve health outcomes.

Study Purpose and Objectives

The purpose of Focus Study 2 was to evaluate how Hoosier Care Connect contracted managed care entities compared during CY 2022 regarding the volume, type, and support for transitions of care post-discharge.

Specifically, the objectives of the study were to address the following questions for CY 2022:

1. How does the volume and type of care transitions following discharge from a hospital setting and readmission post-discharge compare across HCC MCEs in total and by member demographics?
2. What documentation exists, if any, to support effective member transitions of care across facilities, health plans, or Indiana programs?

3. What are each HCC MCEs measure outcomes for required OMPP measures associated with transitions of care?

Background

National Landscape

Care coordination is a function that helps ensure a patient's needs and preferences are known and communicated across health care organizations, care settings, and providers, and is foundational to delivering high quality health care.³⁶ In recent years, there has been a growing recognition of the importance of seamless transitions in the health care system, leading to increased efforts to improve coordination and communication among health care organizations and provider networks. The Affordable Care Act (ACA) of 2010 included provisions aimed at enhancing care transitions such as encouraging accountable care organizations (ACOs) to coordinate care for patients across various settings. For example, the Community-Based Care Transitions Program (CCTP) was created by Section 3026 of the ACA and aimed to improve transitions from inpatient settings to other care settings, improve quality of care, and ultimately reduce hospital readmissions.³⁷ Despite these efforts, challenges persist in the assurance of seamless care coordination.

One major concern is the lack of standardized processes and communication protocols among different care settings and

³⁵ Centers for Medicare & Medicaid Services. (n.d.). *Improving Care Transitions*. Medicaid.gov. Retrieved from <https://www.medicare.gov/medicaid/quality-of-care/quality-improvement-initiatives/improving-care-transitions/index.html>.

³⁶ National Quality Forum. (October 2010). *Quality connections: Care coordination*. Retrieved from https://www.qualityforum.org/Publications/2010/10/Quality_Connections_Care_Coordination.aspx#:~:text=Care%20coordination%E2%80%94a%20function%20that%20foundational%20to%20high%20quality%20healthcare.

[Coordination.aspx#:~:text=Care%20coordination%E2%80%94a%20function%20that%20foundational%20to%20high%20quality%20healthcare](https://www.cms.gov/priorities/innovation/innovation-models/cctp).

³⁷ Centers for Medicare & Medicaid Services. (n.d.). *Comprehensive Care for Joint Replacement Model*. Retrieved from <https://www.cms.gov/priorities/innovation/innovation-models/cctp>.

providers. Patients often move between settings without their health information being adequately shared, leading to gaps in knowledge about their medical history, medications, and treatment plans. This lack of information can result in medication errors, redundant tests, and delayed or inappropriate care.³⁸ Another challenge is the fragmentation of the health care system, with various providers operating independently and often lacking incentives to collaborate effectively. Additionally, social risk factors such as access to health care services, transportation, and social support, can significantly impact a patient's ability to navigate the transition process successfully.

To address these challenges, health care organizations are investing in care management programs, transition and care coordination staff, and health information technology to bridge the gap between different health care settings. Policy initiatives and payment reforms are also being explored to incentivize providers to work collaboratively and prioritize effective care coordination. Addressing these challenges is essential to ensuring smooth transitions and delivering high quality, continuous care to patients across the nation.

State Landscape

OMPP updates and submits a Quality Strategy to CMS at least once every three years. The Quality Strategy is a key document that describes the aims, objectives, and high-level oversight

processes of OMPP. A required element of the Quality Strategy per 42 CFR 438.430 is a transition of care policy.³⁹ OMPPs policy outlines the state's commitment to providing continuity of care during member transitions across Indiana health programs and MCEs. Contracted MCEs are required to implement mechanisms to ensure continuity of care and facilitate care coordination for its members, including assuming financial responsibility for medically necessary care rendered during transitions. OMPPs' MCE contracts identify many pivotal care transitions points that the state expects MCEs, and by extension their contracted provider network, to be accountable for supporting as noted below.

Coordination of transitions of care mentioned in the contract:

- ◆ Coordinate initial enrollment;
- ◆ Coordinate transitions between HCC contractors during the first ninety (90) days of enrollment, or at any time for cause;
- ◆ Coordinate transitions to Medicare;
- ◆ Coordinate transitions of HCC wards and foster children when placement changes, they enter the foster care system or age out of foster care;
- ◆ Coordinate transitions to traditional Medicaid due to receipt of an excluded service;
- ◆ Coordinate transitions between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays;

³⁸ Agency for Healthcare Research and Quality. (June 2014). Care coordination. Retrieved from <https://www.ahrq.gov/ncepcr/care/coordination.html>.

³⁹ Legal Information Institute. (n.d.). Electronic Code of Federal Regulations: 42 CFR 438.340 – Managed Care State Quality Strategy. Retrieved from <https://www.law.cornell.edu/cfr/text/42/438.340>.

- ◆ Coordinating transitions of care for members going from a higher to lower level of care;
- ◆ Coordinate services the member receives from any other MCE or health plan;
- ◆ Coordinate transitions to and from fee-for-service Medicaid;
- ◆ Coordinate care for members transitioning into long-term institutional care and/or into a HCBS waiver program;
- ◆ Coordinate transitions between MCEs, particularly during an inpatient stay;
- ◆ Coordinate members' transition to another treatment provider; and
- ◆ Coordinate members' transition to private insurance, Marketplace coverage, or no insurance.

Only one Indiana health program was included in this focus study: Hoosier Care Connect. The HCC program includes members that are aged, blind, or disabled, but are not dually eligible for Medicare, and foster children. These population groups are particularly susceptible to poor health outcomes if transition points are poorly managed.

Upcoming in 2024, IHCP will begin the Indiana Pathways for Aging program for members over 60 years of age. FSSA will contract with managed care entities to provide long-term services and supports.⁴⁰ Individuals in the Pathways for Aging program are often dually eligible and may be residing in a

nursing facility or receiving home and community-based services (HCBS). These members are at greater risk for poor health outcomes when care transitions and coordination fail.

During the reporting period, MCEs were contracted to provide health care services to Indiana's HCC member population and were included in this focus study: (1) Anthem; (2) MHS; (3) UHC.

Methods

Study Design

The study evaluated how the three HCC MCEs compared based on volume, type, and supports for transitions of care during CY 2022. A mixed method study design was used to collect quantitative and qualitative data to address the study objectives. Details about each study component are provided below. This study was conducted in accordance with the 2023 CMS External Quality Review Protocols Guide.

Table 50. Introduction to Indiana Health Program for Focus Study 2⁴¹

Program	Approximate Number of Members Served	Types of Members Served
Hoosier Care Connect	97,000	Aged, blind, and disabled individuals who are not dually eligible for Medicare, and

⁴⁰ Indiana Family and Social Services Administration. (n.d.). Why Indiana Pathways for Aging. Retrieved from <https://www.in.gov/fssa/indiana-pathways-for-aging/about-indiana-pathways-for-aging/>.

⁴¹ Indiana Family and Social Services Administration. (n.d.). Medicaid Monthly Enrollment Reports. Retrieved from <https://www.in.gov/fssa/ompp/forms-documents-and-tools2/medicaid-monthly-enrollment-reports/>. Accessed on December 7, 2023. Rounded.

Table 50. Introduction to Indiana Health Program for Focus Study 2⁴¹

Program	Approximate Number of Members Served	Types of Members Served
		foster children.

For focus study two, only members enrolled in HCC during CY 2022 were included in the quantitative analysis and only MCEs serving the HCC health program were included in the qualitative components and analyses. There were no exclusion criteria for HCC members or HCC MCEs; members in other health programs and MCEs not serving the HCC program were excluded from the study. The HCC subpopulations are defined in **Table 49**. For each study component and objective, different information was collected and used, including claims data, MCE-provided policy and procedure documents and reports, and key informant interviews. The data sources available for each study component as well as the study objective they address are provided in **Table 51**.

Table 51. Data Sources for Focus Study 2

Data Sources	Study Component	Study Objective
CY 2022 MCE Claims Data	Quantitative: Claims Analysis	Objective 1
CY 2022 IN CPT Data Dictionary	Quantitative: Claims Analysis	Objective 1
MCE Policies and	Qualitative: Document	Objective 2

Table 51. Data Sources for Focus Study 2

Data Sources	Study Component	Study Objective
Procedures	Review	and 3
CY 2022 OMPP MCE Contracts	Qualitative: Document Review	Objective 2 and 3
CY 2022 MCE Provider Contracts	Qualitative: Document Review	Objective 2 and 3
CY 2022 OMPP TOC-relevant required measures for each MCE	Qualitative: Document Review	Objective 2 and 3
CY 2022 MCE Monthly/Annual Enrollment Data	Qualitative: Document Review	Objective 2 and 3
Key Informant Interviews	Qualitative: MCE interviews	Objective 2 and 3

Quantitative Methods

To evaluate how the volume and type of care transitions following discharge from a hospital setting and readmission post-discharge compared across both HCC MCEs in total and by member demographics (study objective 1), primary and secondary variables were first identified. The primary variables of interest included: volume of transitions, type of transitions, hospital setting, and readmission post-discharge. Secondary variables available and included in the claims analysis were age in years, gender (male or female), and race/ethnicity.

The dataset included MCE-submitted encounters, for the period of January 1, 2022, through December 31, 2022, contained in

the state's MMIS and provided to Myers and Stauffer by OMPP as part of a standard data extract process. The claims were first limited to facility inpatient and long-term care and arranged into facility stays. Then, multiple claims spanning sequential dates with the same stay and other information (eligibility information, facility, and other codes) were combined into a single line. This allowed for the total duration of a stay to be determined. To match stays, the following fields were matched:

- ◆ Member ID;
- ◆ Admission Date;
- ◆ Bill Type (first two non-zero digits only);
- ◆ Member Category of Aid; and
- ◆ Managed Care Entity.

The discharge date was not populated in the dataset but was instead determined based on the last end service date for all the claims from a stay. The first inpatient visit for CY 2022 was identified using bill types starting with *11* (hospital inpatient). If another inpatient visit for the member occurred within 30 days, that visit was tagged as a readmission. The immediate discharge location was determined using the Patient Status Code, which shows whether the patient was discharged to home, was discharged to another facility, or left against medical advice. The actual claims for these subsequent visits were identified as well as further visits through the remainder of 2022. The initial visits were then counted by their immediate discharge location and by the follow-up inpatient visits.

Qualitative Methods

Two processes were used to evaluate study objectives two and three, how MCEs support effective member transitions across different settings, plans, or programs; and how each of HCC's MCEs' contract with OMPP required transitions of care-related measure outcomes, respectively.

Documentation Request

First, a document review of MCE-provided policy and procedures documents and reports was performed to determine what documentation/procedures exist to support effective member transitions and study transitions of care related measure outcomes. Documents requested included materials relevant to requirements related to HCC patient discharge processes, communication with patients and caregivers at/following discharge, and procedures for transitions across different settings and plans. Copies of relevant training materials, specific reports containing relevant outcome measures, and any relevant initiative information were also requested. A full list of requested documents can be found in [Appendix F](#).

The data request process was standardized throughout the data collection process. Each MCE (N=3) was contacted and provided a list of requested data and submission instructions. Following document receipt, an MSR was performed to ensure all requested information was accessible, received, and relevant. When issues occurred, the MCE was contacted to submit updated information. Once the MSR was completed, an assigned reviewer conducted a primary review of all documentation,

identified key components from each document, and outlined anything notable to include during the key informant interviews. A secondary reviewer also completed a validation check. Once all MCE documents were reviewed, data were organized by relevance and emerging themes and patterns were identified.

Key Informant Interviews

Second, key informant interviews were conducted with subject-matter staff from each HCC MCE (N=3) to discuss the supports in place to ensure seamless transitions and continuity of care.

MCEs were contacted and provided with a full list of interview questions to ensure the necessary staff were available to participate. Interviews were conducted virtually using a semi-structured approach. Participants were given the opportunity to send additional information via email within one week of their completed interview. With the participant's consent, interviews were recorded to capture detailed responses accurately.

Following interview completion, transcribed interviews and recordings were reviewed and data were organized by emerging themes and patterns. Information collected during the interviews was also compared to information submitted in the document request and used to supplement those data, as appropriate.

Data Analysis and Findings

Below, key findings from both qualitative (Transitions of Care Supports section) and quantitative (Transitions of Care: Volume and Type section) data sources are synthesized.

Transitions of Care Supports

To understand the scope of expectations, MCEs maintain related to transitions of care under review for the focus study, policies and procedures regarding the following transition categories were requested:

- ◆ Policies and procedures regarding inpatient facility discharge processes, inclusive of primary and behavioral health inpatient discharges, for HCC's patient population; and
- ◆ Policies and procedures regarding transitions of care between health plans and Indiana programs, for HCC's patient population.

Analysis of the submitted documents and key informant interviews was conducted and organized into four areas: transfer of patient information, provider expectations, discharge planning and readmission monitoring, and initiatives and strategies to support transitions of care. While MCE HEDIS measures were requested, none were directly related to readmission rates; therefore, they are not included in the analysis.

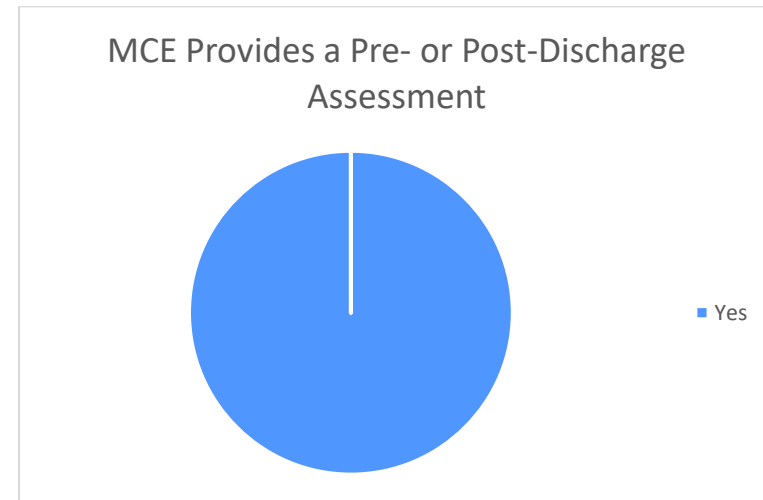
Transfer of Patient Information

MCEs are contractually obligated to facilitate care coordination for their members as they transition between other health programs, MCEs, or care settings. A critical component to ensure continuity of care is the transfer of patient data in an accurate and timely manner. In the modern healthcare landscape, patient care is often delivered by multiple providers and specialists across various settings. Therefore, the seamless

exchange of patient information allows the receiving entity to understand the full scope of the members' needs and avoids redundant testing and assessments. MCEs are responsible for coordinating with other entities to receive or provide information regarding outstanding authorizations, discharge plans, and any relevant care or case management notes.⁴²

MCEs used tools such as state reports and authorization requests to proactively identify transitions. Transition staff were often expected to coordinate with care managers and discharge planners from other MCEs via phone or email to obtain patient information. The MCEs mentioned several barriers to the transfer of patient data such as outdated reports, inconsistent communication with other MCEs' transition staff, and tedious manual processes. To address these challenges, all three MCEs obtained this information by implementing a pre- or post-discharge assessment to ensure member needs were accurately captured. The proportion of MCEs providing a pre- or post-discharge assessment to identify member needs is provided in **Figure 75**.

Figure 75. Proportion of MCEs Providing Pre- or Post-Discharge Assessments



Provider Expectations

Care transitions can be vulnerable points in a members' health care journey, which is why effective provider involvement in this process is crucial. Effective provider involvement allows the receiving entity to better understand a member's needs and ensure care continuity and safety.

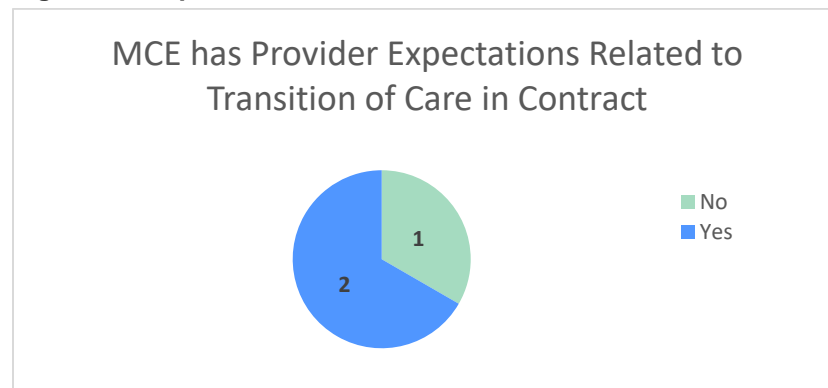
Contracted MCEs are required to create care management plans to identify member health issues and barriers and create interventions to address the member's needs. Care and case management teams are expected to engage the member's primary care provider, as part of the process and when

⁴² Indiana Family and Social Services Administration. (2022). *Final 2022 QSP Plan [PDF]*. State of Indiana. Retrieved from <https://www.in.gov/fssa/ompp/files/Final-2022-QSP-Plan.pdf>.

appropriate, to ensure member information is accurately captured.⁴³ It is essential to engage providers when sharing member information to another entity during a transition, to avoid omitting critical information.⁴⁴

Two of the three MCEs included specific expectations in provider agreements regarding the provider's role in ensuring continuity of care. To further engage providers in the transition process, all three MCEs implemented clinical rounds, which gathered all members of the care team to discuss and address patient needs on a regular basis. The proportion of MCEs including expectations for continuity of care in their provider contracts is depicted in **Figure 76**.

Figure 76. Expectations in Provider Contracts



⁴³ Indiana Family and Social Services Administration. (n.d.). *Quality and Outcomes Reporting*. Retrieved from <https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/>.

⁴⁴ National Quality Forum. (October 2010). *Quality connections: Care coordination*. Retrieved from https://www.qualityforum.org/Publications/2010/10/Quality_Connections_Care

Anthem	MHS	UHC
No	Yes	Yes

Discharge Planning and Readmission Monitoring

MCEs are held accountable for the health outcomes of their members during transitions; therefore, each MCE is required to submit a quarterly Inpatient Readmissions Report, which summarizes the rate at which members are readmitted post-discharge. Proper discharge planning is crucial to avoid unnecessary readmissions and to ensure the successful transition of patients from the initial care setting.

MCEs are required to create care plans for their members after conducting initial assessments. Care Management teams collaborate with a patient's provider, as well as family members and caregiver(s), to gather input on member needs to curate a care plan with specific goals and objectives to meet those needs. These plans are required to be culturally competent and allow the member and their care team to actively participate in the development process.⁴⁵ Upon discharge, these care plans are expected to be shared with the receiving entity and serve as a tool for communicating a member's pending unmet needs.

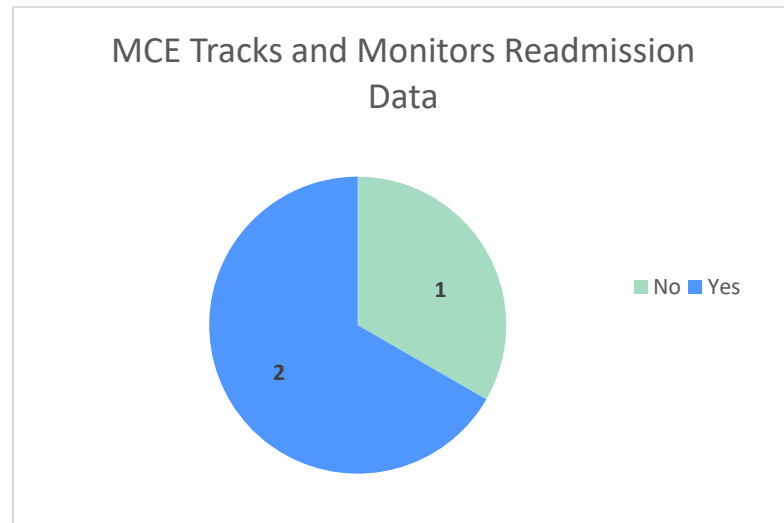
All three MCEs implemented pre-discharge assessments to ensure the member's needs are accurately captured and to

[Coordination.aspx#:~:text=Care%20coordination%E2%80%94a%20function%20that%20foundational%20to%20high%20quality%20healthcare.](#)

⁴⁵ Indiana Family and Social Services Administration. (n.d.). *Quality and Outcomes Reporting*. Retrieved from <https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/>.

provide proactive discharge planning. Additionally, two of the three MCEs track and monitor readmission data in some capacity to demonstrate accountability for care transition outcomes. The proportion of MCEs that track and monitor readmission data is depicted in **Figure 77**.

Figure 77. Proportion of MCEs Tracking and Monitoring Readmission Data



Anthem	MHS	UHC
No	Yes	Yes

Initiatives and Strategies to Support Transitions of Care

All HCC MCEs have implemented strategies, interventions, or programs to support transitions of care and ensure continuity of care for members during transitions. For example, Anthem implemented recurring interdisciplinary and post-acute care rounds that involved several members of the patient’s care team

to discuss complex cases that may benefit from cross-collaboration. The goal of these rounds is to promote effective communication, improve discharge planning, and address gaps in care. UHC implemented a comprehensive post-hospital assessment to support discharge planning and foster communication between the member and their care team. This MCE also offers a program that supplies members with 14 days of meals post-discharge, to ensure members have access to healthy meals during recovery. Finally, MHS implemented a program that prioritizes collaboration between the care team and members with newborns in the neonatal intensive care unit (NICU), with the purpose of improved discharge planning to proactively anticipate the newborn’s needs post-discharge. These examples highlight some of the initiatives MCEs are putting forth to better support care transitions for members. The following lists initiatives identified in use by the MCEs.

- ◆ I2A Referrals;
- ◆ Interdisciplinary Rounds;
- ◆ Medicaid Mobile Care Access Program;
- ◆ Mom’s Meals;
- ◆ NICU Center for Excellence;
- ◆ Post-Acute Care Rounds;
- ◆ Post-Discharge Meals;
- ◆ Post-Hospital Assessment; and
- ◆ QIP for Follow-Up after emergency room (ER) Visits.

Transitions of Care: Volume and Type

To understand HCC MCE member transitions by volume and type, review and analysis of claims data was conducted.

In CY 2022 across all three HCC MCEs, 1,692 members experienced a transition of care from an inpatient stay. Following an initial inpatient stay, members may have been discharged to their home, their home with skilled care, a skilled nursing facility (SNF), another facility, or another hospital. Members may have also left against medical advice (LAMA), may still be a patient, or expired. The top three most common transition types for HCC members were:

- ◆ “Discharged to home, with no further visits” (N = 1,071; 63%);

- ◆ “Discharged to skilled nursing facility (SNF), with no further visits” (N = 110; 6.5%); and
- ◆ “Discharged to other facility, no further visits (N = 100; 5.9%).

Over 1400 HCC members were discharged with no further visits (84%), 52 members were readmitted within 30 days post-discharge (3%), and 106 members were admitted greater than 30 days after being discharged (6%). The greatest percentage of post-discharge readmission outcomes (< 30 days) were attributed to those discharged to home (2.1%); all other care-setting/LAMA post-discharge readmission rates were less than one percent. Similarly, the greatest percentage of post-discharge later admission outcomes (> 30 days) were attributed to those discharged to home. The count and percent of member discharge outcomes are provided in [Table 52](#), [Figure 78](#), and [Figure 79](#).

Table 52. Summary of Discharges by Care Setting

Outcome	Count	Percent
Discharged to home, no further visits	1,071	63.3%
Discharged to home, Readmit <30 days	36	2.1%
Discharged to home, later admission	79	4.7%
Discharged to Home w/ Skilled Care, no further visits	87	5.1%
Discharged to Home w/ Skilled Care, Readmit <30 days	5	<1%
Discharged to Home w/ Skilled Care, later admission	7	<1%
Discharged to SNF, no further visits	110	6.5%

Table 52. Summary of Discharges by Care Setting		
Outcome	Count	Percent
Discharged to SNF, Readmit <30 days	3	<1%
Discharged to SNF, later admission	8	<1%
Discharged to other facility, no further visits	100	5.9%
Discharged to other facility, Readmit <30 days	4	<1%
Discharged to other facility, later admission	9	<1%
LAMA, no further visits	56	3.3%
LAMA, Readmit <30 days	4	<1%
LAMA, later admission	3	<1%
Discharged to other Hospital	27	1.6%
Expired	62	3.7%
Still patient	21	1.2%
Total	1,692	100%

Figure 78. Percentage of members with each transition type, by MCE

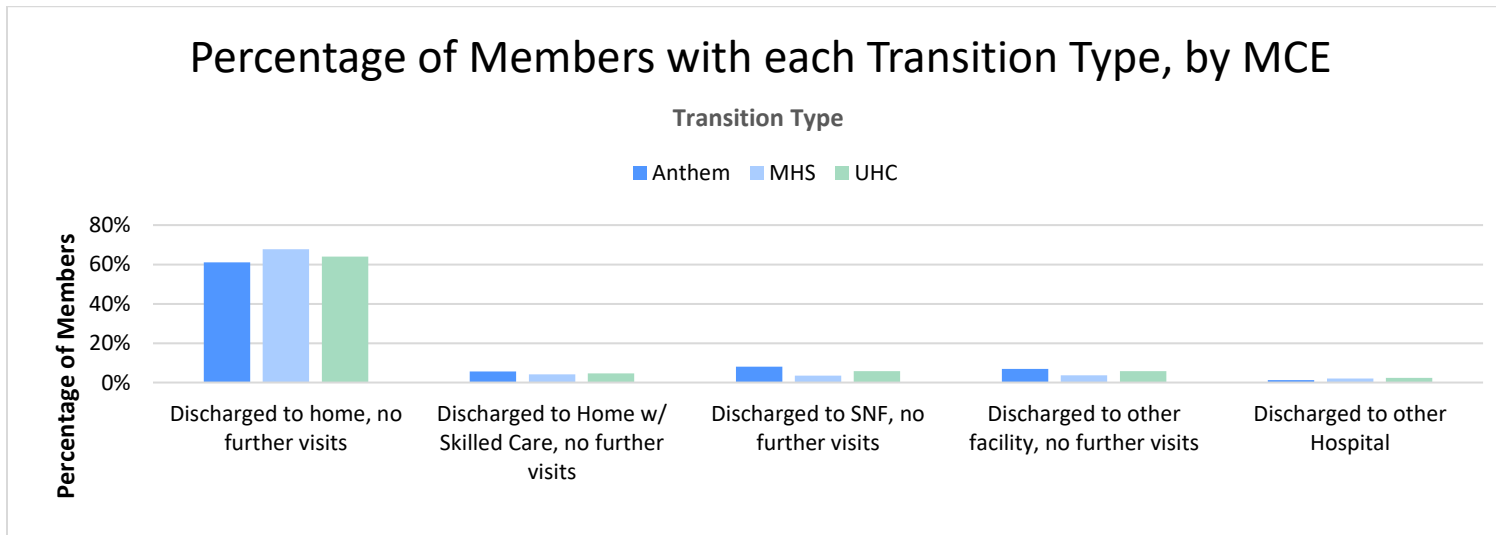
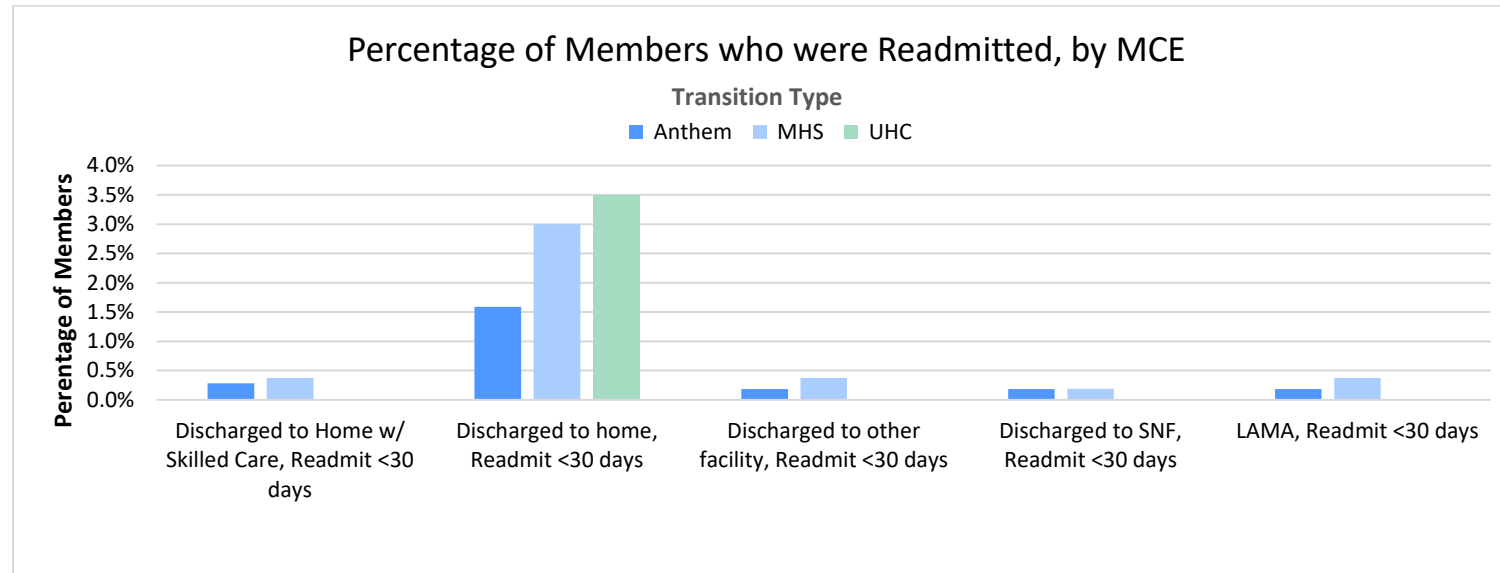


Figure 79. Percentage of members who were readmitted, by MCE



The total number of transitions a member experienced following their initial inpatient stay was assessed in total and by MCE. While the number of transitions members experienced ranged from 0-10, the majority of HCC members underwent only one transition (N = 1,425; 84%), followed by two transitions (N = 200; 12%). Unfortunately, 65 members had three or more transitions while one individual experienced ten transitions throughout CY 2022.

All three MCEs had similar patterns of members with 1-3 transitions. MHS, however, had the greatest number of members who experienced 5 or more transitions (N = 5), whereas Anthem and UHC had one member experience high transition volume each.

Table 53. Number of Transitions per Member, by MCE

Number of Transitions	Anthem	MHS	UHC	Grand Total
0	0	2	0	2
1	904	450	71	1425
2	130	57	13	200
3	36	18	1	55
4	1	2	0	3
5	0	0	0	0
6	0	4	1	5
7	0	1	0	1
10	1	0	0	1
Total	1,072	534	86	1,692

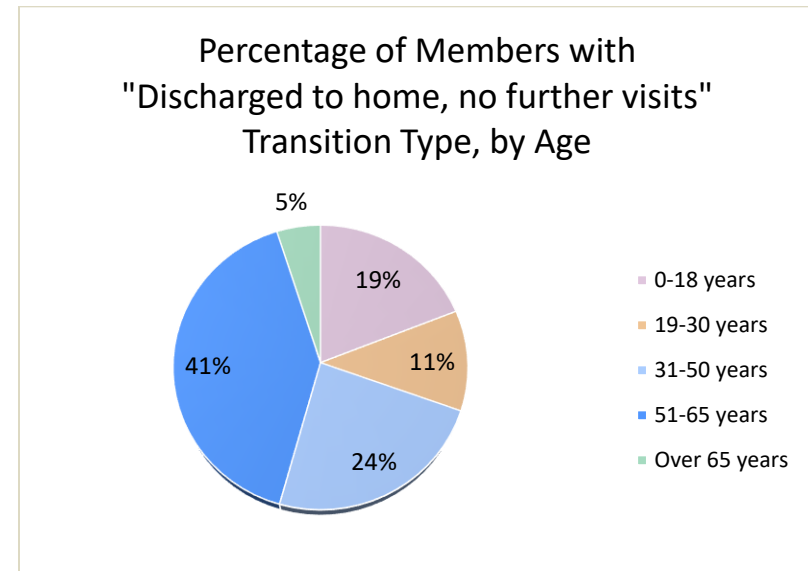
Demographics

HCC members undergoing a transition of care from an inpatient facility included those from 0 to 65 years and older, with the majority between the ages of 51 and 64 years (n = 768; 45.5%). Member age breakouts are provided in **Table 54**. Across all age groups, members were primarily discharged to home with no further visits. When assessing the distribution of total HCC members discharged to home with no further visits, by age group, 51–64 year-olds made up the largest proportion (41%; Figure 15, below). However, when assessing the proportion within an age group, the percentage decreased as member age increased, with 78.5% of 0–18 year-olds and 58.2% of 65+ being discharged to home with no further visits, respectively. As members' age increased, they experienced greater rates of discharges to non-home care settings as well as increased rates of a later admission (> 30 days) after discharge to home. Members between the ages of 51-65 years saw the highest percentage of post-discharge readmission (n=18; 2.3%).

Table 54. Number of Transitions, by Age Group

Age Category	Count	Percent
0 – 18 years	260	15.4%
19 – 30 years	158	9.4%
31 – 50 years	412	24.4%
51 – 64 years	768	45.5%
65 years and older	91	5.4%
Total	1,689	

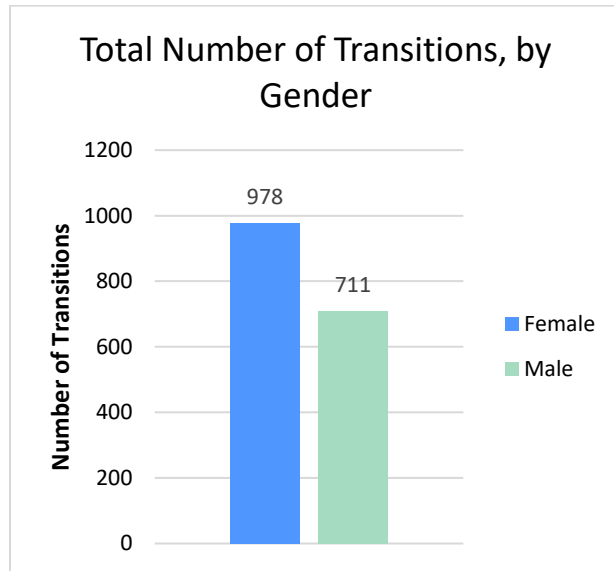
Figure 80. Percentage of Members Discharged to Home without further visits by Age Group



The majority of HCC members undergoing transitions of care were female (n = 978; 58%). Overall, both females and males had similar discharge outcome trends, with majority being discharged to home with no further visits and only those being discharged to home demonstrating readmission post-discharge to home with no further visit. However, while a greater proportion of members were female, the percentage discharged to home with no further visit was nearly the same for both females and males (63% and 64%, respectively), and a greater percentage of females were discharged to SNF, with no further visits (7%) and home with skilled care (6%) compared to males (5.6% and 3.7%, respectively). Additionally, slightly more than 2% of males were readmitted post-discharge to home without

further visits compared to slightly less than 2% of females being readmitted.

Figure 81. Total Number of Transitions of Care, by Gender



73% of HCC members transitioning care were Caucasian, 10% were Black, less than 1% were Asian/Pacific Islander, Hispanic, or other race, no members were American Indian or Alaska Native, and 16.5% did not have race/ethnicity data available.

A greater percentage of Caucasian members were discharged to home with no further visits (64%) compared to Black members (58%). Whereas Black HCC members were discharged to home with skilled care (7%) or SNF without further visits (8%) at slightly greater rates than Caucasians (5% and 6%, respectively), and experienced greater later admission rates after being

discharged to home compared to Caucasians (7% vs. 4%, respectively). Notably, both Black and Caucasian members had a 2% post-discharge readmission rate, when discharged to home.

Table 55. HCC Member Discharge Code Comparison, by Race/Ethnicity

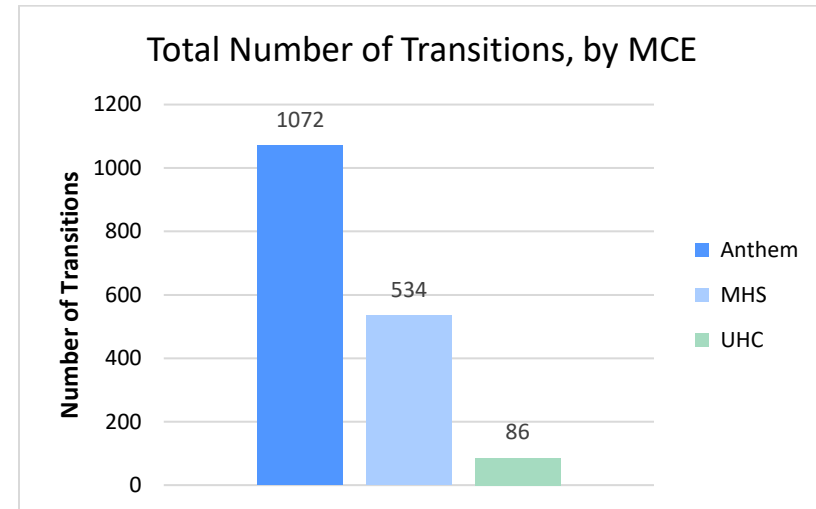
Discharge Code	Black	Caucasian
Discharge to home, no further visits	100 (58%)	788 (64%)
Discharge to home, Readmit < 30 days	3 (2%)	29 (2%)
Discharge to home, later admission	12 (7%)	53 (4%)
Discharge to home w/skilled care, no further visits	12 (7%)	61 (5%)
Discharge to home w/skilled care, Readmit <30 days	0 (0%)	4 (<1%)
Discharge to home w/skilled care, later admission	3 (2%)	2 (<1%)
Discharge to SNF, no further visits	14 (8%)	75 (6%)
Discharge to SNF, Readmit < 30 days	1 (1%)	2 (<1%)
Discharge to SNF, later admission	1 (1%)	6 (<1%)
Discharge to other facility, no further visits	11 (6%)	77 (6%)
Discharge to other facility, Readmit < 30 days	0 (0%)	3 (<1%)
Discharge to other facility, later admission	0 (0%)	8 (1%)
LAMA, no further visits	4 (2%)	39 (3%)
LAMA, Readmit < 30 days	0 (0%)	3 (<1%)

Table 55. HCC Member Discharge Code Comparison, by Race/Ethnicity

Discharge Code	Black	Caucasian
LAMA, later admission	0 (0%)	2 (<1%)
Discharged to other Hospital	3 (2%)	22 (2%)
Expired	5 (3%)	45 (4%)
Still Patient	2 (1%)	14 (1%)
Total	171	1,233

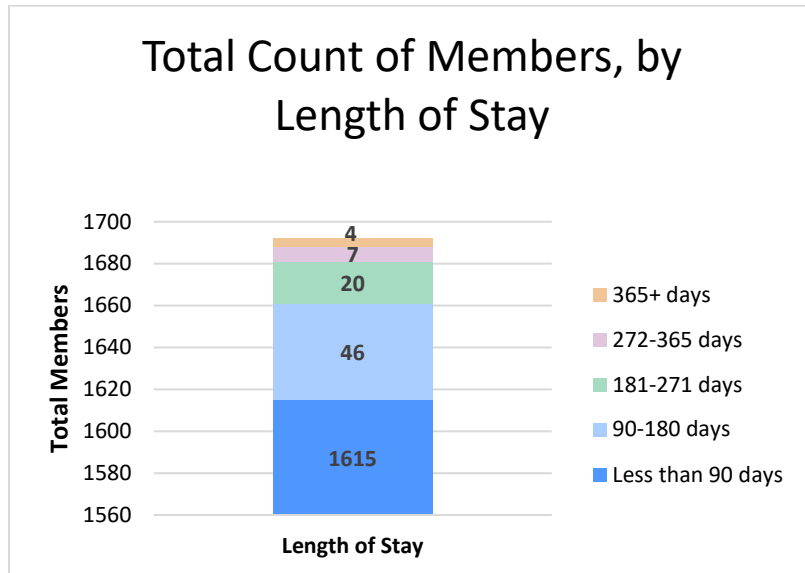
Managed Care Entities

When evaluating each MCE individually, Anthem had the highest number (N = 1,072; 63.4%) of transitions documented in CY 2022, as presented in [Figure 82](#). MHS had the highest percentage (67.8%) of members who were discharged to home, with no further visits, followed by UHC (64%) and Anthem (61%). However, MHS and UHC had higher rates of later admissions after discharge to home (6% and 7%, respectively), compared to Anthem (4%). Whereas post-discharge to home readmission rates (< 30 days) were similar at 2-3% across all three MCEs (Anthem, 2%; MHS and UHC, 3%). Additionally, a greater percentage of Anthem members were discharged to all other care settings compared to UHC and MHS.

Figure 82. Total number of transitions, by MCELengths of Stay

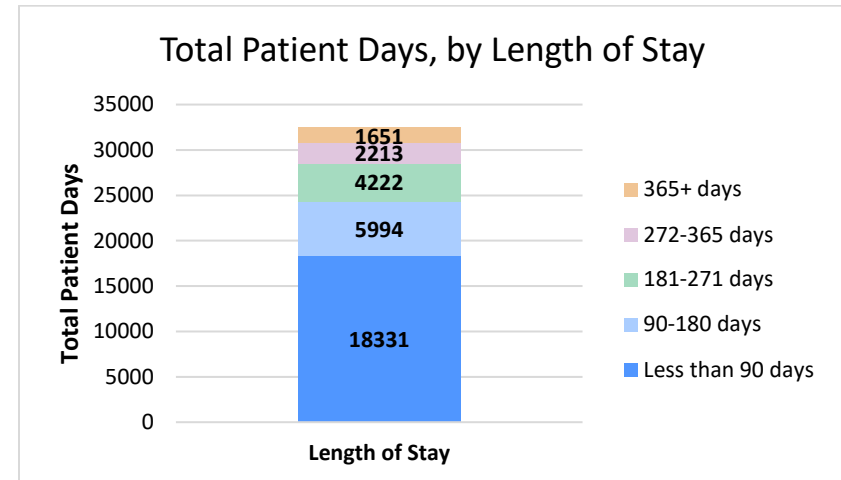
Throughout CY 2022, the majority (95.5%) of HCC members spent less than 90 days receiving care in a facility cumulatively across transitions. However, 2% of members resided in a facility for 180 days or longer, and four members remained in a facility throughout the year. Skilled nursing facilities accounted for majority of the stays that lasted less than 90 days. The count of members by number of days in a facility is provided in **Figure 83**.

Figure 83. Number of members, by care setting and LOS



In addition to evaluating how long members stayed in facilities during CY 2022, the number of cumulative day's members spent, attributed to the different length of stay ranges (e.g., < 90 days, 91-180 days, etc.) were also counted. The count of member days by length of stay is provided in [Figure 84](#).

Figure 84. Number of patient days, by care setting and LOS



Conclusions and Recommendations

Favorably, “Discharged to home, with no further visits” was the most represented transition type among HCC members in CY 2022, which represented 63% of the total transitions documented in CY 2022. The 51–64 year age group, Caucasian, and female members accounted for the largest number of transitions in CY 2022. The second most common transition type documented was “discharged to SNF, with no further visits,” which only represented 6.5% of all transitions. This is consistent with national data that long term care is typically utilized by patients aged 65 and over.⁴⁶ When comparing the MCEs, Anthem had the largest number of transitions documented in CY 2022. Additionally, the majority of members

⁴⁶ U.S. News & World Report. (October 6, 2023). *Nursing Home Facts and Statistics*. Retrieved from <https://health.usnews.com/best-nursing-homes/articles/nursing-home-facts-and-statistics>.

across all MCEs only had one transition in CY 2022, with Anthem representing the majority of those members as well. However, among members who were discharged home with no further visits, all MCEs represented similar percentages of the member population, with MHS (68%) representing the majority of members with that transition type, closely followed by UHC (64%), and Anthem (61%).

These findings demonstrate that performance is similar across all MCEs, and that overall, MCEs are experiencing the same challenges that healthcare organizations across the nation are experiencing. Several barriers still exist to ensuring seamless continuity of care for all members to reduce unnecessary readmissions. Improving care coordination during transitions requires a collaborative effort from care management teams, healthcare providers, and family members or caregiver(s). The following table provides a summary of recommendations to improve supports for transitions of care and improve continuity of care.

Table 56. Recommendations for Focus Study 2	
Area of Focus	Recommendation
Roles and Responsibilities	Assign clear roles and responsibilities to transition team members and provider related to care coordination activities and referral management.

Table 56. Recommendations for Focus Study 2	
Area of Focus	Recommendation
Data Sharing	Establish a clear data sharing process with other MCEs and care settings to set expectations for the flow of patient information. Develop strategies to promote integration with HIEs to exchange clinical data electronically and improve data sharing capabilities.
ADT Alerts	Encourage the use of ADT alerts to reduce avoidable readmissions and improve care coordination. ⁴⁷
Discharge Communication	Foster open communication among providers, patients, and their families. Implement communication protocols to engage patients and their families in the discharge process, ensuring they understand their roles and responsibilities.
Evaluation and Feedback	Implement performance metrics and quality indicators to assess the effectiveness of care coordination efforts. Regularly evaluate these metrics and seek feedback from patients and providers to identify areas for improvement. Use this feedback to refine care coordination efforts moving forward.
Care Coordination Tools	Utilize care coordination tools and software platforms that enable providers to collaborate effectively. These tools may include care management software, patient registries, and coordination applications that help track patient progress, schedule appointments, and share real-time updates among members of the patient’s care team.

⁴⁷ Indiana Family and Social Services Administration. (n.d.). 2022 IHCP Quality Strategy. Retrieved from <https://www.in.gov/fssa/ompp/forms-documents-and-tools2/medicaid-monthly-enrollment-reports/>.

Table 56. Recommendations for Focus Study 2

Area of Focus	Recommendation
Telehealth	Leverage telehealth services to facilitate virtual consultations and provide timely interventions when needed. Telehealth can bridge the gap between different care settings and enhance access to health care services. ⁴⁸

Conclusion

Myers and Stauffer conducted optional EQR activities for the OMPP program and completed a comprehensive assessment of the performance of all five MCEs that serve Indiana’s Medicaid population. Strengths and weaknesses related to each focus study topic for CY 2022 were identified based on available quantitative and qualitative data sources. To improve the quality of services provided in CY 2023 and beyond, Myers and Stauffer made the following conclusions and recommendations for each focus study:

Focus Study 1: HRSN

Overall, MCEs demonstrated a commitment to identifying health-related social needs and addressing unmet needs by providing and tracking referrals to community services, as appropriate. Most MCEs implemented initiatives and strategies to encourage their provider network to screen for health-related social needs and consistently document this data using Z codes. However, the documentation and use of Z codes remains low

across all MCEs and health programs. Although the low uptake of Z codes is consistent with national trends, MCEs are encouraged to continue educating their provider network on the importance of capturing social determinant data and provide robust training on how to properly document Z codes on electronic health records. The top three most commonly used Z codes in CY 2022 across all MCEs were related to upbringing and housing security, and disproportionately affected children under 18 years of age. MCEs are encouraged to focus on interventions related to child welfare and continue to strengthen initiatives aimed at addressing homelessness. Most MCEs implemented processes to ensure members received referrals in a timely manner and conducted consistent follow-up, as appropriate. However, MCEs relied heavily on communication from external organizations to track the completion of referrals, which often prevented the closure of the referral loop. MCEs are encouraged to enhance partnerships with community organizations and foster open communication to ensure both parties are equally involved and responsible for the closure of the referral loop.

Focus Study 2: Transitions of Care

Overall, MCEs demonstrated a commitment to supporting seamless transitions of care. Across all MCEs, the majority of members had a length of stay of less than 90 days and experienced one or fewer transitions subsequent to their inpatient stay. Additionally, readmission rates were fairly low

⁴⁸ Noel K, Messina C, Hou W, Schoenfeld E, Kelly G. Tele-transitions of care (TTOC): a 12-month, randomized controlled trial evaluating the use of Telehealth to achieve

triple aim objectives. *BMC Fam Pract.* 2020 Feb 7;21(1):27. doi: 10.1186/s12875-020-1094-5. PMID: 32033535; PMCID: PMC7007639.

across all MCEs, and the majority of members were sent home after discharge with no further visits. MCEs are encouraged to perform further analysis to identify the cause of members experiencing three or more transitions during their stay and develop interventions to reduce the volume. All MCEs had processes in place to support continuity of care upon admission and discharge. However, many MCEs noted challenges with the timeliness and effectiveness of the transfer of patient data from other entities. MCEs are encouraged to collaborate with other

entities and create a formal data sharing process to efficiently transfer patient data and eliminate the need to duplicate assessments that identify a member's unmet needs.

Overall, the results of both focus studies demonstrated commitment from all five MCEs for providing high quality health care services to Indiana's Medicaid population.

2023 EQR Conclusions and Recommendations

Qsource conducted mandatory EQR activities for the OMPP program for CY 2022. Each of CMS's EQR Protocols is a learning opportunity for the MCEs and OMPP. Qsource used a collaborative approach to assist the State and MCEs with developing best practices for future reviews and ensuring enrollee quality of care was paramount. Qsource is available to collaborate with OMPP and directly assist the MCEs in accomplishing the following recommendations for improvement.

To improve the quality of health for all enrollees, Qsource made the following recommendations.

QIP Validation

Goal one of OMPP's Quality Strategy is to continuously monitor quality improvement measures and strive to maintain high standards to improve the health of enrollees. OMPP contractually requires the MCEs to complete QIPs yearly and 2023 was the initial year for Qsource to evaluate some of the required QIPs. Analysis of each QIP revealed that the MCEs demonstrated an understanding of the improvement process by providing descriptions of the intervention, barriers, and likelihood to create a change, as well as future considerations for the interventions implemented. At the same time, weaknesses were noted in a majority of the QIPs regarding missing or incomplete information, which compromised the ability of Qsource to evaluate and make conclusions about the results and the validity of the study. Prior to 2021, the MCEs were allowed

to report QIP results and evaluation on MCE developed templates and reporting schedules. For the 2021 EQR evaluation, Qsource developed a QIP Summary Form (with accompanying QIP Summary Form Completion Instructions) and a QIP Validation Tool to standardize the process by which each MCE delivers QIP information to OMPP and how the information was assessed. With this requirement, Qsource found improvement in the QIP information submitted for evaluation compared to previous years. Although improvements are still needed in the submission of QIP data and progress measurement, the MCEs have shown moderate improvement; Qsource views the results as a learning opportunity for the MCEs and will assist in education of the MCEs to achieve better results next measurement year. OMPP should continue to monitor the MCEs QIPs as part of its Quality Strategy to ensure quality, timeliness, and access to care for its enrollees.

PMV

PMV is designed to assess the accuracy of reported performance measures and determine the extent to which the reported rates follow the measure specifications and reporting requirements. To assess MCE performance over time, Qsource validated two measures: Total SUD Grievance Calendar Year 2022 and Total SUD Expedited and Non-Expedited Appeals CY 2022. Qsource defined the scope of the validation to include the OMPP required metrics. This validation included data source, reporting frequency, and format of those measures. In addition

to document review, Qsource's audit included a request to review each MCE's ISCA, to ensure that each MCE maintained a health information system that can accurately and completely collect, analyze, integrate, and report data on member and provider characteristics, and on services furnished to members.

Qsource determined that each of the MCEs aligned with the goals and objectives of CMS' Quality Strategy related to quality of care and access to care for enrollees. Each MCE had strategies in place to align with OMPP's goals and objectives relating to access to care for its enrollees and increasing enrollee satisfaction with those services.

In the ISCA, Qsource found that all MCEs were capable of reporting measures and had the capacity to produce accurate and complete encounter data. When reviewing selected encounter fields, the MCEs were mostly accurate and complete.

All MCEs met all specifications for the designated measures. In addition, the data integration, control, and performance measure documentation review indicated an overall high confidence in the MCE's ability to provide quality and timely care for its enrollees. No deficiencies were noted in the MCE's processes for data collection and performance measure reporting.

ANA

As noted in OMPP's Quality Strategy Plan, ensuring enrollees have adequate and timely access is key to quality care. The MCEs are contractually required to maintain an administrative and organizational structure that supports effective and efficient

delivery of services to members. Furthermore, OMPP is continually evaluating ways to increase cost-effectiveness. The overarching goal to improve access to care extends throughout the quality improvement efforts of OMPP and is embedded into the expectations of the contracted health plans.

The MCEs demonstrated a shared strength for providing access to their enrollees to psychiatrists and OB/GYNs within the required travel time standard. Based on the analyses of the MCE's geographical network adequacy, Qsource concluded all MCEs met the requirements for geographic accessibility to a psychiatrist and OB/GYN for 100% of the MCE's members in the accessibility standard of two providers within 60 miles.

Toward achievement of Quality Strategy Plan goals, Qsource recommends that the MCEs be proactive in monitoring and adding providers to their network to ensure a robust provider network for their enrollees, ensure provider lists in enrollee materials are correct, and further ensure PMP network adequacy by targeting the counties identified with additional assessments, such as secret shopper calls and reviewing call center reporting from members.

EDV

The third point in the OMPP Quality Strategy is to ensure medical coverage in a cost-effective manner. The EDV protocol is a voluntary protocol to assess the completeness and accuracy of the encounter data that has been adjudicated (i.e., paid or denied) by the MCE and submitted to the State's FAC. EDV can

assist states in reaching the goals of transparency and payment reform to support its efforts in quality measurement and improvement. Additionally, states are required to provide accurate encounter (and financial) data to the actuaries, and to CMS as part of the Transformed Medicaid Statistical Information System project. Protocol 5 enables states to meet these data validation and monitoring requirements. Protocol 5 also evaluates state/department policies, as well as the policies, procedures, and systems of the MCE, assists states in gauging utilization, identifying potential gaps in services, evaluating program effectiveness, and identifying strengths and opportunities to enhance oversight.

To continue working toward achievement of the Quality Strategy goals, Qsource recommends that the MCEs continue to work with OMPP to ensure that all encounter data is appropriately entered and analyzed. In addition, the MCEs should review their internal claims processes to identify and address barriers to timely payment of claims and encounter submission, as well as collaborate with all providers to ensure receipt of medical records for requested services.

Conducting Focus Studies for Health Care Quality

To address each goal within OMPP's Quality Strategy, OMPP makes use of the optional Protocol 9. These Focus Studies

address critical aspects of data use, performance measurement, and quality improvement within the Medicaid managed care realm by conducting health care quality-related focus studies that typically evaluate a specific service area (clinical or nonclinical) during a single year. In 2023, OMPP selected two focus study areas: Assessing MCEs' approach to HRSNs and Transitions of Care post-discharge for HCC's population.

Overall, the results of both focus studies demonstrated commitment from all five MCEs for providing high quality health care services to Indiana's Medicaid population. However, in order to continue working towards achievement of the Quality Strategy goals, Qsource recommends that MCEs continue to encourage the use of Z codes through incentives and education to better capture social determinant data, as well as continue to work towards improved communication with community organizations for higher involvement and participation in the referral process. In addition, MCEs are encouraged to collaborate with OMPP and other community organizations to create a formal data sharing process for more efficient transference of patient data, eliminating the need to duplicate assessments that identify an enrollee's unmet needs.

Overall, the results of the 2023 EQR activities demonstrated that the MCEs were well-qualified and committed to facilitating timely, accessible, and high-quality healthcare for all enrollees.

Appendix A | PMV Measure Rates

Qsource validated the two performance measures identified by OMPP. Qsource accepted the MCE's data submissions from OMPP for each reported measure. The data consisted of MCE-reported totals for each quarter.

Table A-1. SUD Grievance and Appeals												
Measure Name	Measure	Anthem			CareSource		MDwise		MHS			UHC
		HHW	HIP	HCC	HHW	HIP	HHW	HIP	HHW	HIP	HCC	HCC
Total Pharmacy Grievances	Received and Resolved CY 2022	0	0	0	0	0	1	10	0	4	0	2
Total Grievances	Received and Resolved CY 2022	332	1973	191	1794	2600	298	788	74	474	146	95
Percentage of Pharmacy Grievances	Percentage: Pharmacy Grievances/Total Grievances	0%	0%	0%	0%	0%	0.003%	0.012%	0%	0.008%	0%	0.021%
Total Pharmacy Expedited and Non-Expedited Appeals	Received and Resolved CY 2022	0	125	0	0	2	3	86	4	116	8	68
Total Expedited and Non-Expedited Appeals	Received and Resolved CY 2022	251	1881	152	132	595	324	1511	476	1192	592	102
Percentage of Pharmacy Expedited and Non-Expedited Appeals	Percentage: Pharmacy Expedited and Non-Expedited Appeals/ Total Expedited and Non-Expedited Appeals	0%	0.06%	0%	0%	0.003%	0.009%	0.057%	0.008%	0.097%	0.013%	.667%

Table A-1. SUD Grievance and Appeals												
Measure Name	Measure	Anthem			CareSource		MDwise		MHS			UHC
		HHW	HIP	HCC	HHW	HIP	HHW	HIP	HHW	HIP	HCC	HCC
Total Percentage of Pharmacy Grievance and Appeals CY 2022	Total Percentage of Pharmacy Grievance and Appeals CY 2022	0%	0.03%	0%	0%	0.0006%	0.006%	0.042%	0.008%	0.072%	0.013%	0.355%

Appendix B | ANA Excluded Source Data

Excluded Source Data Records: Anthem

Table B-1 summarizes Anthem’s enrollee and provider records that were excluded from analysis. Of the enrollee records submitted by Anthem, most of the records excluded from the analysis were enrollees with out-of-state residence. The resulting count of enrollees included in the analysis by program were:

- ◆ HHW – 334,605 enrollees
- ◆ HIP – 368,276 enrollees
- ◆ HCC – 59,927 enrollees

Of the provider records submitted by Anthem, most of the records excluded from the analysis were duplicate provider service locations. The resulting count of providers included in the analysis by program were:

- ◆ HHW – 7,321 provider service locations
- ◆ HIP – 7,310 provider service locations
- ◆ HCC – 7,315 provider service locations

Table B-1. Source Records Excluded from Analysis				
Data Source	Health Programs			
Member Records	HHW	HIP	HCC	All Programs
Total Records Submitted	338,473	372,578	60,990	772,041
Total Records Excluded from Analysis	3,858	4,302	1,063	9,223
Invalid address	14	10	4	28
Not Medicaid eligible*	0	0	0	0
Duplicate record	0	0	0	0
Out-of-state residence	3,854	4,292	1,059	9,205

Table B-1. Source Records Excluded from Analysis				
Data Source	Health Programs			
	HHW	HIP	HCC	All Programs
Provider Records				
Total Records Submitted	10,936	10,972	10,950	32,858
Total Records Excluded from Analysis	3,615	3,662	3,635	10,912
Duplicate provider service location	3,583	3,633	3,603	10,819
Not Medicaid eligible*	0	0	0	0
Located more than 60 miles outside of Indiana	32	29	32	93
National Provider Identifier (NPI) deactivated by CMS	0	0	0	0

* "Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against state records. The record was flagged as "Not Medicaid eligible" if the MMIS ID was not found or if the enrollee/provider was not actively enrolled on the snapshot date (October 1, 2022).

Excluded Source Data Records: CareSource

Table B-2 summarizes CareSource’s enrollee and provider records that were excluded from analysis.

From the enrollee records submitted by CareSource, most of the records excluded from the analysis were enrollees with out-of-state residence. The resulting count of enrollees included in the analysis by program were:

- ◆ HHW – 79,742 enrollees
- ◆ HIP – 76,838 enrollees

From the provider records submitted by CareSource, most of the records excluded from the analysis were duplicate provider service locations. The resulting count of providers included in the analysis by program were:

- ◆ HHW – 7,848 provider service locations
- ◆ HIP – 7,768 provider service locations

Table B-2. Source Records Excluded from Analysis			
Data Source	Health Programs		
	HHW	HIP	All Programs
Member Records			
Total Records Submitted	81,026	78,084	159,110
Total Records Excluded from Analysis	1,284	1,246	2,530
Not Medicaid eligible*	72	66	138
Invalid address	0	0	0
Out-of-state residence	0	0	0
Provider Records			
Total Records Submitted	8,811	8,709	17,520
Total Records Excluded from Analysis	963	941	1,904
Duplicate provider service location	943	921	1,864
Not Medicaid eligible*	0	0	0

* "Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against State records. The record was flagged as "Not Medicaid eligible" if the MMIS ID was not found, or if the enrollee/provider was not actively enrolled on the snapshot date (October 1, 2022).

Excluded Source Data Records: MDwise

[Table B-3](#) summarizes MDwise's enrollee and provider records that were excluded from analysis.

Of the enrollee records submitted by MDwise, most of the records excluded from the analysis were enrollees that appeared to not be Medicaid eligible on October 1, 2022. The resulting count of enrollees included in the analysis by program were:

- ◆ HHW – 237,423 enrollees
- ◆ HIP – 174,826 enrollees

Of the provider records submitted by MDwise, most of the records excluded from the analysis were duplicate provider service locations. The resulting count of providers included in the analysis by program were:

- ◆ HHW – 6,295 provider service locations
- ◆ HIP – 6,477 provider service locations

Table B-3. Source Records Excluded from Analysis			
Data Source	Health Programs		
Member Records	HHW	HIP	All Programs
Total Records Submitted	241,066	178,469	419,535
Total Records Excluded From Analysis	3,643	3,643	7,286
Out-of-state residence	3	3	6
Invalid address	1,320	1,271	2,591
Not Medicaid eligible*	0	0	0
Provider Records	HHW	HIP	All Programs
Total Records Submitted	6,836	7,037	13,873
Total Records Excluded From Analysis	541	560	1,101
Duplicate provider service location	541	560	1,101
Located more than 60 miles outside of Indiana	0	0	0
Not Medicaid eligible*	0	0	0

* "Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against state records. The record was flagged as "Not Medicaid eligible" if the MMIS ID was not found or if the enrollee/provider was not actively enrolled on the snapshot date (October 1, 2022).

Excluded Source Data Records: MHS

Table B-4 summarizes MHS’ enrollee and provider records that were excluded from analysis. From the enrollee records submitted by MHS, most of the records excluded from the analysis were enrollees with out-of-state residence. The resulting count of enrollees included in the analysis by program were:

- ◆ HHW – 196,417 enrollees
- ◆ HIP – 139,282 enrollees
- ◆ HCC – 34,321 enrollees

From the provider records submitted by MHS, most of the records excluded from the analysis were duplicate provider service locations. The resulting count of providers included in the analysis by program were:

- ◆ HHW – 2,040 provider service locations
- ◆ HIP – 2,034 provider service locations
- ◆ HCC – 1,985 provider service locations

Table B-4. Source Records Excluded from Analysis

Data Source	Health Programs			
	HHW	HIP	HCC	All Programs
Member Records				
Total Records Submitted	197,055	139,972	34,813	371,840
Total Records Excluded from Analysis	638	690	492	1,820
Out-of-state residence	0	0	0	0
Invalid address	33	81	63	177
Not Medicaid eligible*	0	0	0	0
Provider Records				
Total Records Submitted	2,091	2,083	2,034	6,208
Total Records Excluded from Analysis	51	49	49	149
Not Medicaid eligible*	47	47	46	140
Located more than 60 miles outside of Indiana	0	0	0	0
Duplicate provider service location	4	2	3	9

* "Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against state records. The record was flagged as "Not Medicaid eligible" if the MMIS ID was not found, or if the member/provider was not actively enrolled on the snapshot date (October 1, 2022).

Excluded Source Data Records: UHC

[Table B-5](#) summarizes UHC's enrollee and provider records that were excluded from analysis. From the enrollee records submitted by UHC, most of the records excluded from the analysis were enrollees with out-of-state residence. The resulting count of enrollees included in the analysis were:

- ◆ HCC – 5,266 enrollees

From the provider records submitted by UHC, most of the records excluded from the analysis were duplicate provider service locations. The resulting count of providers included in the analysis were:

- ◆ HCC – 3,934 provider service locations

Table B-5. Source Records Excluded from Analysis	
Data Source	Health Plan
Enrollee Records	
	HCC
Total Records Submitted	5,484
Total Records Excluded from Analysis	218
Invalid address	0
Not Medicaid eligible*	0
Duplicate record	0
Out-of-state residence	218
Provider Records	
	HCC
Total Records Submitted	4,614
Total Records Excluded from Analysis	680
Not Medicaid eligible*	679
Located more than 60 miles outside of Indiana	0
Duplicate provider service location	1
Total Records Submitted	0

* "Not Medicaid eligible" was determined by validating the Medicaid Management Information System (MMIS) ID against State records. The record was flagged as "Not Medicaid eligible" if the MMIS ID was not found, or if the member/provider was not actively enrolled on the snapshot date (October 1, 2022).

Geographic Considerations Regarding the Calculation of Provider-to-Member Ratios

Provider-to-member ratios are a method for assessing the average patient load of healthcare providers within a network. Large patient loads may result in excessive wait periods for patients between the request for an appointment and the scheduled appointment date. The method for assessing provider-to-member ratios counts each provider once regardless of how many service locations the provider has. Hence, the assessment of provider-to-member ratio at a county level may yield different results than for the state overall.

To clarify expectations for counting providers, the OMPP's instructions to MCEs regarding *Report 0902 (Count of Providers)* specifies:

- ◆ “Each facility/provider shown on this report should appear in only one column and in only one county.”
- ◆ “It is understood that providers often serve members in multiple counties. The total unique providers are summed at the top of each column. Therefore, these counts represent the total unique providers under contract with the MCE for the program.”

The methodology for assigning individual providers to exactly one report column (provider network category, i.e., psychiatrist or OB/GYN) and one county when assessing *Report 0902* was as follows:

- ◆ Detailed data from the network adequacy assessment was used to count the number of members within an acceptable driving distance of each provider service location.
- ◆ Each provider's service locations were ranked, favoring the service location with the highest member count. In the case of a tie, in-state locations were ranked higher than out-of-state locations.
- ◆ Each provider's county was assigned based on the service location with the highest ranking.

Appendix C | Detailed Analysis of Provider Network Access

Overall Provider Network Accessibility

Table C-123. Anthem Psychiatrist Provider Network Adequacy by Program

Measure	HHW	HIP	HCC	All Programs*
Count of providers**	575	574	573	580
Count of enrollees	334,605	368,276	59,927	762,808
Provider-to-enrollee ratio	582	642	105	1,315
Count of provider service locations	3,126	3,121	3,118	3,117
Count of enrollees within 60 miles of two psychiatrists	334,605	368,276	59,927	762,808
Percentage of enrollees within 60 miles of two psychiatrists	100%	100%	100%	100%

* Individual providers enrolled in multiple health programs are counted a single time in the "All Programs" provider count.

** Includes out-of-state providers.

Table C-2. Anthem OB/GYN Provider Network Adequacy by Program

Measure	HHW	HIP	HCC	All Programs*
Count of Providers**	936	930	936	940
Count of Members	169,063	217,575	28,667	415,305
Provider-to-Member Ratio	181	234	31	442
Count of Provider Service Locations	4,195	4,189	4,197	4,229
Count of Members within 60 miles of 2 OB/GYNs	169,014	217,540	28,665	415,219
Percentage of Members within 60 miles of 2 OB/GYNs	99.9%	99.9%	99.9%	99.9%

* Individual providers enrolled in multiple health programs are counted a single time in the "All Programs" provider count.

** Includes out-of-state providers.

Table C-3. CareSource Psychiatrist Provider Network Adequacy by Program

Measure	HHW	HIP	All Programs*
Count of Providers**	592	564	593
Count of Enrollees	79,742	76,838	156,580
Provider-to-Enrollee Ratio	1:135	1:136	1:264
Count of Provider Service Locations	3,100	3,032	3,104
Count of Enrollees within 60 miles of 2 Psychiatrists	79,742	76,838	156,580
Percentage of Enrollees within 60 miles of 2 Psychiatrists	100%	100%	100%

* Individual providers enrolled in multiple health programs are counted a single time in the "All Programs" provider count.

** Includes out-of-state providers.

Table C-4. CareSource OB/GYN Provider Network Adequacy by Program

Measure	HHW	HIP	All Programs*
Count of Providers**	1,022	1,015	1,022
Count of Members	40,839	41,044	81,883
Provider-to-Member Ratio	1:40	1:40	1:80
Count of Provider Service Locations	4,748	4,736	4,761
Count of Members within 60 miles of 2 OB/GYNs	40,839	41,044	81,883
Percentage of Members within 60 miles of 2 OB/GYNs	100%	100%	100%

* Individual providers enrolled in multiple health programs are counted a single time in the "All Programs" provider count.

** Includes out-of-state providers.

Table C-5. MDwise Psychiatrist Provider Network Adequacy by Program

Measure	HHW	HIP	All Programs*
Count of providers**	510	510	513
Count of enrollees	237,423	174,826	412,249
Provider-to-enrollee ratio	1:466	1:343	1:804
Count of provider service locations	1,859	1,889	1,933
Count of enrollees within 60 miles of 2 psychiatrists	237,423	174,826	412,249
Percentage of enrollees within 60 miles of 2 psychiatrists	100%	100%	100%

* Individual providers enrolled in multiple health programs are counted a single time in the "All Programs" provider count.

** Includes out-of-state providers.

Table C-6. MDwise OB/GYN Provider Network Adequacy by Program

Measure	HHW	HIP	All Programs*
Count of Providers**	1,083	1,093	1,103
Count of Members	119,411	109,698	229,109
Provider-to-Member Ratio	1:110	1:100	1:208
Count of Provider Service Locations	4,436	4,588	4,801
Count of Members within 60 miles of 2 OB/GYNs	119,411	109,698	229,109
Percentage of Members within 60 miles of 2 OB/GYNs	100%	100%	100%

* Individual providers enrolled in multiple health programs are counted a single time in the "All Programs" provider count.

** Includes out-of-state providers.

Table C-7. MHS Psychiatrist Provider Network Adequacy by Program

Measure	HHW	HIP	HCC	All Programs*
Count of Providers**	400	394	391	414
Count of Enrollees	196,417	139,282	34,321	370,020
Provider-to-Enrollee Ratio	1:491	1:354	1:88	1:894
Count of Provider Service Locations	662	663	660	717
Count of Enrollees within 60 miles of a Psychiatrist	196,417	139,282	34,321	370,020
Percentage of Enrollees within 60 miles of a Psychiatrist	100.0%	100.0%	100.0%	100.0%

* Individual providers enrolled in multiple health programs are counted a single time in the "All Programs" provider count.

** Includes out-of-state providers.

Table C-8. MHS OB/GYN Provider Network Adequacy by Program

Measure	HHW	HIP	HCC	All Programs*
Count of Providers**	806	808	775	825
Count of Members	99,192	85,297	15,934	200,423
Provider-to-Member Ratio	1:123	1:106	1:21	1:243
Count of Provider Service Locations	1,378	1,371	1,325	1,477
Count of Members within 60 miles of 2 OB/GYNs	99,077	85,180	15,910	200,167
Percentage of Members within 60 miles of 2 OB/GYNs	99.9%	99.9%	99.8%	99.9%

* Individual providers enrolled in multiple health programs are counted a single time in the "All Programs" provider count.

** Includes out-of-state providers.

Table C-9. UHC Psychiatrist Network Adequacy by Program

Measure	HCC
Count of Providers**	465
Count of Enrollees	5,266
Provider-to-Enrollee Ratio	1:11
Count of Provider Service Locations	1,786
Count of Enrollees within 60 miles of a Psychiatrist	5,266
Percentage of Enrollees within 60 miles of a Psychiatrist	100.0%

* Includes out-of-state providers.

Table C-10. UHC OB/GYN Network Adequacy by Program

Measure	HCC
Count of Providers*	758
Count of Enrollees	2,387
Provider-to-Enrollee Ratio	1:3
Count of Provider Service Locations	2,148
Count of Enrollees within 30 miles of one OB/GYN	2,377
Percentage of Enrollees within 30 miles of one OB/GYN	99.6%

* Includes out-of-state providers.

Provider Network by County

The following tables are an assessment of each MCE's reporting of their provider networks, specifically psychiatrist and OB/GYN providers. MCEs are contractually required to annually submit to the state a *Report 0902 Count of Enrolled Providers* for each program they manage. The MCE's 0902 reports were compared to the detailed provider listings submitted for the provider network adequacy assessment. The assessment comprises two tables, one for each program managed by each MCE. Counts of providers are presented by county, and a separate table is provided for each program (HHW, HIP, and HCC).

In accordance with the *MCE Reporting Manual Instructions for Report 0902*, each provider enumerated on this report was counted in exactly one provider network category and county. As stated in the manual, “It is understood that providers often serve members in multiple counties. The total unique providers are summed at the top of each column. Therefore, these counts represent the total unique providers under contract with the MCE for the program.”

Table C-11. Anthem HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	663	575	88	1,070	936	134	1,733	1,511	222
Adams	2	2	-	2	2	-	4	4	-
Allen	42	27	15	71	48	23	113	75	38
Bartholomew	16	5	11	9	6	3	25	11	14
Benton	-	-	-	-	-	-	-	-	-
Blackford	-	-	-	-	-	-	-	-	-
Boone	21	11	10	6	7	(1)	27	18	9
Brown	-	-	-	-	-	-	-	-	-
Carroll	1	-	1	1	-	1	2	-	2
Cass	3	-	3	1	3	(2)	4	3	1
Clark	21	15	6	9	5	4	30	20	10
Clay	-	-	-	-	-	-	-	-	-
Clinton	1	3	(2)	-	4	(4)	1	7	(6)
Crawford	-	-	-	-	-	-	-	-	-
Daviess	2	4	(2)	3	1	2	5	5	-
Dearborn	9	8	1	3	4	(1)	12	12	-
Decatur	-	-	-	4	4	-	4	4	-

Table C-11. Anthem HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Dekalb	-	-	-	2	1	1	2	1	1
Delaware	19	13	6	16	15	1	35	28	7
Dubois	4	3	1	6	6	-	10	9	1
Elkhart	13	14	(1)	21	14	7	34	28	6
Fayette	2	-	2	1	1	-	3	1	2
Floyd	1	3	(2)	6	3	3	7	6	1
Fountain	-	-	-	-	-	-	-	-	-
Franklin	1	-	1	4	4	-	5	4	1
Fulton	-	-	-	6	4	2	6	4	2
Gibson	1	1	-	2	2	-	3	3	-
Grant	5	5	-	6	7	(1)	11	12	(1)
Greene	1	1	-	4	4	-	5	5	-
Hamilton	3	7	(4)	79	93	(14)	82	100	(18)
Hancock	6	4	2	5	7	(2)	11	11	-
Harrison	-	-	-	1	1	-	1	1	-
Hendricks	9	6	3	32	21	11	41	27	14
Henry	-	-	-	8	-	8	8	-	8
Howard	23	11	12	9	11	(2)	32	22	10
Huntington	-	-	-	2	4	(2)	2	4	(2)
Jackson	1	1	-	7	6	1	8	7	1

Table C-11. Anthem HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Jasper	-	-	-	1	5	(4)	1	5	(4)
Jay	-	1	(1)	1	1	-	1	2	(1)
Jefferson	1	1	-	4	4	-	5	5	-
Jennings	-	-	-	-	1	(1)	-	1	(1)
Johnson	9	10	(1)	9	9	-	18	19	(1)
Knox	5	5	-	4	4	-	9	9	-
Kosciusko	4	5	(1)	5	4	1	9	9	-
LaGrange	-	2	(2)	2	3	(1)	2	5	(3)
Lake	66	55	11	69	58	11	135	113	22
LaPorte	7	6	1	8	5	3	15	11	4
Lawrence	-	-	-	2	3	(1)	2	3	(1)
Madison	2	5	(3)	22	14	8	24	19	5
Marion	131	133	(2)	174	160	14	305	293	12
Marshall	5	-	5	6	5	1	11	5	6
Martin	-	-	-	-	-	-	-	-	-
Miami	-	-	-	2	2	-	2	2	-
Monroe	30	40	(10)	18	19	(1)	48	59	(11)
Montgomery	2	3	(1)	7	2	5	9	5	4
Morgan	-	2	(2)	10	4	6	10	6	4
Newton	-	-	-	-	-	-	-	-	-

Table C-11. Anthem HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Noble	1	2	(1)	3	1	2	4	3	1
Ohio	-	-	-	-	-	-	-	-	-
Orange	-	-	-	7	7	-	7	7	-
Owen	-	1	(1)	-	-	-	-	1	(1)
Parke	1	1	-	-	-	-	1	1	-
Perry	-	1	(1)	-	1	(1)	-	2	(2)
Pike	-	-	-	-	-	-	-	-	-
Porter	13	14	(1)	14	8	6	27	22	5
Posey	-	1	(1)	-	-	-	-	1	(1)
Pulaski	-	-	-	-	-	-	-	-	-
Putnam	1	-	1	-	1	(1)	1	1	-
Randolph	-	-	-	2	1	1	2	1	1
Ripley	1	-	1	-	-	-	1	-	1
Rush	-	-	-	1	1	-	1	1	-
St. Joseph	17	14	3	38	38	-	55	52	3
Scott	1	1	-	1	3	(2)	2	4	(2)
Shelby	-	3	(3)	2	2	-	2	5	(3)
Spencer	-	3	(3)	-	-	-	-	3	(3)
Starke	-	-	-	-	1	(1)	-	1	(1)
Steuben	2	2	-	3	3	-	5	5	-

Table C-11. Anthem HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Sullivan	1	1	-	1	1	-	2	2	-
Switzerland	-	-	-	-	-	-	-	-	-
Tippecanoe	16	20	(4)	15	12	3	31	32	(1)
Tipton	-	-	-	-	-	-	-	-	-
Union	2	-	2	-	-	-	2	-	2
Vanderburgh	18	14	4	25	16	9	43	30	13
Vermillion	-	-	-	-	-	-	-	-	-
Vigo	11	8	3	15	22	(7)	26	30	(4)
Wabash	1	1	-	2	2	-	3	3	-
Warren	-	-	-	-	-	-	-	-	-
Warrick	4	5	(1)	32	19	13	36	24	12
Washington	-	-	-	1	1	-	1	1	-
Wayne	3	6	(3)	5	6	(1)	8	12	(4)
Wells	-	-	-	1	2	(1)	1	2	(1)
White	-	1	(1)	3	1	2	3	2	1
Whitley	-	-	-	3	3	-	3	3	-
Out of State	101	66	35	226	193	33	327	259	68

Table C-12. Anthem HIP – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	648	574	74	1,066	930	136	1,714	1,504	210
Adams	2	2	-	2	2	-	4	4	-
Allen	42	26	16	71	44	27	113	70	43
Bartholomew	16	5	11	9	6	3	25	11	14
Benton	-	-	-	-	-	-	-	-	-
Blackford	-	-	-	-	-	-	-	-	-
Boone	21	12	9	6	5	1	27	17	10
Brown	-	-	-	-	-	-	-	-	-
Carroll	1	-	1	1	1	-	2	1	1
Cass	4	2	2	1	1	-	5	3	2
Clark	21	15	6	9	5	4	30	20	10
Clay	-	-	-	-	-	-	-	-	-
Clinton	1	3	(2)	-	3	(3)	1	6	(5)
Crawford	-	-	-	-	-	-	-	-	-
Daviess	2	5	(3)	3	1	2	5	6	(1)
Dearborn	9	8	1	3	5	(2)	12	13	(1)
Decatur	-	-	-	4	4	-	4	4	-
DeKalb	-	-	-	2	1	1	2	1	1
Delaware	19	15	4	16	14	2	35	29	6
Dubois	4	3	1	6	6	-	10	9	1
Elkhart	13	14	(1)	21	15	6	34	29	5

Table C-12. Anthem HIP – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Fayette	2	-	2	1	1	-	3	1	2
Floyd	1	2	(1)	6	3	3	7	5	2
Fountain	-	-	-	-	-	-	-	-	-
Franklin	1	-	1	4	4	-	5	4	1
Fulton	-	-	-	6	6	-	6	6	-
Gibson	1	1	-	2	2	-	3	3	-
Grant	5	5	-	5	6	(1)	10	11	(1)
Greene	1	1	-	4	4	-	5	5	-
Hamilton	4	5	(1)	82	88	(6)	86	93	(7)
Hancock	5	5	-	5	6	(1)	10	11	(1)
Harrison	-	-	-	1	1	-	1	1	-
Hendricks	9	5	4	32	23	9	41	28	13
Henry	-	1	(1)	8	-	8	8	1	7
Howard	22	10	12	9	14	(5)	31	24	7
Huntington	-	-	-	2	3	(1)	2	3	(1)
Jackson	1	1	-	7	7	-	8	8	-
Jasper	-	-	-	1	5	(4)	1	5	(4)
Jay	-	2	(2)	1	1	-	1	3	(2)
Jefferson	1	1	-	4	4	-	5	5	-
Jennings	-	-	-	-	1	(1)	-	1	(1)
Johnson	10	8	2	10	11	(1)	20	19	1

Table C-12. Anthem HIP – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Knox	8	6	2	4	5	(1)	12	11	1
Kosciusko	4	3	1	5	4	1	9	7	2
LaGrange	-	2	(2)	2	3	(1)	2	5	(3)
Lake	68	61	7	69	59	10	137	120	17
LaPorte	7	8	(1)	9	5	4	16	13	3
Lawrence	-	-	-	2	3	(1)	2	3	(1)
Madison	2	11	(9)	21	13	8	23	24	(1)
Marion	132	130	2	173	159	14	305	289	16
Marshall	5	1	4	6	4	2	11	5	6
Martin	-	-	-	-	-	-	-	-	-
Miami	-	-	-	2	1	1	2	1	1
Monroe	31	39	(8)	18	18	-	49	57	(8)
Montgomery	2	4	(2)	7	3	4	9	7	2
Morgan	-	3	(3)	10	5	5	10	8	2
Newton	-	-	-	-	-	-	-	-	-
Noble	1	2	(1)	3	1	2	4	3	1
Ohio	-	-	-	-	-	-	-	-	-
Orange	-	2	(2)	7	7	-	7	9	(2)
Owen	-	1	(1)	-	-	-	-	1	(1)
Parke	1	-	1	-	-	-	1	-	1
Perry	-	-	-	-	1	(1)	-	1	(1)

Table C-12. Anthem HIP – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Pike	-	-	-	-	-	-	-	-	-
Porter	13	13	-	14	10	4	27	23	4
Posey	-	1	(1)	-	-	-	-	1	(1)
Pulaski	-	-	-	-	-	-	-	-	-
Putnam	1	-	1	-	-	-	1	-	1
Randolph	-	-	-	2	1	1	2	1	1
Ripley	1	-	1	-	-	-	1	-	1
Rush	-	-	-	1	1	-	1	1	-
St. Joseph	17	11	6	37	41	(4)	54	52	2
Scott	1	1	-	1	3	(2)	2	4	(2)
Shelby	-	1	(1)	2	2	-	2	3	(1)
Spencer	-	1	(1)	-	-	-	-	1	(1)
Starke	-	-	-	-	-	-	-	-	-
Steuben	2	1	1	3	3	-	5	4	1
Sullivan	1	1	-	1	1	-	2	2	-
Switzerland	-	-	-	-	-	-	-	-	-
Tippecanoe	16	18	(2)	15	16	(1)	31	34	(3)
Tipton	-	1	(1)	-	1	(1)	-	2	(2)
Union	2	-	2	-	-	-	2	-	2
Vanderburgh	19	15	4	25	15	10	44	30	14
Vermillion	-	-	-	-	-	-	-	-	-

Table C-12. Anthem HIP – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Vigo	11	9	2	16	21	(5)	27	30	(3)
Wabash	1	2	(1)	2	4	(2)	3	6	(3)
Warren	-	-	-	-	-	-	-	-	-
Warrick	4	4	-	33	19	14	37	23	14
Washington	-	-	-	1	1	-	1	1	-
Wayne	3	5	(2)	5	6	(1)	8	11	(3)
Wells	-	-	-	1	2	(1)	1	2	(1)
White	-	-	-	3	-	3	3	-	3
Whitley	-	1	(1)	3	3	-	3	4	(1)
Out of State	77	60	17	219	186	33	296	246	50

Table C-13. Anthem HCC – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	663	573	90	1,071	936	135	1,734	1,509	225
Adams	2	2	-	2	1	1	4	3	1
Allen	42	30	12	71	46	25	113	76	37
Bartholomew	16	3	13	9	6	3	25	9	16
Benton	-	-	-	-	-	-	-	-	-

Table C-13. Anthem HCC – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Blackford	-	-	-	-	-	-	-	-	-
Boone	21	8	13	6	6	-	27	14	13
Brown	-	-	-	-	-	-	-	-	-
Carroll	1	-	1	1	-	1	2	-	2
Cass	3	2	1	1	2	(1)	4	4	-
Clark	21	11	10	9	5	4	30	16	14
Clay	-	-	-	-	-	-	-	-	-
Clinton	1	1	-	-	1	(1)	1	2	(1)
Crawford	-	-	-	-	-	-	-	-	-
Daviess	2	3	(1)	3	1	2	5	4	1
Dearborn	9	8	1	3	4	(1)	12	12	-
Decatur	-	-	-	4	5	(1)	4	5	(1)
Dekalb	-	-	-	2	1	1	2	1	1
Delaware	19	11	8	16	12	4	35	23	12
Dubois	4	3	1	6	6	-	10	9	1
Elkhart	13	13	-	21	14	7	34	27	7
Fayette	2	-	2	1	2	(1)	3	2	1
Floyd	1	4	(3)	6	3	3	7	7	-
Fountain	-	-	-	-	-	-	-	-	-
Franklin	1	-	1	4	4	-	5	4	1

Table C-13. Anthem HCC – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Fulton	-	1	(1)	6	6	-	6	7	(1)
Gibson	1	1	-	2	2	-	3	3	-
Grant	5	5	-	6	7	(1)	11	12	(1)
Greene	1	1	-	4	4	-	5	5	-
Hamilton	3	7	(4)	79	90	(11)	82	97	(15)
Hancock	6	5	1	5	7	(2)	11	12	(1)
Harrison	-	-	-	1	1	-	1	1	-
Hendricks	9	8	1	32	17	15	41	25	16
Henry	-	1	(1)	8	1	7	8	2	6
Howard	23	10	13	9	13	(4)	32	23	9
Huntington	-	-	-	2	4	(2)	2	4	(2)
Jackson	1	1	-	7	7	-	8	8	-
Jasper	-	-	-	1	5	(4)	1	5	(4)
Jay	-	1	(1)	1	1	-	1	2	(1)
Jefferson	1	1	-	4	4	-	5	5	-
Jennings	-	-	-	-	-	-	-	-	-
Johnson	9	10	(1)	9	11	(2)	18	21	(3)
Knox	5	5	-	4	4	-	9	9	-
Kosciusko	4	5	(1)	5	4	1	9	9	-
LaGrange	-	1	(1)	2	3	(1)	2	4	(2)

Table C-13. Anthem HCC – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Lake	66	54	12	69	57	12	135	111	24
Laporte	7	7	-	9	5	4	16	12	4
Lawrence	-	-	-	2	3	(1)	2	3	(1)
Madison	2	7	(5)	22	16	6	24	23	1
Marion	131	137	(6)	174	160	14	305	297	8
Marshall	5	1	4	6	5	1	11	6	5
Martin	-	-	-	-	-	-	-	-	-
Miami	-	-	-	2	2	-	2	2	-
Monroe	30	41	(11)	18	17	1	48	58	(10)
Montgomery	2	3	(1)	7	2	5	9	5	4
Morgan	-	2	(2)	10	8	2	10	10	-
Newton	-	-	-	-	-	-	-	-	-
Noble	1	2	(1)	3	1	2	4	3	1
Ohio	-	-	-	-	-	-	-	-	-
Orange	-	-	-	7	6	1	7	6	1
Owen	-	-	-	-	-	-	-	-	-
Parke	1	1	-	-	-	-	1	1	-
Perry	-	-	-	-	1	(1)	-	1	(1)
Pike	-	-	-	-	-	-	-	-	-
Porter	13	13	-	14	8	6	27	21	6

Table C-13. Anthem HCC – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Posey	-	1	(1)	-	-	-	-	1	(1)
Pulaski	-	-	-	-	-	-	-	-	-
Putnam	1	-	1	-	1	(1)	1	1	-
Randolph	-	-	-	2	1	1	2	1	1
Ripley	1	-	1	-	-	-	1	-	1
Rush	-	-	-	1	1	-	1	1	-
St. Joseph	17	13	4	38	42	(4)	55	55	-
Scott	1	3	(2)	1	2	(1)	2	5	(3)
Shelby	-	1	(1)	2	1	1	2	2	-
Spencer	-	1	(1)	-	-	-	-	1	(1)
Starke	-	1	(1)	-	1	(1)	-	2	(2)
Steuben	2	1	1	3	3	-	5	4	1
Sullivan	1	1	-	1	1	-	2	2	-
Switzerland	-	-	-	-	-	-	-	-	-
Tippecanoe	16	16	-	15	15	-	31	31	-
Tipton	-	2	(2)	-	1	(1)	-	3	(3)
Union	2	-	2	-	-	-	2	-	2
Vanderburgh	18	15	3	25	15	10	43	30	13
Vermillion	-	-	-	-	-	-	-	-	-
Vigo	11	11	-	15	25	(10)	26	36	(10)

Table C-13. Anthem HCC – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Wabash	1	-	1	2	2	-	3	2	1
Warren	-	-	-	-	-	-	-	-	-
Warrick	4	4	-	32	20	12	36	24	12
Washington	-	1	(1)	1	1	-	1	2	(1)
Wayne	3	5	(2)	5	5	-	8	10	(2)
Wells	-	1	(1)	1	2	(1)	1	3	(2)
White	-	-	-	3	2	1	3	2	1
Whitley	-	1	(1)	3	2	1	3	3	-
Out of State	101	65	36	226	192	34	327	257	70

Table C-14. CareSource HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN Provider			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	602	592	10	1,078	1,022	56	1,680	1,614	66
Adams	1	2	(1)	4	1	3	5	3	2
Allen	35	37	(2)	56	68	(12)	91	105	(14)
Bartholomew	9	9	-	8	8	0	17	17	-
Benton	1	-	1	-	-	-	1	-	1
Blackford	-	-	-	-	1	(1)	-	1	(1)

Table C-14. CareSource HHW – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN Provider			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Boone	9	7	2	6	8	(2)	15	15	-
Brown	-	-	-	-	-	-	-	-	-
Carroll	-	-	-	-	-	-	-	-	-
Cass	2	3	(1)	2	4	(2)	4	7	(3)
Clark	11	18	(7)	8	10	(2)	19	28	(9)
Clay	-	-	-	-	-	-	-	-	-
Clinton	3	3	-	1	2	(1)	4	5	(1)
Crawford	-	1	(1)	-	-	-	-	1	(1)
Daviess	4	2	2	3	3	-	7	5	2
Dearborn	6	7	(1)	5	5	-	11	12	(1)
Decatur	-	-	-	1	2	(1)	1	2	(1)
Dekalb	-	1	(1)	2	2	0	2	3	(1)
Delaware	12	18	(6)	10	18	(8)	22	36	(14)
Dubois	1	6	(5)	5	4	1	6	10	(4)
Elkhart	12	17	(5)	16	18	(2)	28	35	(7)
Fayette	-	-	-	0	1	(1)	-	1	(1)
Floyd	1	2	(1)	8	7	1	9	9	-
Fountain	-	-	-	-	-	-	-	-	-
Franklin	-	-	-	4	4	-	4	4	-
Fulton	1	-	1	2	2	-	3	2	1

Table C-14. CareSource HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN Provider			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Gibson	1	1	-	2	2	-	3	3	-
Grant	3	3	-	5	9	(4)	8	12	(4)
Greene	-	-	-	3	2	1	3	2	1
Hamilton	11	6	5	61	78	(17)	72	84	(12)
Hancock	6	4	2	8	9	(1)	14	13	1
Harrison	-	-	-	2	1	1	2	1	1
Hendricks	11	6	5	30	27	3	41	33	8
Henry	-	1	(1)	6	10	(4)	6	11	(5)
Howard	9	11	(2)	13	11	2	22	22	-
Huntington	-	-	-	2	6	(4)	2	6	(4)
Jackson	1	1	-	3	7	(4)	4	8	(4)
Jasper	-	-	-	1	3	(2)	1	3	(2)
Jay	-	-	-	3	-	3	3	-	3
Jefferson	-	-	-	0	3	(3)	-	3	(3)
Jennings	-	-	-	1	-	1	1	-	1
Johnson	10	13	(3)	10	15	(5)	20	28	(8)
Knox	5	6	(1)	6	6	-	11	12	(1)
Kosciusko	2	2	-	3	5	(2)	5	7	(2)
Lagrange	-	1	(1)	2	3	(1)	2	4	(2)
Lake	46	49	(3)	54	54	-	100	103	(3)

Table C-14. CareSource HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN Provider			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
LaPorte	6	6	-	7	8	(1)	13	14	(1)
Lawrence	-	-	-	5	1	4	5	1	4
Madison	12	12	-	26	8	18	38	20	18
Marion	145	139	6	181	167	14	326	306	20
Marshall	3	2	1	2	1	1	5	3	2
Martin	-	-	-	-	-	-	-	-	-
Miami	-	-	-	3	2	1	3	2	1
Monroe	39	35	4	18	20	(2)	57	55	2
Montgomery	1	3	(2)	8	1	7	9	4	5
Morgan	2	1	1	17	7	10	19	8	11
Newton	-	-	-	-	-	-	-	-	-
Noble	1	1	-	3	1	2	4	2	2
Ohio	-	-	-	-	-	-	-	-	-
Orange	2	-	2	7	5	2	9	5	4
Owen	-	-	-	1	-	1	1	-	1
Parke	-	-	-	-	-	-	-	-	-
Perry	-	-	-	1	2	(1)	1	2	(1)
Pike	-	-	-	-	-	-	-	-	-
Porter	13	10	3	13	12	1	26	22	4
Posey	-	-	-	-	-	-	-	-	-

Table C-14. CareSource HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN Provider			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Pulaski	-	-	-	-	-	-	-	-	-
Putnam	-	-	-	1	-	1	1	-	1
Randolph	1	-	1	3	2	1	4	2	2
Ripley	1	-	1	1	-	1	2	-	2
Rush	1	1	0	2	-	2	3	1	2
St. Joseph	2	11	(9)	5	50	(45)	7	61	(54)
Scott	-	-	-	4	-	4	4	-	4
Shelby	1	-	1	-	3	(3)	1	3	(2)
Spencer	21	-	21	54	-	54	75	-	75
Starke	-	-	-	1	-	1	1	-	1
Steuben	-	2	(2)	2	2	-	2	4	(2)
Sullivan	1	1	-	-	-	-	1	1	-
Switzerland	-	-	-	-	-	-	-	-	-
Tippecanoe	17	19	(2)	21	17	4	38	36	2
Tipton	-	-	-	2	-	2	2	-	2
Union	-	-	-	-	-	-	-	-	-
Vanderburgh	14	15	(1)	21	16	5	35	31	4
Vermillion	-	-	-	-	-	-	-	-	-
Vigo	10	10	-	14	18	(4)	24	28	(4)
Wabash	-	-	-	1	1	-	1	1	-

Table C-14. CareSource HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN Provider			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Warren	-	-	-	-	-	-	-	-	-
Warrick	6	3	3	30	30	-	36	33	3
Washington	3	-	3	-	-	-	3	-	3
Wayne	9	6	3	7	5	2	16	11	5
Wells	-	-	-	1	1	-	1	1	-
White	-	-	-	2	-	2	2	-	2
Whitley	-	-	-	5	1	4	5	1	4
Out of State	78	78	-	253	222	31	331	300	31

Table C-15. CareSource HIP – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN Provider			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	568	564	4	1,058	1,015	43	1,626	1,579	47
Adams	1	2	(1)	5	1	4	6	3	3
Allen	35	37	(2)	56	68	(12)	91	105	(14)
Bartholomew	9	9	-	9	8	1	18	17	1
Benton	-	-	-	-	-	-	-	-	-
Blackford	-	-	-	-	1	(1)	-	1	(1)
Boone	10	7	3	6	8	(2)	16	15	1

Table C-15. CareSource HIP – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN Provider			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Brown	-	-	-	-	-	-	-	-	-
Carroll	-	-	-	-	-	-	-	-	-
Cass	2	3	(1)	2	4	(2)	4	7	(3)
Clark	11	18	(7)	6	10	(4)	17	28	(11)
Clay	-	-	-	-	-	-	-	-	-
Clinton	4	3	1	2	2	-	6	5	1
Crawford	0	1	(1)	-	-	-	-	1	(1)
Daviess	4	2	2	3	3	-	7	5	2
Dearborn	6	7	(1)	1	5	(4)	7	12	(5)
Decatur	-	-	-	1	2	(1)	1	2	(1)
DeKalb	0	1	(1)	3	2	1	3	3	-
Delaware	13	18	(5)	10	18	(8)	23	36	(13)
Dubois	1	6	(5)	5	4	1	6	10	(4)
Elkhart	14	17	(3)	16	18	(2)	30	35	(5)
Fayette	-	-	-	-	1	(1)	-	1	(1)
Floyd	2	2	-	9	7	2	11	9	2
Fountain	-	-	-	-	-	-	-	-	-
Franklin	1	-	1	4	4	-	5	4	1
Fulton	1	-	1	2	2	-	3	2	1
Gibson	1	1	-	2	2	-	3	3	-
Grant	4	3	-	5	9	(4)	9	12	(3)

Table C-15. CareSource HIP – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN Provider			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Greene	-	-	-	3	2	1	3	2	1
Hamilton	14	6	8	66	78	(12)	80	84	(4)
Hancock	7	4	3	8	9	(1)	15	13	2
Harrison	-	-	-	1	1	-	1	1	-
Hendricks	8	6	2	28	27	1	36	33	3
Henry	1	1	-	5	10	(5)	6	11	(5)
Howard	10	11	(1)	13	11	2	23	22	1
Huntington	-	-	-	2	6	(4)	2	6	(4)
Jackson	1	1	-	4	7	(3)	5	8	(3)
Jasper	-	-	-	2	3	(1)	2	3	(1)
Jay	-	-	-	4	-	4	4	-	4
Jefferson	-	-	-	1	3	(2)	1	3	(2)
Jennings	-	-	-	-	-	-	-	-	-
Johnson	9	12	(3)	10	15	(5)	19	27	(8)
Knox	5	6	(1)	7	6	1	12	12	-
Kosciusko	1	2	(1)	4	5	(1)	5	7	(2)
Lagrange	1	1	-	2	3	(1)	3	4	(1)
Lake	45	49	(4)	54	54	-	99	103	(4)
LaPorte	6	6	-	10	8	2	16	14	2
Lawrence	-	-	-	5	1	4	5	1	4
Madison	13	12	1	19	8	11	32	20	12

Table C-15. CareSource HIP – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN Provider			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Marion	136	140	(4)	178	167	11	314	307	7
Marshall	3	2	1	2	1	1	5	3	2
Martin	-	-	-	-	-	-	-	-	-
Miami	-	-	-	3	2	1	3	2	1
Monroe	38	37	1	19	20	(1)	57	57	-
Montgomery	2	3	(1)	7	1	6	9	4	5
Morgan	2	1	1	18	7	11	20	8	12
Newton	-	-	-	-	-	-	-	-	-
Noble	1	1	-	3	1	2	4	2	2
Ohio	-	-	-	-	-	-	-	-	-
Orange	3	-	3	7	5	2	10	5	5
Owen	-	-	-	1	-	1	1	-	1
Parke	-	-	-	-	-	-	-	-	-
Perry	1	-	1	1	2	(1)	2	2	-
Pike	-	-	-	-	-	-	-	-	-
Porter	11	10	1	16	12	4	27	22	5
Posey	-	-	-	-	-	-	-	-	-
Pulaski	-	-	-	-	-	-	-	-	-
Putnam	-	-	-	1	-	1	1	-	1
Randolph	1	-	1	4	2	2	5	2	3
Ripley	1	-	1	-	-	-	1	-	1

Table C-15. CareSource HIP – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN Provider			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Rush	1	1	-	2	-	2	3	1	2
St. Joseph	2	11	(9)	4	50	(46)	6	61	(55)
Scott	1	-	1	3	-	3	4	-	4
Shelby	-	-	-	-	3	(3)	-	3	(3)
Spencer	18	-	18	50	-	50	68	-	68
Starke	-	-	-	-	-	-	-	-	-
Steuben	2	2	-	2	2	-	4	4	-
Sullivan	1	1	-	-	-	-	1	1	-
Switzerland	-	-	-	-	-	-	-	-	-
Tippecanoe	16	18	(2)	18	17	1	34	35	(1)
Tipton	-	-	-	-	-	-	-	-	-
Union	-	-	-	-	-	-	-	-	-
Vanderburgh	15	15	-	20	16	4	35	31	4
Vermillion	-	-	-	-	-	-	-	-	-
Vigo	10	10	-	15	18	(3)	25	28	(3)
Wabash	-	-	-	1	1	-	1	1	-
Warren	-	-	-	-	-	-	-	-	-
Warrick	7	3	4	31	30	1	38	33	5
Washington	2	-	2	-	-	-	2	-	2
Wayne	7	6	1	6	5	1	13	11	2
Wells	-	-	-	1	1	-	1	1	-

Table C-15. CareSource HIP – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN Provider			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
White	-	-	-	1	-	1	1	-	1
Whitley	-	-	-	4	1	3	4	1	3
Out of State	47	49	(2)	245	215	30	292	264	28

Table C-16. MDwise HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	959	510	449	1,918	1,083	835	2,877	1,593	1,284
Adams	4	-	4	20	2	18	24	2	22
Allen	29	25	4	89	74	15	118	99	19
Bartholomew	16	7	9	15	9	6	31	16	15
Benton	1	-	1	-	-	-	1	-	1
Blackford	-	-	-	1	-	1	1	-	1
Boone	20	4	16	26	7	19	46	11	35
Brown	1	-	1	-	-	-	1	-	1
Carroll	2	-	2	-	1	(1)	2	1	1
Cass	2	-	2	3	3	-	5	3	2
Clark	18	10	8	10	10	0	28	20	8
Clay	-	-	-	1	1	-	1	1	-

Table C-16. MDwise HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Clinton	1	-	1	11	-	11	12	-	12
Crawford	11	2	9	-	-	-	11	2	9
Daviess	6	2	4	3	3	-	9	5	4
Dearborn	7	8	(1)	8	4	4	15	12	3
Decatur	1	1	-	6	3	3	7	4	3
Dekalb	-	-	-	28	3	25	28	3	25
Delaware	20	18	2	21	18	3	41	36	5
Dubois	20	6	14	6	5	1	26	11	15
Elkhart	1	1	-	22	12	10	23	13	10
Fayette	4	2	2	8	4	4	12	6	6
Floyd	11	2	9	13	10	3	24	12	12
Fountain	1	-	1	-	-	-	1	-	1
Franklin	1	1	-	4	3	1	5	4	1
Fulton	2	-	2	7	3	4	9	3	6
Gibson	8	1	7	1	1	-	9	2	7
Grant	7	1	6	10	4	6	17	5	12
Greene	-	-	-	2	3	(1)	2	3	(1)
Hamilton	22	5	17	183	80	103	205	85	120
Hancock	9	2	7	10	5	5	19	7	12
Harrison	-	-	-	3	3	-	3	3	-

Table C-16. MDwise HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Hendricks	9	1	8	68	25	43	77	26	51
Henry	9	1	8	10	4	6	19	5	14
Howard	13	5	8	14	11	3	27	16	11
Huntington	2	1	1	4	2	2	6	3	3
Jackson	1	1	-	11	5	6	12	6	6
Jasper	1	1	-	11	3	8	12	3	9
Jay	3	-	3	7	-	7	10	-	10
Jefferson	3	-	3	3	3	-	6	3	3
Jennings	4	1	3	3	2	1	7	3	4
Johnson	13	3	10	45	15	30	58	18	40
Knox	8	6	2	5	4	1	13	10	3
Kosciusko	3	2	1	23	4	19	26	6	20
LaGrange	1	-	1	4	1	3	5	1	4
Lake	40	34	6	68	59	9	108	93	15
LaPorte	5	3	2	19	7	12	24	10	14
Lawrence	3	-	3	14	7	7	17	7	10
Madison	30	11	19	71	29	42	101	40	61
Marion	184	134	50	286	197	89	470	331	139
Marshall	8	3	5	10	4	6	18	7	11
Martin	3	-	3	-	-	-	3	-	3

Table C-16. MDwise HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Miami	2	-	2	4	2	2	6	2	4
Monroe	44	34	10	40	19	21	84	53	31
Montgomery	5	2	3	13	2	11	18	4	14
Morgan	8	2	6	22	1	21	30	3	27
Newton	-	-	-	-	-	-	-	-	-
Noble	1	-	1	5	3	2	6	3	3
Ohio	-	-	-	-	-	-	-	-	-
Orange	11	1	10	7	3	4	18	4	14
Owen	2	-	2	-	-	-	2	-	2
Parke	-	-	-	-	-	-	-	-	-
Perry	12	1	11	1	1	-	13	2	11
Pike	4	-	4	-	-	-	4	-	4
Porter	9	1	8	38	11	27	47	12	35
Posey	5	-	5	-	-	-	5	-	5
Pulaski	2	1	1	-	-	-	2	1	1
Putnam	2	-	2	4	-	4	6	-	6
Randolph	7	-	7	7	2	5	14	2	12
Ripley	1	1	-	5	1	4	6	2	4
Rush	5	-	5	6	2	4	11	2	9
St. Joseph	7	16	(9)	10	46	(36)	17	62	(45)

Table C-16. MDwise HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Scott	8	-	8	6	1	5	14	1	13
Shelby	11	-	11	-	2	(2)	11	2	9
Spencer	28	-	28	72	1	71	100	1	99
Starke	8	5	3	8	-	8	16	5	11
Steuben	2	2	-	3	2	1	5	4	1
Sullivan	1	1	-	1	1	-	2	2	-
Switzerland	-	-	-	3	-	3	3	-	3
Tippecanoe	18	9	9	37	21	16	55	30	25
Tipton	2	-	2	7	4	3	9	4	5
Union	1	1	-	-	-	-	1	1	-
Vanderburgh	20	15	5	49	30	19	69	45	24
Vermillion	1	-	1	4	-	4	5	-	5
Vigo	8	7	1	33	18	15	41	25	16
Wabash	3	-	3	5	-	5	8	-	8
Warren	-	-	-	-	-	-	-	-	-
Warrick	15	4	11	41	37	4	56	41	15
Washington	10	1	9	3	1	2	13	2	11
Wayne	15	6	9	9	3	6	24	9	15
Wells	1	-	1	2	1	1	3	1	2
White	1	-	1	9	-	9	10	-	10

Table C-16. MDwise HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Whitley	1	-	1	9	2	7	10	2	8
Out of State	110	96	14	268	213	55	378	309	69

Table C-17. MDwise HIP – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	968	510	458	1,951	1,093	858	2,919	1,603	1,316
Adams	4	-	4	20	2	18	24	2	22
Allen	29	25	4	92	76	16	121	101	20
Bartholomew	16	7	9	13	8	5	29	15	14
Benton	1	-	1	-	-	-	1	-	1
Blackford	-	-	-	1	-	1	1	-	1
Boone	19	5	14	25	8	17	44	13	31
Brown	1	-	1	-	-	-	1	-	1
Carroll	2	-	2	-	1	(1)	2	1	1
Cass	2	-	2	3	3	-	5	3	2
Clark	19	11	8	11	11	-	30	22	8
Clay	-	-	-	1	1	-	1	1	-
Clinton	2	-	2	11	1	10	13	1	12

Table C-17. MDwise HIP – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Crawford	11	1	10	-	-	-	11	1	10
Daviess	6	2	4	3	3	-	9	5	4
Dearborn	7	8	(1)	8	5	3	15	13	2
Decatur	1	-	1	6	2	4	7	2	5
DeKalb	0	-	-	28	2	26	28	2	26
Delaware	19	17	2	22	19	3	41	36	5
Dubois	20	4	16	7	6	1	27	10	17
Elkhart	-	-	-	23	13	10	23	13	10
Fayette	4	2	2	8	5	3	12	7	5
Floyd	11	2	9	15	10	5	26	12	14
Fountain	1	-	1	-	-	-	1	-	1
Franklin	1	1	-	6	5	1	7	6	1
Fulton	2	-	2	7	3	4	9	3	6
Gibson	7	2	5	1	1	-	8	3	5
Grant	7	-	7	10	4	6	17	4	13
Greene	-	-	-	2	2	-	2	2	-
Hamilton	22	7	15	181	78	103	203	85	118
Hancock	10	1	9	10	4	6	20	5	15
Harrison	-	-	-	3	3	-	3	3	-
Hendricks	9	1	8	69	23	46	78	24	54
Henry	9	-	9	9	3	6	18	3	15

Table C-17. MDwise HIP – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Howard	14	5	9	13	11	2	27	16	11
Huntington	3	2	1	5	2	3	7	3	4
Jackson	2	1	1	12	5	7	14	6	8
Jasper	1	-	1	11	3	8	12	3	9
Jay	3	-	3	7	-	7	10	-	10
Jefferson	3	-	3	4	4	-	7	4	3
Jennings	4	1	3	3	1	2	7	2	5
Johnson	14	3	11	48	20	28	62	23	39
Knox	8	6	2	6	5	1	14	11	3
Kosciusko	3	2	1	24	4	20	27	6	21
LaGrange	1	-	1	4	1	3	5	1	4
Lake	41	33	8	68	61	7	109	94	15
LaPorte	5	3	2	22	9	13	27	12	15
Lawrence	3	1	2	15	4	11	18	5	13
Madison	31	14	17	70	26	44	101	40	61
Marion	185	131	54	295	199	96	480	330	150
Marshall	8	1	7	10	3	7	18	4	14
Martin	3	-	3	-	-	-	3	-	3
Miami	2	-	2	4	2	2	6	2	4
Monroe	44	34	10	41	22	19	85	56	29
Montgomery	5	1	4	13	2	11	18	3	15

Table C-17. MDwise HIP – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Morgan	9	1	8	23	2	21	32	3	29
Newton	-	-	-	-	-	-	-	-	-
Noble	1	-	1	5	2	3	6	2	4
Ohio	-	-	-	-	-	-	-	-	-
Orange	11	2	9	7	3	4	18	5	13
Owen	2	-	2	-	-	-	2	-	2
Parke	-	-	-	-	-	-	-	-	-
Perry	12	-	12	1	1	-	13	1	12
Pike	4	-	4	-	-	-	4	-	4
Porter	9	3	6	38	11	27	47	14	33
Posey	5	-	5	-	-	-	5	-	5
Pulaski	2	1	1	-	-	-	2	1	1
Putnam	2	1	1	4	-	4	6	1	5
Randolph	8	-	8	8	2	6	16	2	14
Ripley	2	1	1	5	1	4	7	2	5
Rush	5	-	5	6	3	3	11	3	8
St. Joseph	8	18	(10)	10	49	(39)	18	67	(49)
Scott	9	1	8	6	1	5	15	2	13
Shelby	11	2	9	-	2	(2)	11	4	7
Spencer	29	1	28	78	-	78	107	1	106
Starke	8	5	3	8	-	8	16	5	11

Table C-17. MDwise HIP – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Steuben	2	2	-	3	2	1	5	4	1
Sullivan	1	1	-	1	1	-	2	2	-
Switzerland	-	-	-	3	-	3	3	-	3
Tippecanoe	17	10	7	38	20	18	55	30	25
Tipton	2	-	2	7	4	3	9	4	5
Union	2	-	2	-	-	-	2	-	2
Vanderburgh	20	14	6	50	30	20	70	44	26
Vermillion	1	-	1	2	-	2	3	-	3
Vigo	10	8	2	35	20	15	45	28	17
Wabash	3	-	3	5	2	3	8	2	6
Warren	-	-	-	-	-	-	-	-	-
Warrick	15	4	11	41	37	4	56	41	15
Washington	10	1	9	3	1	2	13	2	11
Wayne	15	7	8	9	2	7	24	9	15
Wells	1	-	1	3	2	1	4	2	2
White	1	-	1	9	-	9	10	-	10
Whitley	1	-	1	9	1	8	10	1	9
Out of State	106	94	12	264	208	56	370	302	68

Table C-18. MHS HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	409	400	9	811	806	5	1,220	1,206	14
Adams	1	1	-	1	1	-	2	2	-
Allen	20	26	(6)	49	51	(2)	69	77	(8)
Bartholomew	8	7	1	5	7	(2)	13	14	(1)
Benton	-	-	-	-	-	-	-	-	-
Blackford	-	-	-	-	-	-	-	-	-
Boone	8	4	4	15	16	(1)	23	20	3
Brown	-	-	-	-	-	-	-	-	-
Carroll	-	-	-	-	-	-	-	-	-
Cass	-	-	-	4	4	-	4	4	-
Clark	9	13	(4)	11	10	1	20	23	(3)
Clay	-	-	-	-	-	-	-	-	-
Clinton	1	-	1	1	-	1	2	-	2
Crawford	-	-	-	-	-	-	-	-	-
Daviess	2	1	1	3	3	-	5	4	1
Dearborn	2	4	(2)	4	5	(1)	6	9	(3)
Decatur	-	-	-	3	3	-	3	3	-
Dekalb	-	-	-	3	4	(1)	3	4	(1)
Delaware	9	13	(4)	12	12	-	21	25	(4)
Dubois	4	7	(3)	6	6	-	10	13	(3)

Table C-18. MHS HHW – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Elkhart	8	8	-	19	19	-	27	27	-
Fayette	2	2	-	-	-	-	2	2	-
Floyd	2	1	1	8	8	-	10	9	1
Fountain	-	-	-	-	-	-	-	-	-
Franklin	-	-	-	3	2	1	3	2	1
Fulton	-	-	-	2	2	-	2	2	-
Gibson	2	2	-	1	1	-	3	3	-
Grant	1	1	-	1	1	-	2	2	-
Greene	-	-	-	3	3	-	3	3	-
Hamilton	8	10	(2)	53	58	(5)	61	68	(7)
Hancock	5	5	-	5	6	(1)	10	11	(1)
Harrison	1	-	1	1	1	-	2	1	1
Hendricks	5	5	-	29	25	4	34	30	4
Henry	1	-	1	6	5	1	7	5	2
Howard	11	11	-	8	7	1	19	18	1
Huntington	2	-	2	2	-	2	4	-	4
Jackson	1	-	1	4	4	-	5	4	1
Jasper	1	-	1	1	-	1	2	-	2
Jay	-	-	-	1	-	1	1	-	1
Jefferson	2	1	1	4	4	-	6	5	1

Table C-18. MHS HHW – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Jennings	-	-	-	2	-	2	2	-	2
Johnson	10	9	(1)	21	17	4	31	26	5
Knox	3	5	(2)	3	2	1	6	7	(1)
Kosciusko	1	2	(1)	3	2	1	4	4	-
LaGrange	2	1	1	1	1	-	3	2	1
Lake	25	25	-	36	39	(3)	61	64	(3)
LaPorte	5	4	1	4	3	1	9	7	2
Lawrence	2	-	2	5	3	2	7	3	4
Madison	9	5	4	14	13	1	23	18	5
Marion	99	109	(10)	120	137	(17)	219	246	(27)
Marshall	2	2	-	11	4	7	13	6	7
Martin	1	-	1	-	-	-	1	-	1
Miami	-	-	-	1	1	-	1	1	-
Monroe	26	25	1	11	14	(3)	37	39	(2)
Montgomery	-	-	-	5	3	2	5	3	2
Morgan	-	-	-	12	8	4	12	8	4
Newton	-	-	-	-	-	-	-	-	-
Noble	-	-	-	1	1	-	1	1	-
Ohio	2	-	2	-	-	-	2	-	2
Orange	-	-	-	3	2	1	3	2	1

Table C-18. MHS HHW – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Owen	-	-	-	-	-	-	-	-	-
Parke	-	-	-	1	1	-	1	1	-
Perry	1	-	1	1	1	-	2	1	1
Pike	-	-	-	-	-	-	-	-	-
Porter	7	7	-	14	12	2	21	19	2
Posey	-	-	-	-	-	-	-	-	-
Pulaski	1	1	-	1	-	1	2	1	1
Putnam	-	-	-	-	-	-	-	-	-
Randolph	-	-	-	5	3	2	5	3	2
Ripley	2	2	-	2	2	-	4	4	-
Rush	-	-	-	1	-	1	1	-	1
St. Joseph	19	16	3	31	38	(7)	50	54	(4)
Scott	-	-	-	1	-	1	1	-	1
Shelby	-	-	-	4	4	-	4	4	-
Spencer	-	-	-	-	-	-	-	-	-
Starke	2	2	-	-	-	-	2	2	-
Steuben	1	1	-	3	3	-	4	4	-
Sullivan	-	-	-	-	-	-	-	-	-
Switzerland	-	-	-	-	-	-	-	-	-
Tippecanoe	12	11	1	16	18	(2)	28	29	(1)

Table C-18. MHS HHW – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Tipton	-	-	-	-	-	-	-	-	-
Union	1	1	-	-	-	-	1	1	-
Vanderburgh	15	15	-	20	18	2	35	33	2
Vermillion	-	-	-	-	-	-	-	-	-
Vigo	7	8	(1)	12	9	3	19	17	2
Wabash	-	-	-	2	2	-	2	2	-
Warren	-	-	-	-	-	-	-	-	-
Warrick	2	-	2	24	24	-	26	24	2
Washington	1	-	1	-	-	-	1	-	1
Wayne	5	3	2	5	5	-	10	8	2
Wells	-	-	-	1	1	-	1	1	-
White	-	-	-	-	-	-	-	-	-
Whitley	1	-	1	3	2	1	4	2	2
Out of State	29	24	5	143	145	(2)	172	169	3

Table C-19. MHS HIP – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	406	394	12	812	808	4	1,218	1,202	16
Adams	1	1	-	1	1	-	2	2	-
Allen	21	26	(5)	50	51	(1)	71	77	(6)
Bartholomew	7	7	-	5	7	(2)	12	14	(2)
Benton	-	-	-	-	-	-	-	-	-
Blackford	-	-	-	-	-	-	-	-	-
Boone	8	4	4	15	17	(2)	23	21	2
Brown	-	-	-	-	-	-	-	-	-
Carroll	-	-	-	-	-	-	-	-	-
Cass	1	1	-	4	4	-	5	5	-
Clark	9	14	(5)	9	9	-	18	23	(5)
Clay	-	-	-	-	-	-	-	-	-
Clinton	1	-	1	1	-	1	2	-	2
Crawford	-	-	-	-	-	-	-	-	-
Daviess	2	1	1	3	3	-	5	4	1
Dearborn	2	3	(1)	4	5	(1)	6	8	(2)
Decatur	-	-	-	3	3	-	3	3	-
DeKalb	-	-	-	3	4	(1)	3	4	(1)
Delaware	9	12	(3)	13	13	-	22	25	(3)
Dubois	5	7	(2)	5	5	-	10	12	(2)
Elkhart	8	8	-	19	18	1	27	26	1

Table C-19. MHS HIP – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Fayette	2	1	1	-	-	-	2	1	1
Floyd	2	1	1	8	8	-	10	9	1
Fountain	-	-	-	-	-	-	-	-	-
Franklin	-	-	-	3	2	1	3	2	1
Fulton	-	-	-	2	2	-	2	2	-
Gibson	2	2	-	1	1	-	3	3	-
Grant	1	1	-	1	1	-	2	2	-
Greene	-	-	-	3	3	-	3	3	-
Hamilton	8	10	(2)	55	58	(3)	63	68	(5)
Hancock	4	4	-	5	6	(1)	9	10	(1)
Harrison	1	-	1	1	1	-	2	1	1
Hendricks	4	4	-	27	25	2	31	29	2
Henry	1	-	1	5	5	-	6	5	1
Howard	10	11	(1)	8	7	1	18	18	-
Huntington	2	-	2	2	1	1	4	1	3
Jackson	-	-	-	4	4	-	4	4	-
Jasper	1	-	1	1	-	1	2	-	2
Jay	-	-	-	1	-	1	1	-	1
Jefferson	2	1	1	4	4	-	6	5	1
Jennings	-	-	-	2	-	2	2	-	2
Johnson	10	8	2	21	16	5	31	24	7

Table C-19. MHS HIP – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Knox	2	4	(2)	3	2	1	5	6	(1)
Kosciusko	1	2	(1)	3	3	-	4	5	(1)
LaGrange	2	1	1	1	1	-	3	2	1
Lake	26	27	(1)	37	40	(3)	63	67	(4)
LaPorte	4	3	1	4	3	1	8	6	2
Lawrence	2	-	2	5	3	2	7	3	4
Madison	9	6	3	14	13	1	23	19	4
Marion	99	107	(8)	120	138	(18)	219	245	(26)
Marshall	2	2	-	11	4	7	13	6	7
Martin	1	-	1	-	-	-	1	-	1
Miami	-	-	-	1	1	-	1	1	-
Monroe	27	26	1	11	14	(3)	38	40	(2)
Montgomery	-	-	-	6	3	3	6	3	3
Morgan	1	-	1	12	8	4	13	8	5
Newton	-	-	-	-	-	-	-	-	-
Noble	1	-	1	1	1	-	2	1	1
Ohio	2	-	2	-	-	-	2	-	2
Orange	-	-	-	3	2	1	3	2	1
Owen	-	-	-	-	-	-	-	-	-
Parke	-	-	-	1	1	-	1	1	-
Perry	1	-	1	1	1	-	2	1	1

Table C-19. MHS HIP – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Pike	-	-	-	-	-	-	-	-	-
Porter	7	7	-	13	12	1	20	19	1
Posey	-	-	-	-	-	-	-	-	-
Pulaski	-	-	-	1	-	1	1	-	1
Putnam	-	-	-	-	-	-	-	-	-
Randolph	1	-	1	5	3	2	6	3	3
Ripley	1	2	(1)	2	2	-	3	4	(1)
Rush	-	-	-	1	-	1	1	-	1
St. Joseph	19	16	3	30	37	(7)	49	53	(4)
Scott	-	-	-	1	-	1	1	-	1
Shelby	-	-	-	4	4	-	4	4	-
Spencer	-	-	-	-	-	-	-	-	-
Starke	2	2	-	-	-	-	2	2	-
Steuben	1	1	-	3	3	-	4	4	-
Sullivan	-	-	-	-	-	-	-	-	-
Switzerland	-	-	-	-	-	-	-	-	-
Tippecanoe	11	11	-	16	18	(2)	27	29	(2)
Tipton	-	-	-	-	-	-	-	-	-
Union	1	1	-	-	-	-	1	1	-
Vanderburgh	15	13	2	20	18	2	35	31	4
Vermillion	-	-	-	-	-	-	-	-	-

Table C-19. MHS HIP – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Vigo	7	8	(1)	12	8	4	19	16	3
Wabash	-	-	-	1	1	-	1	1	-
Warren	-	-	-	-	-	-	-	-	-
Warrick	1	1	-	24	24	-	25	25	-
Washington	1	-	1	-	-	-	1	-	1
Wayne	5	3	2	5	5	-	10	8	2
Wells	-	-	-	1	1	-	1	1	-
White	-	-	-	-	-	-	-	-	-
Whitley	1	-	1	2	1	1	3	1	2
Out of State	29	24	5	148	149	(1)	177	173	4

Table C-20. MHS HCC – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	401	391	10	783	775	8	1,184	1,166	18
Adams	1	1	-	1	1	-	2	2	-
Allen	19	25	(6)	48	49	(1)	67	74	(7)
Bartholomew	7	6	1	5	7	(2)	12	13	(1)
Benton	-	-	-	-	-	-	-	-	-

Table C-20. MHS HCC – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Blackford	-	-	-	-	-	-	-	-	-
Boone	8	4	4	16	18	(2)	24	22	2
Brown	-	-	-	-	-	-	-	-	-
Carroll	-	-	-	-	-	-	-	-	-
Cass	1	1	-	4	4	-	5	5	-
Clark	9	13	(4)	10	10	-	19	23	(4)
Clay	-	-	-	-	-	-	-	-	-
Clinton	1	-	1	1	-	1	2	-	2
Crawford	-	-	-	-	-	-	-	-	-
Daviess	2	1	1	3	3	-	5	4	1
Dearborn	2	3	(1)	4	5	(1)	6	8	(2)
Decatur	-	-	-	3	3	-	3	3	-
Dekalb	-	-	-	3	4	(1)	3	4	(1)
Delaware	9	13	(4)	13	14	(1)	22	27	(5)
Dubois	5	7	(2)	6	6	-	11	13	(2)
Elkhart	6	6	-	19	19	-	25	25	-
Fayette	2	2	-	-	-	-	2	2	-
Floyd	2	1	1	8	8	-	10	9	1
Fountain	-	-	-	-	-	-	-	-	-
Franklin	-	-	-	3	2	1	3	2	1

Table C-20. MHS HCC – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Fulton	-	-	-	2	2	-	2	2	-
Gibson	2	2	-	1	1	-	3	3	-
Grant	1	1	-	1	1	-	2	2	-
Greene	-	-	-	3	3	-	3	3	-
Hamilton	9	9	-	53	57	(4)	62	66	(4)
Hancock	5	5	-	5	6	(1)	10	11	(1)
Harrison	1	-	1	1	1	-	2	1	1
Hendricks	5	5	-	25	23	2	30	28	2
Henry	1	-	1	6	5	1	7	5	2
Howard	10	10	-	8	7	1	18	17	1
Huntington	2	-	2	1	1	-	3	1	2
Jackson	1	-	1	4	4	-	5	4	1
Jasper	1	-	1	1	-	1	2	-	2
Jay	-	-	-	1	-	1	1	-	1
Jefferson	2	1	1	4	4	-	6	5	1
Jennings	-	-	-	2	-	2	2	-	2
Johnson	9	7	2	18	14	4	27	21	6
Knox	2	4	(2)	3	2	1	5	6	(1)
Kosciusko	1	2	(1)	3	2	1	4	4	-
LaGrange	2	1	1	1	-	1	3	1	2

Table C-20. MHS HCC – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Lake	25	26	(1)	36	39	(3)	61	65	(4)
LaPorte	5	4	1	4	3	1	9	7	2
Lawrence	2	-	2	3	2	1	5	2	3
Madison	9	5	4	13	12	1	22	17	5
Marion	99	110	(11)	120	134	(14)	219	244	(25)
Marshall	2	2	-	11	4	7	13	6	7
Martin	1	-	1	-	-	-	1	-	1
Miami	-	-	-	1	1	-	1	1	-
Monroe	24	23	1	13	14	(1)	37	37	-
Montgomery	-	-	-	6	3	3	6	3	3
Morgan	-	-	-	12	8	4	12	8	4
Newton	-	-	-	-	-	-	-	-	-
Noble	1	-	1	1	1	-	2	1	1
Ohio	2	-	2	-	-	-	2	-	2
Orange	-	-	-	3	2	1	3	2	1
Owen	-	-	-	-	-	-	-	-	-
Parke	-	-	-	1	1	-	1	1	-
Perry	-	-	-	1	1	-	1	1	-
Pike	-	-	-	-	-	-	-	-	-
Porter	7	7	-	14	13	1	21	20	1

Table C-20. MHS HCC – Count of Providers by Provider Network Category and County									
County	Psychiatrist			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Posey	-	-	-	-	-	-	-	-	-
Pulaski	-	-	-	1	-	1	1	-	1
Putnam	-	-	-	-	-	-	-	-	-
Randolph	-	-	-	5	3	2	5	3	2
Ripley	1	2	(1)	2	2	-	3	4	(1)
Rush	-	-	-	1	-	1	1	-	1
St. Joseph	19	16	3	30	37	(7)	49	53	(4)
Scott	-	-	-	1	-	1	1	-	1
Shelby	-	-	-	4	4	-	4	4	-
Spencer	-	-	-	-	-	-	-	-	-
Starke	2	2	-	-	-	-	2	2	-
Steuben	1	1	-	3	3	-	4	4	-
Sullivan	-	-	-	-	-	-	-	-	-
Switzerland	-	-	-	-	-	-	-	-	-
Tippecanoe	11	12	(1)	16	18	(2)	27	30	(3)
Tipton	-	-	-	-	-	-	-	-	-
Union	1	1	-	-	-	-	1	1	-
Vanderburgh	15	13	2	18	17	1	33	30	3
Vermillion	-	-	-	-	-	-	-	-	-
Vigo	7	8	(1)	12	9	3	19	17	2

Table C-20. MHS HCC – Count of Providers by Provider Network Category and County

County	Psychiatrist			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Wabash	-	-	-	2	1	1	2	1	1
Warren	-	-	-	-	-	-	-	-	-
Warrick	2	1	1	10	9	1	12	10	2
Washington	1	-	1	-	-	-	1	-	1
Wayne	6	4	2	5	5	-	11	9	2
Wells	-	-	-	1	1	-	1	1	-
White	-	-	-	-	-	-	-	-	-
Whitley	1	-	1	1	1	-	2	1	1
Out of State	29	24	5	142	141	1	171	165	6

Table C-21. UHC HCC – Count of Providers by Provider Network Category and County

County	Psychiatrists			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	516	465	51	780	758	22	1,296	1,223	73
Adams	-	-	-	1	1	-	1	1	-
Allen	37	34	3	59	58	1	96	92	4
Bartholomew	6	6	-	7	7	-	13	13	-
Benton	-	-	-	-	-	-	-	-	-
Blackford	-	-	-	-	-	-	-	-	-

Table C-21. UHC HCC – Count of Providers by Provider Network Category and County

County	Psychiatrists			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Boone	1	3	(2)	-	9	(9)	1	12	(11)
Brown	-	-	-	-	-	-	-	-	-
Carroll	-	-	-	-	-	-	-	-	-
Cass	2	2	-	4	4	-	6	6	-
Clark	22	14	8	7	7	-	29	21	8
Clay	-	-	-	-	-	-	-	-	-
Clinton	1	1	-	-	-	-	1	1	-
Crawford	-	-	-	-	-	-	-	-	-
Daviess	1	1	-	3	3	-	4	4	-
Dearborn	12	10	2	4	3	1	16	13	3
Decatur	-	-	-	2	2	-	2	2	-
Dekalb	-	-	-	3	3	-	3	3	-
Delaware	13	16	(3)	9	9	-	22	25	(3)
Dubois	1	3	(2)	5	5	-	6	8	(2)
Elkhart	11	15	(4)	20	23	(3)	31	38	(7)
Fayette	-	1	(1)	-	1	(1)	-	2	(2)
Floyd	2	2	-	9	9	-	11	11	-
Fountain	-	-	-	-	-	-	-	-	-
Franklin	-	1	(1)	1	1	-	1	2	(1)
Fulton	-	-	-	2	2	-	2	2	-

Table C-21. UHC HCC – Count of Providers by Provider Network Category and County

County	Psychiatrists			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Gibson	1	1	-	1	1	-	2	2	-
Grant	3	3	-	5	4	1	8	7	1
Greene	-	-	-	1	1	-	1	1	-
Hamilton	2	6	(4)	42	91	(49)	44	97	(53)
Hancock	4	3	1	-	-	-	4	3	1
Harrison	-	-	-	1	1	-	1	1	-
Hendricks	7	4	3	21	22	(1)	28	26	2
Henry	-	1	(1)	4	4	-	4	5	(1)
Howard	11	11	-	8	9	(1)	19	20	(1)
Huntington	-	-	-	1	2	(1)	1	2	(1)
Jackson	-	-	-	-	6	(6)	-	6	(6)
Jasper	-	-	-	-	3	(3)	-	3	(3)
Jay	-	-	-	-	-	-	-	-	-
Jefferson	2	1	1	4	4	-	6	5	1
Jennings	-	-	-	-	-	-	-	-	-
Johnson	4	4	-	8	14	(6)	12	18	(6)
Knox	5	4	1	3	3	-	8	7	1
Kosciusko	2	4	(2)	4	3	1	6	7	(1)
LaGrange	-	-	-	2	2	-	2	2	-
Lake	47	37	10	59	57	2	106	94	12

Table C-21. UHC HCC – Count of Providers by Provider Network Category and County									
County	Psychiatrists			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
LaPorte	2	3	(1)	5	6	(1)	7	9	(2)
Lawrence	-	1	(1)	1	1	-	1	2	(1)
Madison	3	8	(5)	22	22	-	25	30	(5)
Marion	168	139	29	218	146	72	386	285	101
Marshall	-	-	-	2	2	-	2	2	-
Martin	-	-	-	-	-	-	-	-	-
Miami	-	-	-	-	1	(1)	-	1	(1)
Monroe	25	19	6	12	8	4	37	27	10
Montgomery	2	1	1	5	1	4	7	2	5
Morgan	1	1	-	3	4	(1)	4	5	(1)
Newton	-	-	-	-	-	-	-	-	-
Noble	1	1	-	2	2	-	3	3	-
Ohio	-	-	-	-	-	-	-	-	-
Orange	-	-	-	5	4	1	5	4	1
Owen	-	-	-	-	-	-	-	-	-
Parke	-	1	(1)	-	-	-	-	1	(1)
Perry	-	-	-	-	-	-	-	-	-
Pike	-	-	-	-	-	-	-	-	-
Porter	5	13	(8)	7	8	(1)	12	21	(9)
Posey	-	-	-	-	-	-	-	-	-

Table C-21. UHC HCC – Count of Providers by Provider Network Category and County

County	Psychiatrists			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Pulaski	-	-	-	-	-	-	-	-	-
Putnam	-	1	(1)	-	-	-	-	1	(1)
Randolph	-	1	(1)	2	1	1	2	2	-
Ripley	1	-	1	-	-	-	1	-	1
Rush	-	-	-	-	-	-	-	-	-
St. Joseph	23	10	13	46	41	5	69	51	18
Scott	1	2	(1)	5	-	5	6	2	4
Shelby	1	1	-	2	2	-	3	3	-
Spencer	-	1	(1)	-	-	-	-	1	(1)
Starke	-	-	-	-	-	-	-	-	-
Steuben	2	2	-	1	2	(1)	3	4	(1)
Sullivan	1	1	-	1	1	-	2	2	-
Switzerland	-	-	-	-	-	-	-	-	-
Tippecanoe	18	21	(3)	23	18	5	41	39	2
Tipton	-	-	-	-	-	-	-	-	-
Union	-	-	-	-	-	-	-	-	-
Vanderburgh	17	15	2	22	20	2	39	35	4
Vermillion	-	-	-	-	-	-	-	-	-
Vigo	16	10	6	13	13	-	29	23	6
Wabash	-	-	-	4	2	2	4	2	2

Table C-21. UHC HCC – Count of Providers by Provider Network Category and County

County	Psychiatrists			OB/GYN Providers			Total		
	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0902	Myers and Stauffer Calculated	Over (Under) Reported
Warren	-	-	-	-	-	-	-	-	-
Warrick	3	3	-	34	34	-	37	37	-
Washington	-	-	-	-	-	-	-	-	-
Wayne	9	5	4	6	5	1	15	10	5
Wells	-	-	-	1	1	-	1	1	-
White	-	-	-	-	-	-	-	-	-
Whitley	-	-	-	2	2	-	2	2	-
Out of State	20	17	3	36	37	(1)	56	54	2

Provider Network Accessibility by County

The following tables are an assessment of each MCE’s reporting of their provider network accessibility to their enrollees, specifically the accessibility of psychiatrist and OB/GYN providers. MCEs are contractually required to annually submit to the State a *Report 0903 Member Access to Providers* for each program they manage. Each MCE’s 0903 reports were compared to the provider network accessibility and calculated from the detailed provider and enrollee listings the MCE submitted for the provider network adequacy assessment. The assessment comprises separate tables for each program (HHW, HIP, and HCC). Counts of enrollees are presented by county.

Table C-22. Anthem HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	334,015	334,605	(590)	-	-	-	-	-	-
Adams	1,008	1,015	(7)	-	-	-	-	-	-
Allen	21,497	21,384	113	-	-	-	-	-	-
Bartholomew	2,399	2,370	29	-	-	-	-	-	-
Benton	293	366	(73)	-	-	-	-	-	-
Blackford	611	622	(11)	-	-	-	-	-	-
Boone	1,484	1,533	(49)	-	-	-	-	-	-
Brown	567	255	312	-	-	-	-	-	-
Carroll	571	473	98	-	-	-	-	-	-
Cass	1,589	1,597	(8)	-	-	-	-	-	-
Clark	5,353	5,397	(44)	-	-	-	-	-	-
Clay	1,106	1,169	(63)	-	-	-	-	-	-
Clinton	1,238	1,236	2	-	-	-	-	-	-
Crawford	625	670	(45)	-	-	-	-	-	-
Daviess	1,771	1,719	52	-	-	-	-	-	-
Dearborn	1,215	1,219	(4)	-	-	-	-	-	-
Decatur	1,067	1,136	(69)	-	-	-	-	-	-
DeKalb	1,838	1,778	60	-	-	-	-	-	-
Delaware	4,004	4,071	(67)	-	-	-	-	-	-
Dubois	1,114	1,142	(28)	-	-	-	-	-	-

Table C-22. Anthem HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Elkhart	6,736	6,483	253	-	-	-	-	-	-
Fayette	1,351	1,375	(24)	-	-	-	-	-	-
Floyd	3,553	3,506	47	-	-	-	-	-	-
Fountain	613	701	(88)	-	-	-	-	-	-
Franklin	906	729	177	-	-	-	-	-	-
Fulton	1,060	1,027	33	-	-	-	-	-	-
Gibson	2,066	2,081	(15)	-	-	-	-	-	-
Grant	3,196	3,220	(24)	-	-	-	-	-	-
Greene	2,000	1,969	31	-	-	-	-	-	-
Hamilton	6,681	6,666	15	-	-	-	-	-	-
Hancock	4,082	4,097	(15)	-	-	-	-	-	-
Harrison	2,527	2,523	4	-	-	-	-	-	-
Hendricks	5,424	4,639	785	-	-	-	-	-	-
Henry	2,163	2,255	(92)	-	-	-	-	-	-
Howard	3,510	3,589	(79)	-	-	-	-	-	-
Huntington	1,198	1,299	(101)	-	-	-	-	-	-
Jackson	2,637	2,727	(90)	-	-	-	-	-	-
Jasper	1,552	1,664	(112)	-	-	-	-	-	-
Jay	930	962	(32)	-	-	-	-	-	-
Jefferson	1,255	1,209	46	-	-	-	-	-	-

Table C-22. Anthem HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Jennings	1,239	1,179	60	-	-	-	-	-	-
Johnson	9,638	10,021	(383)	-	-	-	-	-	-
Knox	1,570	1,591	(21)	-	-	-	-	-	-
Kosciusko	2,600	2,583	17	-	-	-	-	-	-
LaGrange	727	739	(12)	-	-	-	-	-	-
Lake	30,965	30,803	162	-	-	-	-	-	-
LaPorte	6,070	6,224	(154)	-	-	-	-	-	-
Lawrence	2,641	2,721	(80)	-	-	-	-	-	-
Madison	9,621	9,697	(76)	-	-	-	-	-	-
Marion	71,438	71,011	427	-	-	-	-	-	-
Marshall	2,572	2,505	67	-	-	-	-	-	-
Martin	524	530	(6)	-	-	-	-	-	-
Miami	1,416	1,463	(47)	-	-	-	-	-	-
Monroe	5,161	5,073	88	-	-	-	-	-	-
Montgomery	1,717	1,722	(5)	-	-	-	-	-	-
Morgan	3,699	4,804	(1,105)	-	-	-	-	-	-
Newton	709	563	146	-	-	-	-	-	-
Noble	1,455	1,465	(10)	-	-	-	-	-	-
Ohio	147	132	15	-	-	-	-	-	-
Orange	764	727	37	-	-	-	-	-	-

Table C-22. Anthem HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Owen	1,361	1,370	(9)	-	-	-	-	-	-
Parke	544	545	(1)	-	-	-	-	-	-
Perry	1,109	1,054	55	-	-	-	-	-	-
Pike	717	699	18	-	-	-	-	-	-
Porter	7,490	7,326	164	-	-	-	-	-	-
Posey	1,246	1,068	178	-	-	-	-	-	-
Pulaski	573	595	(22)	-	-	-	-	-	-
Putnam	1,627	1,762	(135)	-	-	-	-	-	-
Randolph	856	871	(15)	-	-	-	-	-	-
Ripley	1,250	1,408	(158)	-	-	-	-	-	-
Rush	1,108	1,070	38	-	-	-	-	-	-
Scott	1,355	1,546	(191)	-	-	-	-	-	-
Shelby	2,028	1,966	62	-	-	-	-	-	-
Spencer	971	1,054	(83)	-	-	-	-	-	-
St. Joseph	12,110	12,702	(592)	-	-	-	-	-	-
Starke	1,402	1,268	134	-	-	-	-	-	-
Steuben	1,142	1,156	(14)	-	-	-	-	-	-
Sullivan	1,009	1,028	(19)	-	-	-	-	-	-
Switzerland	394	331	63	-	-	-	-	-	-
Tippecanoe	6,434	6,347	87	-	-	-	-	-	-

Table C-22. Anthem HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Tipton	542	470	72	-	-	-	-	-	-
Union	280	274	6	-	-	-	-	-	-
Vanderburgh	15,051	15,130	(79)	-	-	-	-	-	-
Vermillion	589	581	8	-	-	-	-	-	-
Vigo	3,928	3,989	(61)	-	-	-	-	-	-
Wabash	961	1,014	(53)	-	-	-	-	-	-
Warren	206	139	67	-	-	-	-	-	-
Warrick	3,661	3,679	(18)	-	-	-	-	-	-
Washington	1,781	1,725	56	-	-	-	-	-	-
Wayne	2,085	2,142	(57)	-	-	-	-	-	-
Wells	1,128	1,103	25	-	-	-	-	-	-
White	761	847	(86)	-	-	-	-	-	-
Whitley	853	920	(67)	-	-	-	-	-	-

Table C-23. Anthem HIP – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	362,097	368,276	(6,179)	-	-	-	-	-	-
Adams	1,026	1,046	(20)	-	-	-	-	-	-
Allen	18,396	18,624	(228)	-	-	-	-	-	-
Bartholomew	3,146	3,195	(49)	-	-	-	-	-	-
Benton	284	335	(51)	-	-	-	-	-	-
Blackford	725	721	4	-	-	-	-	-	-
Boone	1,782	1,841	(59)	-	-	-	-	-	-
Brown	824	416	408	-	-	-	-	-	-
Carroll	650	535	115	-	-	-	-	-	-
Cass	1,554	1,622	(68)	-	-	-	-	-	-
Clark	6,467	6,640	(173)	-	-	-	-	-	-
Clay	1,360	1,411	(51)	-	-	-	-	-	-
Clinton	1,125	1,161	(36)	-	-	-	-	-	-
Crawford	703	761	(58)	-	-	-	-	-	-
Daviess	1,809	1,777	32	-	-	-	-	-	-
Dearborn	1,610	1,608	2	-	-	-	-	-	-
Decatur	1,325	1,415	(90)	-	-	-	-	-	-
DeKalb	1,590	1,575	15	-	-	-	-	-	-
Delaware	6,130	6,289	(159)	-	-	-	-	-	-
Dubois	1,271	1,358	(87)	-	-	-	-	-	-

Table C-23. Anthem HIP – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
Elkhart	7,420	7,366	54	-	-	-	-	-	-
Fayette	1,762	1,781	(19)	-	-	-	-	-	-
Floyd	3,909	3,938	(29)	-	-	-	-	-	-
Fountain	714	815	(101)	-	-	-	-	-	-
Franklin	876	782	94	-	-	-	-	-	-
Fulton	1,121	1,085	36	-	-	-	-	-	-
Gibson	2,112	2,164	(52)	-	-	-	-	-	-
Grant	4,595	4,663	(68)	-	-	-	-	-	-
Greene	2,359	2,329	30	-	-	-	-	-	-
Hamilton	7,575	7,742	(167)	-	-	-	-	-	-
Hancock	3,641	3,745	(104)	-	-	-	-	-	-
Harrison	2,432	2,503	(71)	-	-	-	-	-	-
Hendricks	5,247	4,492	755	-	-	-	-	-	-
Henry	2,936	3,061	(125)	-	-	-	-	-	-
Howard	4,527	4,718	(191)	-	-	-	-	-	-
Huntington	1,388	1,467	(79)	-	-	-	-	-	-
Jackson	2,416	2,560	(144)	-	-	-	-	-	-
Jasper	1,754	1,950	(196)	-	-	-	-	-	-
Jay	1,106	1,189	(83)	-	-	-	-	-	-
Jefferson	1,923	1,875	48	-	-	-	-	-	-

Table C-23. Anthem HIP – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
Jennings	1,585	1,502	83	-	-	-	-	-	-
Johnson	8,380	8,836	(456)	-	-	-	-	-	-
Knox	2,400	2,466	(66)	-	-	-	-	-	-
Kosciusko	2,668	2,665	3	-	-	-	-	-	-
LaGrange	799	792	7	-	-	-	-	-	-
Lake	35,142	35,528	(386)	-	-	-	-	-	-
LaPorte	7,424	7,657	(233)	-	-	-	-	-	-
Lawrence	2,998	3,107	(109)	-	-	-	-	-	-
Madison	10,254	10,568	(314)	-	-	-	-	-	-
Marion	70,007	70,882	(875)	-	-	-	-	-	-
Marshall	2,036	2,086	(50)	-	-	-	-	-	-
Martin	561	600	(39)	-	-	-	-	-	-
Miami	1,722	1,848	(126)	-	-	-	-	-	-
Monroe	7,573	7,622	(49)	-	-	-	-	-	-
Montgomery	1,815	1,851	(36)	-	-	-	-	-	-
Morgan	4,008	4,888	(880)	-	-	-	-	-	-
Newton	719	560	159	-	-	-	-	-	-
Noble	1,411	1,449	(38)	-	-	-	-	-	-
Ohio	170	177	(7)	-	-	-	-	-	-
Orange	930	923	7	-	-	-	-	-	-

Table C-23. Anthem HIP – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
Owen	1,522	1,527	(5)	-	-	-	-	-	-
Parke	708	696	12	-	-	-	-	-	-
Perry	1,242	1,208	34	-	-	-	-	-	-
Pike	761	747	14	-	-	-	-	-	-
Porter	9,498	9,365	133	-	-	-	-	-	-
Posey	1,211	1,091	120	-	-	-	-	-	-
Pulaski	635	679	(44)	-	-	-	-	-	-
Putnam	1,745	1,900	(155)	-	-	-	-	-	-
Randolph	1,085	1,124	(39)	-	-	-	-	-	-
Ripley	1,231	1,368	(137)	-	-	-	-	-	-
Rush	1,083	1,047	36	-	-	-	-	-	-
Scott	1,899	2,186	(287)	-	-	-	-	-	-
Shelby	2,395	2,363	32	-	-	-	-	-	-
Spencer	1,050	1,148	(98)	-	-	-	-	-	-
St. Joseph	14,380	15,110	(730)	-	-	-	-	-	-
Starke	1,647	1,507	140	-	-	-	-	-	-
Steuben	1,220	1,264	(44)	-	-	-	-	-	-
Sullivan	1,229	1,278	(49)	-	-	-	-	-	-
Switzerland	511	426	85	-	-	-	-	-	-
Tippecanoe	6,558	6,593	(35)	-	-	-	-	-	-

Table C-23. Anthem HIP – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
Tipton	655	604	51	-	-	-	-	-	-
Union	292	296	(4)	-	-	-	-	-	-
Vanderburgh	15,997	16,475	(478)	-	-	-	-	-	-
Vermillion	784	801	(17)	-	-	-	-	-	-
Vigo	6,508	6,650	(142)	-	-	-	-	-	-
Wabash	1,075	1,112	(37)	-	-	-	-	-	-
Warren	226	173	53	-	-	-	-	-	-
Warrick	3,163	3,155	8	-	-	-	-	-	-
Washington	1,785	1,723	62	-	-	-	-	-	-
Wayne	3,136	3,229	(93)	-	-	-	-	-	-
Wells	965	988	(23)	-	-	-	-	-	-
White	808	907	(99)	-	-	-	-	-	-
Whitley	901	974	(73)	-	-	-	-	-	-

Table C-24. Anthem HCC – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to a Psychiatrist			Without Sufficient Access to an OB/GYN		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	59,880	59,927	(47)	-	-	-	-	-	-
Adams	178	178	-	-	-	-	-	-	-
Allen	3,408	3,384	24	-	-	-	-	-	-
Bartholomew	388	397	(9)	-	-	-	-	-	-
Benton	43	42	1	-	-	-	-	-	-
Blackford	116	119	(3)	-	-	-	-	-	-
Boone	231	259	(28)	-	-	-	-	-	-
Brown	99	45	54	-	-	-	-	-	-
Carroll	122	108	14	-	-	-	-	-	-
Cass	351	351	-	-	-	-	-	-	-
Clark	940	939	1	-	-	-	-	-	-
Clay	338	342	(4)	-	-	-	-	-	-
Clinton	202	204	(2)	-	-	-	-	-	-
Crawford	123	130	(7)	-	-	-	-	-	-
Daviess	237	221	16	-	-	-	-	-	-
Dearborn	358	345	13	-	-	-	-	-	-
Decatur	180	190	(10)	-	-	-	-	-	-
DeKalb	296	281	15	-	-	-	-	-	-
Delaware	1,153	1,141	12	-	-	-	-	-	-
Dubois	131	136	(5)	-	-	-	-	-	-

Table C-24. Anthem HCC – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to a Psychiatrist			Without Sufficient Access to an OB/GYN		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Elkhart	919	897	22	-	-	-	-	-	-
Fayette	411	400	11	-	-	-	-	-	-
Floyd	722	712	10	-	-	-	-	-	-
Fountain	137	149	(12)	-	-	-	-	-	-
Franklin	150	129	21	-	-	-	-	-	-
Fulton	177	176	1	-	-	-	-	-	-
Gibson	228	233	(5)	-	-	-	-	-	-
Grant	826	834	(8)	-	-	-	-	-	-
Greene	415	427	(12)	-	-	-	-	-	-
Hamilton	999	1,003	(4)	-	-	-	-	-	-
Hancock	454	457	(3)	-	-	-	-	-	-
Harrison	320	332	(12)	-	-	-	-	-	-
Hendricks	657	564	93	-	-	-	-	-	-
Henry	529	534	(5)	-	-	-	-	-	-
Howard	954	1,006	(52)	-	-	-	-	-	-
Huntington	248	277	(29)	-	-	-	-	-	-
Jackson	318	338	(20)	-	-	-	-	-	-
Jasper	189	214	(25)	-	-	-	-	-	-
Jay	182	202	(20)	-	-	-	-	-	-
Jefferson	256	269	(13)	-	-	-	-	-	-

Table C-24. Anthem HCC – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to a Psychiatrist			Without Sufficient Access to an OB/GYN		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Jennings	269	259	10	-	-	-	-	-	-
Johnson	1,028	1,067	(39)	-	-	-	-	-	-
Knox	333	319	14	-	-	-	-	-	-
Kosciusko	374	371	3	-	-	-	-	-	-
LaGrange	135	138	(3)	-	-	-	-	-	-
Lake	6,060	5,989	71	-	-	-	-	-	-
LaPorte	1,169	1,202	(33)	-	-	-	-	-	-
Lawrence	498	512	(14)	-	-	-	-	-	-
Madison	1,717	1,738	(21)	-	-	-	-	-	-
Marion	12,742	12,686	56	-	-	-	-	-	-
Marshall	292	293	(1)	-	-	-	-	-	-
Martin	79	84	(5)	-	-	-	-	-	-
Miami	357	372	(15)	-	-	-	-	-	-
Monroe	852	861	(9)	-	-	-	-	-	-
Montgomery	306	302	4	-	-	-	-	-	-
Morgan	542	661	(119)	-	-	-	-	-	-
Newton	110	84	26	-	-	-	-	-	-
Noble	287	277	10	-	-	-	-	-	-
Ohio	38	34	4	-	-	-	-	-	-
Orange	134	135	(1)	-	-	-	-	-	-

Table C-24. Anthem HCC – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to a Psychiatrist			Without Sufficient Access to an OB/GYN		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Owen	213	191	22	-	-	-	-	-	-
Parke	124	118	6	-	-	-	-	-	-
Perry	199	181	18	-	-	-	-	-	-
Pike	136	130	6	-	-	-	-	-	-
Porter	1,134	1,117	17	-	-	-	-	-	-
Posey	216	185	31	-	-	-	-	-	-
Pulaski	103	108	(5)	-	-	-	-	-	-
Putnam	276	299	(23)	-	-	-	-	-	-
Randolph	232	231	1	-	-	-	-	-	-
Ripley	236	250	(14)	-	-	-	-	-	-
Rush	142	146	(4)	-	-	-	-	-	-
Scott	413	434	(21)	-	-	-	-	-	-
Shelby	290	279	11	-	-	-	-	-	-
Spencer	133	148	(15)	-	-	-	-	-	-
St. Joseph	2,154	2,200	(46)	-	-	-	-	-	-
Starke	244	234	10	-	-	-	-	-	-
Steuben	155	156	(1)	-	-	-	-	-	-
Sullivan	253	248	5	-	-	-	-	-	-
Switzerland	87	82	5	-	-	-	-	-	-
Tippecanoe	1,040	1,042	(2)	-	-	-	-	-	-

Table C-24. Anthem HCC – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to a Psychiatrist			Without Sufficient Access to an OB/GYN		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Tipton	84	66	18	-	-	-	-	-	-
Union	44	49	(5)	-	-	-	-	-	-
Vanderburgh	2,567	2,617	(50)	-	-	-	-	-	-
Vermillion	176	181	(5)	-	-	-	-	-	-
Vigo	1,583	1,578	5	-	-	-	-	-	-
Wabash	277	267	10	-	-	-	-	-	-
Warren	58	45	13	-	-	-	-	-	-
Warrick	437	418	19	-	-	-	-	-	-
Washington	314	283	31	-	-	-	-	-	-
Wayne	776	799	(23)	-	-	-	-	-	-
Wells	174	170	4	-	-	-	-	-	-
White	108	129	(21)	-	-	-	-	-	-
Whitley	195	197	(2)	-	-	-	-	-	-

Table C-25. CareSource HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	79,589	79,742	(153)	-	-	-	-	-	-
Adams	403	391	12	-	-	-	-	-	-
Allen	5,661	5,683	(22)	-	-	-	-	-	-
Bartholomew	650	681	(31)	-	-	-	-	-	-
Benton	98	94	4	-	-	-	-	-	-
Blackford	150	162	(12)	-	-	-	-	-	-
Boone	496	511	(15)	-	-	-	-	-	-
Brown	130	128	2	-	-	-	-	-	-
Carroll	280	269	11	-	-	-	-	-	-
Cass	597	589	8	-	-	-	-	-	-
Clark	1,605	1,581	24	-	-	-	-	-	-
Clay	295	305	(10)	-	-	-	-	-	-
Clinton	542	553	(11)	-	-	-	-	-	-
Crawford	102	104	(2)	-	-	-	-	-	-
Daviess	293	286	7	-	-	-	-	-	-
Dearborn	637	630	7	-	-	-	-	-	-
Decatur	364	372	(8)	-	-	-	-	-	-
DeKalb	456	465	(9)	-	-	-	-	-	-
Delaware	1,254	1,284	(30)	-	-	-	-	-	-
Dubois	345	345	-	-	-	-	-	-	-

Table C-25. CareSource HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Elkhart	1,430	1,459	(29)	-	-	-	-	-	-
Fayette	449	439	10	-	-	-	-	-	-
Floyd	807	822	(15)	-	-	-	-	-	-
Fountain	183	182	1	-	-	-	-	-	-
Franklin	327	313	14	-	-	-	-	-	-
Fulton	110	125	(15)	-	-	-	-	-	-
Gibson	240	249	(9)	-	-	-	-	-	-
Grant	911	932	(21)	-	-	-	-	-	-
Greene	365	363	2	-	-	-	-	-	-
Hamilton	2,402	2,443	(41)	-	-	-	-	-	-
Hancock	645	681	(36)	-	-	-	-	-	-
Harrison	388	387	1	-	-	-	-	-	-
Hendricks	1,575	1,693	(118)	-	-	-	-	-	-
Henry	537	532	5	-	-	-	-	-	-
Howard	1,134	1,169	(35)	-	-	-	-	-	-
Huntington	446	449	(3)	-	-	-	-	-	-
Jackson	719	723	(4)	-	-	-	-	-	-
Jasper	265	275	(10)	-	-	-	-	-	-
Jay	311	324	(13)	-	-	-	-	-	-
Jefferson	194	202	(8)	-	-	-	-	-	-

Table C-25. CareSource HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Jennings	361	364	(3)	-	-	-	-	-	-
Johnson	1,800	1,795	5	-	-	-	-	-	-
Knox	282	288	(6)	-	-	-	-	-	-
Kosciusko	973	974	(1)	-	-	-	-	-	-
LaGrange	229	228	1	-	-	-	-	-	-
Lake	5,282	5,207	75	-	-	-	-	-	-
LaPorte	1,185	1,198	(13)	-	-	-	-	-	-
Lawrence	471	484	(13)	-	-	-	-	-	-
Madison	1,774	1,776	(2)	-	-	-	-	-	-
Marion	18,735	18,567	168	-	-	-	-	-	-
Marshall	337	331	6	-	-	-	-	-	-
Martin	64	64	-	-	-	-	-	-	-
Miami	533	526	7	-	-	-	-	-	-
Monroe	1,167	1,139	28	-	-	-	-	-	-
Montgomery	453	460	(7)	-	-	-	-	-	-
Morgan	757	786	(29)	-	-	-	-	-	-
Newton	143	146	(3)	-	-	-	-	-	-
Noble	535	544	(9)	-	-	-	-	-	-
Ohio	66	66	-	-	-	-	-	-	-
Orange	165	156	9	-	-	-	-	-	-

Table C-25. CareSource HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Owen	234	237	(3)	-	-	-	-	-	-
Parke	144	147	(3)	-	-	-	-	-	-
Perry	172	176	(4)	-	-	-	-	-	-
Pike	98	102	(4)	-	-	-	-	-	-
Porter	1,204	1,191	13	-	-	-	-	-	-
Posey	159	162	(3)	-	-	-	-	-	-
Pulaski	93	99	(6)	-	-	-	-	-	-
Putnam	348	340	8	-	-	-	-	-	-
Randolph	430	436	(6)	-	-	-	-	-	-
Ripley	314	310	4	-	-	-	-	-	-
Rush	184	182	2	-	-	-	-	-	-
Scott	593	306	287	-	-	-	-	-	-
Shelby	166	604	(438)	-	-	-	-	-	-
Spencer	1,857	145	1,712	-	-	-	-	-	-
St. Joseph	306	1,873	(1,567)	-	-	-	-	-	-
Starke	232	226	6	-	-	-	-	-	-
Steuben	388	372	16	-	-	-	-	-	-
Sullivan	205	210	(5)	-	-	-	-	-	-
Switzerland	105	103	2	-	-	-	-	-	-
Tippecanoe	2,321	2,303	18	-	-	-	-	-	-

Table C-25. CareSource HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Tipton	126	126	-	-	-	-	-	-	-
Union	161	150	11	-	-	-	-	-	-
Vanderburgh	1,838	1,803	35	-	-	-	-	-	-
Vermillion	138	149	(11)	-	-	-	-	-	-
Vigo	1,172	1,161	11	-	-	-	-	-	-
Wabash	379	369	10	-	-	-	-	-	-
Warren	83	88	(5)	-	-	-	-	-	-
Warrick	394	431	(37)	-	-	-	-	-	-
Washington	361	355	6	-	-	-	-	-	-
Wayne	1,317	1,300	17	-	-	-	-	-	-
Wells	332	344	(12)	-	-	-	-	-	-
White	323	327	(4)	-	-	-	-	-	-
Whitley	304	321	(17)	-	-	-	-	-	-

Table C-26. CareSource HIP – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	76,467	76,838	(371)	-	-	-	-	-	-
Adams	290	278	12	-	-	-	-	-	-
Allen	5,046	5,095	(49)	-	-	-	-	-	-
Bartholomew	690	695	(5)	-	-	-	-	-	-
Benton	76	73	3	-	-	-	-	-	-
Blackford	129	133	(4)	-	-	-	-	-	-
Boone	499	525	(26)	-	-	-	-	-	-
Brown	162	165	(3)	-	-	-	-	-	-
Carroll	185	184	1	-	-	-	-	-	-
Cass	466	464	2	-	-	-	-	-	-
Clark	1,627	1,674	(47)	-	-	-	-	-	-
Clay	257	269	(12)	-	-	-	-	-	-
Clinton	373	362	11	-	-	-	-	-	-
Crawford	107	110	(3)	-	-	-	-	-	-
Daviess	285	272	13	-	-	-	-	-	-
Dearborn	642	644	(2)	-	-	-	-	-	-
Decatur	329	333	(4)	-	-	-	-	-	-
DeKalb	369	374	(5)	-	-	-	-	-	-
Delaware	1,256	1,285	(29)	-	-	-	-	-	-
Dubois	239	235	4	-	-	-	-	-	-

Table C-26. CareSource HIP – Reported and Actual Network Deficiencies by Provider Category									
County	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
Elkhart	1,200	1,213	(13)	-	-	-	-	-	-
Fayette	524	508	16	-	-	-	-	-	-
Floyd	925	934	(9)	-	-	-	-	-	-
Fountain	175	173	2	-	-	-	-	-	-
Franklin	296	273	23	-	-	-	-	-	-
Fulton	168	164	4	-	-	-	-	-	-
Gibson	252	260	(8)	-	-	-	-	-	-
Grant	918	956	(38)	-	-	-	-	-	-
Greene	356	360	(4)	-	-	-	-	-	-
Hamilton	2,175	2,228	(53)	-	-	-	-	-	-
Hancock	682	684	(2)	-	-	-	-	-	-
Harrison	402	407	(5)	-	-	-	-	-	-
Hendricks	1,269	1,327	(58)	-	-	-	-	-	-
Henry	540	555	(15)	-	-	-	-	-	-
Howard	1,213	1,227	(14)	-	-	-	-	-	-
Huntington	431	435	(4)	-	-	-	-	-	-
Jackson	459	448	11	-	-	-	-	-	-
Jasper	292	298	(6)	-	-	-	-	-	-
Jay	260	253	7	-	-	-	-	-	-
Jefferson	285	284	1	-	-	-	-	-	-

Table C-26. CareSource HIP – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
Jennings	296	300	(4)	-	-	-	-	-	-
Johnson	1,721	1,717	4	-	-	-	-	-	-
Knox	336	353	(17)	-	-	-	-	-	-
Kosciusko	720	718	2	-	-	-	-	-	-
LaGrange	188	188	-	-	-	-	-	-	-
Lake	5,478	5,422	56	-	-	-	-	-	-
LaPorte	1,057	1,086	(29)	-	-	-	-	-	-
Lawrence	492	516	(24)	-	-	-	-	-	-
Madison	2,044	2,052	(8)	-	-	-	-	-	-
Marion	17,453	17,426	27	-	-	-	-	-	-
Marshall	303	307	(4)	-	-	-	-	-	-
Martin	95	101	(6)	-	-	-	-	-	-
Miami	459	466	(7)	-	-	-	-	-	-
Monroe	1,504	1,504	-	-	-	-	-	-	-
Montgomery	427	419	8	-	-	-	-	-	-
Morgan	646	666	(20)	-	-	-	-	-	-
Newton	115	107	8	-	-	-	-	-	-
Noble	430	429	1	-	-	-	-	-	-
Ohio	62	65	(3)	-	-	-	-	-	-
Orange	193	188	5	-	-	-	-	-	-

Table C-26. CareSource HIP – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
Owen	251	239	12	-	-	-	-	-	-
Parke	148	150	(2)	-	-	-	-	-	-
Perry	198	199	(1)	-	-	-	-	-	-
Pike	114	109	5	-	-	-	-	-	-
Porter	1,265	1,247	18	-	-	-	-	-	-
Posey	170	166	4	-	-	-	-	-	-
Pulaski	123	130	(7)	-	-	-	-	-	-
Putnam	340	358	(18)	-	-	-	-	-	-
Randolph	349	344	5	-	-	-	-	-	-
Ripley	296	303	(7)	-	-	-	-	-	-
Rush	170	168	2	-	-	-	-	-	-
Scott	604	391	213	-	-	-	-	-	-
Shelby	161	631	(470)	-	-	-	-	-	-
Spencer	2,022	160	1,862	-	-	-	-	-	-
St. Joseph	384	2,034	(1,650)	-	-	-	-	-	-
Starke	244	241	3	-	-	-	-	-	-
Steuben	330	323	7	-	-	-	-	-	-
Sullivan	169	161	8	-	-	-	-	-	-
Switzerland	123	122	1	-	-	-	-	-	-
Tippecanoe	2,102	2,092	10	-	-	-	-	-	-

Table C-26. CareSource HIP – Reported and Actual Network Deficiencies by Provider Category									
County	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
Tipton	104	103	1	-	-	-	-	-	-
Union	119	118	1	-	-	-	-	-	-
Vanderburgh	2,140	2,157	(17)	-	-	-	-	-	-
Vermillion	123	116	7	-	-	-	-	-	-
Vigo	1,258	1,259	(1)	-	-	-	-	-	-
Wabash	342	334	8	-	-	-	-	-	-
Warren	62	64	(2)	-	-	-	-	-	-
Warrick	377	395	(18)	-	-	-	-	-	-
Washington	371	370	1	-	-	-	-	-	-
Wayne	1,321	1,343	(22)	-	-	-	-	-	-
Wells	298	303	(5)	-	-	-	-	-	-
White	254	250	4	-	-	-	-	-	-
Whitley	267	271	(4)	-	-	-	-	-	-

Table C-27. MDwise HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	238,091	237,423	668	-	-	-	-	-	-
Adams	694	711	(17)	-	-	-	-	-	-
Allen	17,962	17,833	129	-	-	-	-	-	-
Bartholomew	2,736	2,751	(15)	-	-	-	-	-	-
Benton	515	563	(48)	-	-	-	-	-	-
Blackford	662	669	(7)	-	-	-	-	-	-
Boone	1,062	1,081	(19)	-	-	-	-	-	-
Brown	265	262	3	-	-	-	-	-	-
Carroll	865	857	8	-	-	-	-	-	-
Cass	2,902	2,935	(33)	-	-	-	-	-	-
Clark	2,890	2,874	16	-	-	-	-	-	-
Clay	1,611	1,603	8	-	-	-	-	-	-
Clinton	2,653	2,658	(5)	-	-	-	-	-	-
Crawford	128	130	(2)	-	-	-	-	-	-
Daviess	1,120	1,127	(7)	-	-	-	-	-	-
Dearborn	2,045	2,076	(31)	-	-	-	-	-	-
Decatur	1,156	1,166	(10)	-	-	-	-	-	-
DeKalb	1,590	1,610	(20)	-	-	-	-	-	-
Delaware	5,359	5,365	(6)	-	-	-	-	-	-
Dubois	389	400	(11)	-	-	-	-	-	-

Table C-27. MDwise HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Elkhart	2,320	2,286	34	-	-	-	-	-	-
Fayette	1,332	1,316	16	-	-	-	-	-	-
Floyd	1,737	1,726	11	-	-	-	-	-	-
Fountain	708	707	1	-	-	-	-	-	-
Franklin	703	785	(82)	-	-	-	-	-	-
Fulton	736	712	24	-	-	-	-	-	-
Gibson	508	486	22	-	-	-	-	-	-
Grant	1,599	1,591	8	-	-	-	-	-	-
Greene	852	859	(7)	-	-	-	-	-	-
Hamilton	4,619	4,640	(21)	-	-	-	-	-	-
Hancock	897	931	(34)	-	-	-	-	-	-
Harrison	596	609	(13)	-	-	-	-	-	-
Hendricks	4,101	3,911	190	-	-	-	-	-	-
Henry	2,492	2,518	(26)	-	-	-	-	-	-
Howard	4,013	4,062	(49)	-	-	-	-	-	-
Huntington	1,625	1,665	(40)	-	-	-	-	-	-
Jackson	1,265	1,255	10	-	-	-	-	-	-
Jasper	1,056	1,092	(36)	-	-	-	-	-	-
Jay	768	772	(4)	-	-	-	-	-	-
Jefferson	587	617	(30)	-	-	-	-	-	-

Table C-27. MDwise HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Jennings	1,275	1,261	14	-	-	-	-	-	-
Johnson	3,078	3,067	11	-	-	-	-	-	-
Knox	489	483	6	-	-	-	-	-	-
Kosciusko	2,321	2,284	37	-	-	-	-	-	-
LaGrange	834	817	17	-	-	-	-	-	-
Lake	19,402	19,233	169	-	-	-	-	-	-
LaPorte	5,190	5,066	124	-	-	-	-	-	-
Lawrence	1,149	1,128	21	-	-	-	-	-	-
Madison	2,559	2,577	(18)	-	-	-	-	-	-
Marion	63,977	63,915	62	-	-	-	-	-	-
Marshall	1,083	1,082	1	-	-	-	-	-	-
Martin	178	185	(7)	-	-	-	-	-	-
Miami	1,915	1,857	58	-	-	-	-	-	-
Monroe	1,586	1,586	-	-	-	-	-	-	-
Montgomery	957	961	(4)	-	-	-	-	-	-
Morgan	1,662	1,722	(60)	-	-	-	-	-	-
Newton	556	537	19	-	-	-	-	-	-
Noble	2,177	2,252	(75)	-	-	-	-	-	-
Ohio	303	265	38	-	-	-	-	-	-
Orange	329	322	7	-	-	-	-	-	-

Table C-27. MDwise HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Owen	529	527	2	-	-	-	-	-	-
Parke	883	891	(8)	-	-	-	-	-	-
Perry	262	248	14	-	-	-	-	-	-
Pike	137	146	(9)	-	-	-	-	-	-
Porter	3,030	3,046	(16)	-	-	-	-	-	-
Posey	384	380	4	-	-	-	-	-	-
Pulaski	389	364	25	-	-	-	-	-	-
Putnam	642	663	(21)	-	-	-	-	-	-
Randolph	1,420	1,441	(21)	-	-	-	-	-	-
Ripley	1,050	1,010	40	-	-	-	-	-	-
Rush	444	434	10	-	-	-	-	-	-
Scott	842	937	(95)	-	-	-	-	-	-
Shelby	199	848	(649)	-	-	-	-	-	-
Spencer	5,073	196	4,877	-	-	-	-	-	-
St. Joseph	935	5,048	(4,113)	-	-	-	-	-	-
Starke	925	942	(17)	-	-	-	-	-	-
Steuben	1,118	1,076	42	-	-	-	-	-	-
Sullivan	1,037	1,067	(30)	-	-	-	-	-	-
Switzerland	430	393	37	-	-	-	-	-	-
Tippecanoe	6,249	6,199	50	-	-	-	-	-	-

Table C-27. MDwise HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Tipton	332	321	11	-	-	-	-	-	-
Union	288	265	23	-	-	-	-	-	-
Vanderburgh	2,409	2,373	36	-	-	-	-	-	-
Vermillion	1,086	1,094	(8)	-	-	-	-	-	-
Vigo	7,780	7,698	82	-	-	-	-	-	-
Wabash	1,392	1,371	21	-	-	-	-	-	-
Warren	418	384	34	-	-	-	-	-	-
Warrick	450	445	5	-	-	-	-	-	-
Washington	750	756	(6)	-	-	-	-	-	-
Wayne	3,864	3,864	-	-	-	-	-	-	-
Wells	964	931	33	-	-	-	-	-	-
White	1,040	1,051	(11)	-	-	-	-	-	-
Whitley	1,202	1,203	(1)	-	-	-	-	-	-

Table C-28. MDwise HIP – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	174,324	174,826	(502)	-	-	-	-	-	-
Adams	501	502	(1)	-	-	-	-	-	-
Allen	12,594	12,592	2	-	-	-	-	-	-
Bartholomew	1,770	1,786	(16)	-	-	-	-	-	-
Benton	325	341	(16)	-	-	-	-	-	-
Blackford	574	568	6	-	-	-	-	-	-
Boone	850	882	(32)	-	-	-	-	-	-
Brown	301	318	(17)	-	-	-	-	-	-
Carroll	538	553	(15)	-	-	-	-	-	-
Cass	1,504	1,517	(13)	-	-	-	-	-	-
Clark	2,286	2,284	2	-	-	-	-	-	-
Clay	1,377	1,394	(17)	-	-	-	-	-	-
Clinton	1,552	1,544	8	-	-	-	-	-	-
Crawford	152	165	(13)	-	-	-	-	-	-
Daviess	639	653	(14)	-	-	-	-	-	-
Dearborn	1,808	1,806	2	-	-	-	-	-	-
Decatur	877	916	(39)	-	-	-	-	-	-
DeKalb	1,058	1,088	(30)	-	-	-	-	-	-
Delaware	4,778	4,816	(38)	-	-	-	-	-	-
Dubois	319	326	(7)	-	-	-	-	-	-

Table C-28. MDwise HIP – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
Elkhart	1,458	1,502	(44)	-	-	-	-	-	-
Fayette	1,263	1,247	16	-	-	-	-	-	-
Floyd	1,415	1,400	15	-	-	-	-	-	-
Fountain	616	634	(18)	-	-	-	-	-	-
Franklin	549	607	(58)	-	-	-	-	-	-
Fulton	521	526	(5)	-	-	-	-	-	-
Gibson	501	493	8	-	-	-	-	-	-
Grant	1,530	1,523	7	-	-	-	-	-	-
Greene	855	856	(1)	-	-	-	-	-	-
Hamilton	3,582	3,637	(55)	-	-	-	-	-	-
Hancock	910	926	(16)	-	-	-	-	-	-
Harrison	520	523	(3)	-	-	-	-	-	-
Hendricks	2,770	2,706	64	-	-	-	-	-	-
Henry	1,974	1,988	(14)	-	-	-	-	-	-
Howard	2,973	3,028	(55)	-	-	-	-	-	-
Huntington	1,224	1,228	(4)	-	-	-	-	-	-
Jackson	805	805	-	-	-	-	-	-	-
Jasper	806	822	(16)	-	-	-	-	-	-
Jay	528	526	2	-	-	-	-	-	-
Jefferson	603	599	4	-	-	-	-	-	-

Table C-28. MDwise HIP – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
Jennings	1,008	1,006	2	-	-	-	-	-	-
Johnson	2,583	2,586	(3)	-	-	-	-	-	-
Knox	602	858	17	-	-	-	-	-	-
Kosciusko	1,664	1,606	58	-	-	-	-	-	-
LaGrange	505	490	15	-	-	-	-	-	-
Lake	13,258	13,226	32	-	-	-	-	-	-
LaPorte	3,675	3,617	58	-	-	-	-	-	-
Lawrence	1,095	1,103	(8)	-	-	-	-	-	-
Madison	2,753	2,738	15	-	-	-	-	-	-
Marion	39,225	39,565	(340)	-	-	-	-	-	-
Marshall	766	766	-	-	-	-	-	-	-
Martin	166	164	2	-	-	-	-	-	-
Miami	1,466	1,391	75	-	-	-	-	-	-
Monroe	2,249	2,254	(5)	-	-	-	-	-	-
Montgomery	791	799	(8)	-	-	-	-	-	-
Morgan	1,426	1,466	(40)	-	-	-	-	-	-
Newton	374	372	2	-	-	-	-	-	-
Noble	1,369	1,415	(46)	-	-	-	-	-	-
Ohio	247	217	30	-	-	-	-	-	-
Orange	356	353	3	-	-	-	-	-	-

Table C-28. MDwise HIP – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
Owen	541	550	(9)	-	-	-	-	-	-
Parke	752	759	(7)	-	-	-	-	-	-
Perry	244	239	5	-	-	-	-	-	-
Pike	136	136	-	-	-	-	-	-	-
Porter	2,490	2,504	(14)	-	-	-	-	-	-
Posey	363	363	-	-	-	-	-	-	-
Pulaski	330	328	2	-	-	-	-	-	-
Putnam	677	691	(14)	-	-	-	-	-	-
Randolph	1,097	1,100	(3)	-	-	-	-	-	-
Ripley	800	808	(8)	-	-	-	-	-	-
Rush	385	374	11	-	-	-	-	-	-
Scott	843	899	(56)	-	-	-	-	-	-
Shelby	220	827	(607)	-	-	-	-	-	-
Spencer	4,008	219	3,789	-	-	-	-	-	-
St. Joseph	902	4,028	(3,126)	-	-	-	-	-	-
Starke	758	772	(14)	-	-	-	-	-	-
Steuben	824	813	11	-	-	-	-	-	-
Sullivan	870	904	(34)	-	-	-	-	-	-
Switzerland	343	317	26	-	-	-	-	-	-
Tippecanoe	4,547	4,520	27	-	-	-	-	-	-

Table C-28. MDwise HIP – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYNs		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
Tipton	256	249	7	-	-	-	-	-	-
Union	226	221	5	-	-	-	-	-	-
Vanderburgh	2,450	2,448	2	-	-	-	-	-	-
Vermillion	880	878	2	-	-	-	-	-	-
Vigo	6,512	6,437	75	-	-	-	-	-	-
Wabash	946	956	(10)	-	-	-	-	-	-
Warren	300	292	8	-	-	-	-	-	-
Warrick	492	493	(1)	-	-	-	-	-	-
Washington	603	613	(10)	-	-	-	-	-	-
Wayne	3,484	3,484	-	-	-	-	-	-	-
Wells	641	629	12	-	-	-	-	-	-
White	828	823	5	-	-	-	-	-	-
Whitley	792	806	(14)	-	-	-	-	-	-

Table C-29. MHS HHW – Reported and Actual Network Deficiencies by Provider Category									
County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	194,597	196,417	(1,820)	-	-	-	-	-	-
Adams	792	814	(22)	-	-	-	-	-	-
Allen	8,890	8,992	(102)	-	-	-	-	-	-
Bartholomew	3,125	3,162	(37)	-	-	-	-	-	-
Benton	202	213	(11)	-	-	-	-	-	-
Blackford	326	334	(8)	-	-	-	-	-	-
Boone	1,230	1,244	(14)	-	-	-	-	-	-
Brown	385	387	(2)	-	-	-	-	-	-
Carroll	390	383	7	-	-	-	-	-	-
Cass	1,013	1,038	(25)	-	-	-	-	-	-
Clark	4,462	4,473	(11)	-	-	-	-	-	-
Clay	430	437	(7)	-	-	-	-	-	-
Clinton	748	779	(31)	-	-	-	-	-	-
Crawford	450	442	8	-	-	-	-	-	-
Daviess	733	714	19	-	-	-	-	-	-
Dearborn	458	452	6	-	-	-	-	-	-
Decatur	448	454	(6)	-	-	-	-	-	-
DeKalb	916	919	(3)	-	-	-	-	-	-
Delaware	3,225	3,239	(14)	-	-	-	-	-	-
Dubois	1,687	1,712	(25)	-	-	-	-	-	-

Table C-29. MHS HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Elkhart	20,263	20,403	(140)	-	-	-	-	-	-
Fayette	521	526	(5)	-	-	-	-	-	-
Floyd	1,419	1,449	(30)	-	-	-	-	-	-
Fountain	299	306	(7)	-	-	-	-	-	-
Franklin	211	220	(9)	-	-	-	-	-	-
Fulton	899	894	5	-	-	-	-	-	-
Gibson	349	350	(1)	-	-	-	-	-	-
Grant	4,031	4,041	(10)	-	-	-	-	-	-
Greene	466	474	(8)	-	-	-	-	-	-
Hamilton	4,943	5,005	(62)	-	-	-	-	-	-
Hancock	727	737	(10)	-	-	-	-	-	-
Harrison	654	678	(24)	-	-	-	-	-	-
Hendricks	3,942	3,813	129	-	-	-	-	-	-
Henry	730	729	1	-	-	-	-	-	-
Howard	2,295	2,355	(60)	-	-	-	-	-	-
Huntington	779	796	(17)	-	-	-	-	-	-
Jackson	1,499	1,510	(11)	-	-	-	-	-	-
Jasper	890	892	(2)	-	-	-	-	-	-
Jay	598	606	(8)	-	-	-	-	-	-
Jefferson	1,867	1,899	(32)	-	-	-	-	-	-

Table C-29. MHS HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Jennings	1,003	982	21	-	-	-	-	-	-
Johnson	3,593	3,623	(30)	-	-	-	-	-	-
Knox	2,108	2,142	(34)	-	-	-	-	-	-
Kosciusko	2,950	2,911	39	-	-	-	-	-	-
LaGrange	710	702	8	-	-	-	-	-	-
Lake	12,962	13,109	(147)	-	-	-	-	-	-
LaPorte	2,381	2,366	15	-	-	-	-	-	-
Lawrence	1,032	1,034	(2)	-	-	-	-	-	-
Madison	4,511	4,523	(12)	-	-	-	-	-	-
Marion	29,650	30,185	(535)	-	-	-	-	-	-
Marshall	1,659	1,699	(40)	-	-	-	-	-	-
Martin	344	354	(10)	-	-	-	-	-	-
Miami	903	911	(8)	-	-	-	-	-	-
Monroe	1,811	1,803	8	-	-	-	-	-	-
Montgomery	1,272	1,294	(22)	-	-	-	-	-	-
Morgan	1,510	1,539	(29)	-	-	-	-	-	-
Newton	414	418	(4)	-	-	-	-	-	-
Noble	1,315	1,376	(61)	-	-	-	-	-	-
Ohio	62	60	2	-	-	-	-	-	-
Orange	1,351	1,388	(37)	-	-	-	-	-	-

Table C-29. MHS HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Owen	544	571	(27)	-	-	-	-	-	-
Parke	209	207	2	-	-	-	-	-	-
Perry	325	320	5	-	-	-	-	-	-
Pike	295	291	4	-	-	-	-	-	-
Porter	2,998	3,032	(34)	-	-	-	-	-	-
Posey	273	273	-	-	-	-	-	-	-
Pulaski	460	464	(4)	-	-	-	-	-	-
Putnam	1,098	1,080	18	-	-	-	-	-	-
Randolph	757	764	(7)	-	-	-	-	-	-
Ripley	475	486	(11)	-	-	-	-	-	-
Rush	383	397	(14)	-	-	-	-	-	-
Scott	901	909	(8)	-	-	-	-	-	-
Shelby	2,193	2,177	16	-	-	-	-	-	-
Spencer	419	469	(50)	-	-	-	-	-	-
St. Joseph	17,666	17,843	(177)	-	-	-	-	-	-
Starke	609	609	-	-	-	-	-	-	-
Steuben	991	991	-	-	-	-	-	-	-
Sullivan	196	201	(5)	-	-	-	-	-	-
Switzerland	367	356	11	-	-	-	-	-	-
Tippecanoe	4,044	4,079	(35)	-	-	-	-	-	-

Table C-29. MHS HHW – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Tipton	433	417	16	-	-	-	-	-	-
Union	130	119	11	-	-	-	-	-	-
Vanderburgh	2,444	2,511	(67)	-	-	-	-	-	-
Vermillion	183	183	-	-	-	-	-	-	-
Vigo	982	1,003	(21)	-	-	-	-	-	-
Wabash	739	746	(7)	-	-	-	-	-	-
Warren	152	138	14	-	-	-	-	-	-
Warrick	613	571	42	-	-	-	-	-	-
Washington	745	746	(1)	-	-	-	-	-	-
Wayne	2,296	2,325	(29)	-	-	-	-	-	-
Wells	522	516	6	-	-	-	-	-	-
White	912	919	(7)	-	-	-	-	-	-
Whitley	410	414	(4)	-	-	-	-	-	-

Table C-30. MHS HIP – Reported and Actual Network Deficiencies by Provider Category									
County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	138,456	139,282	(826)	-	-	-	-	-	-
Adams	583	583	-	-	-	-	-	-	-
Allen	7,504	7,544	(40)	-	-	-	-	-	-
Bartholomew	2,195	2,216	(21)	-	-	-	-	-	-
Benton	178	191	(13)	-	-	-	-	-	-
Blackford	246	248	(2)	-	-	-	-	-	-
Boone	906	903	3	-	-	-	-	-	-
Brown	339	333	6	-	-	-	-	-	-
Carroll	344	323	21	-	-	-	-	-	-
Cass	747	751	(4)	-	-	-	-	-	-
Clark	2,638	2,638	-	-	-	-	-	-	-
Clay	370	367	3	-	-	-	-	-	-
Clinton	480	491	(11)	-	-	-	-	-	-
Crawford	372	369	3	-	-	-	-	-	-
Daviess	494	484	10	-	-	-	-	-	-
Dearborn	430	428	2	-	-	-	-	-	-
Decatur	469	481	(12)	-	-	-	-	-	-
DeKalb	764	771	(7)	-	-	-	-	-	-
Delaware	2,608	2,621	(13)	-	-	-	-	-	-
Dubois	666	677	(11)	-	-	-	-	-	-

Table C-30. MHS HIP – Reported and Actual Network Deficiencies by Provider Category									
County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
Elkhart	8,159	8,210	(51)	-	-	-	-	-	-
Fayette	531	537	(6)	-	-	-	-	-	-
Floyd	1,222	1,216	6	-	-	-	-	-	-
Fountain	278	281	(3)	-	-	-	-	-	-
Franklin	231	243	(12)	-	-	-	-	-	-
Fulton	565	561	4	-	-	-	-	-	-
Gibson	389	388	1	-	-	-	-	-	-
Grant	2,458	2,487	(29)	-	-	-	-	-	-
Greene	468	474	(6)	-	-	-	-	-	-
Hamilton	3,474	3,462	12	-	-	-	-	-	-
Hancock	742	761	(19)	-	-	-	-	-	-
Harrison	576	582	(6)	-	-	-	-	-	-
Hendricks	2,410	2,340	70	-	-	-	-	-	-
Henry	728	729	(1)	-	-	-	-	-	-
Howard	2,402	2,465	(63)	-	-	-	-	-	-
Huntington	672	669	3	-	-	-	-	-	-
Jackson	876	880	(4)	-	-	-	-	-	-
Jasper	616	630	(14)	-	-	-	-	-	-
Jay	376	376	-	-	-	-	-	-	-
Jefferson	1,192	1,222	(30)	-	-	-	-	-	-

Table C-30. MHS HIP – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
Jennings	800	781	19	-	-	-	-	-	-
Johnson	2,678	2,706	(28)	-	-	-	-	-	-
Knox	1,648	1,661	(13)	-	-	-	-	-	-
Kosciusko	1,820	1,791	29	-	-	-	-	-	-
LaGrange	451	448	3	-	-	-	-	-	-
Lake	11,184	11,215	(31)	-	-	-	-	-	-
LaPorte	1,936	1,929	7	-	-	-	-	-	-
Lawrence	876	876	-	-	-	-	-	-	-
Madison	3,752	3,773	(21)	-	-	-	-	-	-
Marion	21,326	21,686	(360)	-	-	-	-	-	-
Marshall	940	950	(10)	-	-	-	-	-	-
Martin	218	226	(8)	-	-	-	-	-	-
Miami	862	838	24	-	-	-	-	-	-
Monroe	2,001	2,026	(25)	-	-	-	-	-	-
Montgomery	789	798	(9)	-	-	-	-	-	-
Morgan	1,148	1,152	(4)	-	-	-	-	-	-
Newton	348	329	19	-	-	-	-	-	-
Noble	735	750	(15)	-	-	-	-	-	-
Ohio	70	59	11	-	-	-	-	-	-
Orange	1,173	1,186	(13)	-	-	-	-	-	-

Table C-30. MHS HIP – Reported and Actual Network Deficiencies by Provider Category									
County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
Owen	502	508	(6)	-	-	-	-	-	-
Parke	206	205	1	-	-	-	-	-	-
Perry	247	244	3	-	-	-	-	-	-
Pike	226	223	3	-	-	-	-	-	-
Porter	2,559	2,560	(1)	-	-	-	-	-	-
Posey	252	251	1	-	-	-	-	-	-
Pulaski	321	319	2	-	-	-	-	-	-
Putnam	833	820	13	-	-	-	-	-	-
Randolph	580	582	(2)	-	-	-	-	-	-
Ripley	411	407	4	-	-	-	-	-	-
Rush	351	357	(6)	-	-	-	-	-	-
Scott	661	655	6	-	-	-	-	-	-
Shelby	1,424	1,424	-	-	-	-	-	-	-
Spencer	334	347	(13)	-	-	-	-	-	-
St. Joseph	9,739	9,838	(99)	-	-	-	-	-	-
Starke	611	610	1	-	-	-	-	-	-
Steuben	814	809	5	-	-	-	-	-	-
Sullivan	222	226	(4)	-	-	-	-	-	-
Switzerland	297	290	7	-	-	-	-	-	-
Tippecanoe	2,788	2,832	(44)	-	-	-	-	-	-

Table C-30. MHS HIP – Reported and Actual Network Deficiencies by Provider Category									
County	Number of Members Enrolled			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported	MCE Reported	Myers and Stauffer Calculated	Over (Under) Reported
Tipton	289	280	9	-	-	-	-	-	-
Union	95	91	4	-	-	-	-	-	-
Vanderburgh	2,800	2,849	(49)	-	-	-	-	-	-
Vermillion	191	186	5	-	-	-	-	-	-
Vigo	1,298	1,308	(10)	-	-	-	-	-	-
Wabash	580	579	1	-	-	-	-	-	-
Warren	135	126	9	-	-	-	-	-	-
Warrick	661	654	7	-	-	-	-	-	-
Washington	649	643	6	-	-	-	-	-	-
Wayne	1,649	1,659	(10)	-	-	-	-	-	-
Wells	405	403	2	-	-	-	-	-	-
White	497	506	(9)	-	-	-	-	-	-
Whitley	376	379	(3)	-	-	-	-	-	-

Table C-31. MHS HCC – Reported and Actual Network Deficiencies by Provider Category

County	Number of Members Enrolled			Without Sufficient Access to a Psychiatrist			Without Sufficient Access to an OB/GYN Provider		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	34,412	34,321	91	-	-	-	-	-	-
Adams	128	127	1	-	-	-	-	-	-
Allen	1,967	1,956	11	-	-	-	-	-	-
Bartholomew	455	447	8	-	-	-	-	-	-
Benton	63	64	(1)	-	-	-	-	-	-
Blackford	92	91	1	-	-	-	-	-	-
Boone	196	196	-	-	-	-	-	-	-
Brown	42	42	-	-	-	-	-	-	-
Carroll	62	61	1	-	-	-	-	-	-
Cass	220	222	(2)	-	-	-	-	-	-
Clark	534	537	(3)	-	-	-	-	-	-
Clay	133	137	(4)	-	-	-	-	-	-
Clinton	174	171	3	-	-	-	-	-	-
Crawford	93	86	7	-	-	-	-	-	-
Daviess	101	97	4	-	-	-	-	-	-
Dearborn	97	103	(6)	-	-	-	-	-	-
Decatur	109	106	3	-	-	-	-	-	-
DeKalb	182	184	(2)	-	-	-	-	-	-
Delaware	1,030	1,015	15	-	-	-	-	-	-
Dubois	128	130	(2)	-	-	-	-	-	-

Table C-31. MHS HCC – Reported and Actual Network Deficiencies by Provider Category									
County	Number of Members Enrolled			Without Sufficient Access to a Psychiatrist			Without Sufficient Access to an OB/GYN Provider		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Elkhart	1,441	1,429	12	-	-	-	-	-	-
Fayette	184	194	(10)	-	-	-	-	-	-
Floyd	232	227	5	-	-	-	-	-	-
Fountain	91	96	(5)	-	-	-	-	-	-
Franklin	62	67	(5)	-	-	-	-	-	-
Fulton	138	137	1	-	-	-	-	-	-
Gibson	81	80	1	-	-	-	-	-	-
Grant	719	723	(4)	-	-	-	-	-	-
Greene	153	139	14	-	-	-	-	-	-
Hamilton	628	623	5	-	-	-	-	-	-
Hancock	135	137	(2)	-	-	-	-	-	-
Harrison	108	108	-	-	-	-	-	-	-
Hendricks	472	463	9	-	-	-	-	-	-
Henry	248	246	2	-	-	-	-	-	-
Howard	701	709	(8)	-	-	-	-	-	-
Huntington	157	152	5	-	-	-	-	-	-
Jackson	242	243	(1)	-	-	-	-	-	-
Jasper	138	143	(5)	-	-	-	-	-	-
Jay	104	104	-	-	-	-	-	-	-
Jefferson	213	221	(8)	-	-	-	-	-	-

Table C-31. MHS HCC – Reported and Actual Network Deficiencies by Provider Category									
County	Number of Members Enrolled			Without Sufficient Access to a Psychiatrist			Without Sufficient Access to an OB/GYN Provider		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Jennings	215	216	(1)	-	-	-	-	-	-
Johnson	544	547	(3)	-	-	-	-	-	-
Knox	343	345	(2)	-	-	-	-	-	-
Kosciusko	370	352	18	-	-	-	-	-	-
LaGrange	106	102	4	-	-	-	-	-	-
Lake	3,094	3,083	11	-	-	-	-	-	-
LaPorte	517	512	5	-	-	-	-	-	-
Lawrence	240	238	2	-	-	-	-	-	-
Madison	799	797	2	-	-	-	-	-	-
Marion	6,364	6,405	(41)	-	-	-	-	-	-
Marshall	166	178	(12)	-	-	-	-	-	-
Martin	51	51	-	-	-	-	-	-	-
Miami	234	217	17	-	-	-	-	-	-
Monroe	386	394	(8)	-	-	-	-	-	-
Montgomery	193	186	7	-	-	-	-	-	-
Morgan	296	293	3	-	-	-	-	-	-
Newton	78	73	5	-	-	-	-	-	-
Noble	208	211	(3)	-	-	-	-	-	-
Ohio	11	17	(6)	-	-	-	-	-	-
Orange	198	188	10	-	-	-	-	-	-

Table C-31. MHS HCC – Reported and Actual Network Deficiencies by Provider Category									
County	Number of Members Enrolled			Without Sufficient Access to a Psychiatrist			Without Sufficient Access to an OB/GYN Provider		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Owen	121	120	1	-	-	-	-	-	-
Parke	62	63	(1)	-	-	-	-	-	-
Perry	55	55	-	-	-	-	-	-	-
Pike	45	46	(1)	-	-	-	-	-	-
Porter	410	407	3	-	-	-	-	-	-
Posey	103	99	4	-	-	-	-	-	-
Pulaski	78	78	-	-	-	-	-	-	-
Putnam	120	124	(4)	-	-	-	-	-	-
Randolph	140	149	(9)	-	-	-	-	-	-
Ripley	113	102	11	-	-	-	-	-	-
Rush	63	60	3	-	-	-	-	-	-
Scott	192	193	(1)	-	-	-	-	-	-
Shelby	217	218	(1)	-	-	-	-	-	-
Spencer	77	76	1	-	-	-	-	-	-
St. Joseph	2,016	1,998	18	-	-	-	-	-	-
Starke	148	146	2	-	-	-	-	-	-
Steuben	148	145	3	-	-	-	-	-	-
Sullivan	86	85	1	-	-	-	-	-	-
Switzerland	57	50	7	-	-	-	-	-	-
Tippecanoe	882	884	(2)	-	-	-	-	-	-

Table C-31. MHS HCC – Reported and Actual Network Deficiencies by Provider Category									
County	Number of Members Enrolled			Without Sufficient Access to a Psychiatrist			Without Sufficient Access to an OB/GYN Provider		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Tipton	63	61	2	-	-	-	-	-	-
Union	28	26	2	-	-	-	-	-	-
Vanderburgh	516	509	7	-	-	-	-	-	-
Vermillion	74	73	1	-	-	-	-	-	-
Vigo	662	667	(5)	-	-	-	-	-	-
Wabash	233	228	5	-	-	-	-	-	-
Warren	34	29	5	-	-	-	-	-	-
Warrick	107	108	(1)	-	-	-	-	-	-
Washington	136	137	(1)	-	-	-	-	-	-
Wayne	654	659	(5)	-	-	-	-	-	-
Wells	109	110	(1)	-	-	-	-	-	-
White	122	123	(1)	-	-	-	-	-	-
Whitley	75	75	-	-	-	-	-	-	-

Table C-32. UHC HCC – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
All Counties	5,436	5,266	170	-	-	-	-	-	-
Adams	16	15	1	-	-	-	-	-	-
Allen	349	344	5	-	-	-	-	-	-
Bartholomew	49	52	(3)	-	-	-	-	-	-
Benton	11	9	2	-	-	-	-	-	-
Blackford	12	11	1	-	-	-	-	-	-
Boone	34	36	(2)	-	-	-	-	-	-
Brown	7	7	-	-	-	-	-	-	-
Carroll	15	13	2	-	-	-	-	-	-
Cass	43	47	(4)	-	-	-	-	-	-
Clark	101	97	4	-	-	-	-	-	-
Clay	34	36	(2)	-	-	-	-	-	-
Clinton	34	30	4	-	-	-	-	-	-
Crawford	2	2	-	-	-	-	-	-	-
Daviess	28	22	6	-	-	-	-	-	-
Dearborn	63	67	(4)	-	-	-	-	-	-
Decatur	25	20	5	-	-	-	-	-	-
DeKalb	27	28	(1)	-	-	-	-	-	-
Delaware	112	106	6	-	-	-	-	-	-
Dubois	19	17	2	-	-	-	-	-	-

Table C-32. UHC HCC – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Elkhart	79	79	-	-	-	-	-	-	-
Fayette	38	32	6	-	-	-	-	-	-
Floyd	51	49	2	-	-	-	-	-	-
Fountain	12	10	2	-	-	-	-	-	-
Franklin	15	18	(3)	-	-	-	-	-	-
Fulton	6	8	(2)	-	-	-	-	-	-
Gibson	19	18	1	-	-	-	-	-	-
Grant	64	61	3	-	-	-	-	-	-
Greene	31	27	4	-	-	-	-	-	-
Hamilton	162	161	1	-	-	-	-	-	-
Hancock	46	40	6	-	-	-	-	-	-
Harrison	14	16	(2)	-	-	-	-	-	-
Hendricks	102	104	(2)	-	-	-	-	-	-
Henry	67	56	11	-	-	-	-	-	-
Howard	128	118	10	-	-	-	-	-	-
Huntington	18	13	5	-	-	-	-	-	-
Jackson	32	31	1	-	-	-	-	-	-
Jasper	15	16	(1)	-	-	-	-	-	-
Jay	11	10	1	-	-	-	-	-	-
Jefferson	23	26	(3)	-	-	-	-	-	-

Table C-32. UHC HCC – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Jennings	31	28	3	-	-	-	-	-	-
Johnson	98	100	(2)	-	-	-	-	-	-
Knox	20	23	(3)	-	-	-	-	-	-
Kosciusko	44	34	10	-	-	-	-	-	-
LaGrange	18	15	3	-	-	-	-	-	-
Lake	464	430	34	-	-	-	-	-	-
LaPorte	88	84	4	-	-	-	-	-	-
Lawrence	35	34	1	-	-	-	-	-	-
Madison	105	113	(8)	-	-	-	-	-	-
Marion	1,147	1,111	36	-	-	-	-	-	-
Marshall	18	21	(3)	-	-	-	-	-	-
Martin	-	3	(3)	-	-	-	-	-	-
Miami	37	36	1	-	-	-	-	-	-
Monroe	58	55	3	-	-	-	-	-	-
Montgomery	22	25	(3)	-	-	-	-	-	-
Morgan	48	52	(4)	-	-	-	-	-	-
Newton	5	7	(2)	-	-	-	-	-	-
Noble	34	35	(1)	-	-	-	-	-	-
Ohio	5	6	(1)	-	-	-	-	-	-
Orange	13	10	3	-	-	-	-	-	-

Table C-32. UHC HCC – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Owen	17	16	1	-	-	-	-	-	-
Parke	15	16	(1)	-	-	-	-	-	-
Perry	13	16	(3)	-	-	-	-	-	-
Pike	4	3	1	-	-	-	-	-	-
Porter	82	80	2	-	-	-	-	-	-
Posey	16	14	2	-	-	-	-	-	-
Pulaski	11	11	-	-	-	-	-	-	-
Putnam	16	14	2	-	-	-	-	-	-
Randolph	32	32	-	-	-	-	-	-	-
Ripley	27	24	3	-	-	-	-	-	-
Rush	13	15	(2)	-	-	-	-	-	-
Scott	30	28	2	-	-	-	-	-	-
Shelby	26	24	2	-	-	-	-	-	-
Spencer	10	10	-	-	-	-	-	-	-
St. Joseph	150	144	6	-	-	-	-	-	-
Starke	16	18	(2)	-	-	-	-	-	-
Steuben	28	23	5	-	-	-	-	-	-
Sullivan	24	24	-	-	-	-	-	-	-
Switzerland	10	11	(1)	-	-	-	-	-	-
Tippecanoe	146	137	9	-	-	-	-	-	-

Table C-32. UHC HCC – Reported and Actual Network Deficiencies by Provider Category

County	Number of Enrollees			Without Sufficient Access to Psychiatrists			Without Sufficient Access to OB/GYN Providers		
	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported	MCE Report 0903	Myers and Stauffer Calculated	Over (Under) Reported
Tipton	5	7	(2)	-	-	-	-	-	-
Union	5	8	(3)	-	-	-	-	-	-
Vanderburgh	115	114	1	-	-	-	-	-	-
Vermillion	19	16	3	-	-	-	-	-	-
Vigo	154	146	8	-	-	-	-	-	-
Wabash	32	30	2	-	-	-	-	-	-
Warren	6	7	(1)	-	-	-	-	-	-
Warrick	23	24	(1)	-	-	-	-	-	-
Washington	24	20	4	-	-	-	-	-	-
Wayne	110	103	7	-	-	-	-	-	-
Wells	20	22	(2)	-	-	-	-	-	-
White	16	17	(1)	-	-	-	-	-	-
Whitley	17	18	(1)	-	-	-	-	-	-

Appendix D | EDV Encounter Matching

Completion Percentages

Table D-1. Non-Rx Completion Percentages – Counts

HCC						
Description	Anthem	CS	MDwise	MHS	UHC	Total
Total Claims	100%	N/A	N/A	100%	100%	100%
Matched Encounters	99.6%	N/A	N/A	83.7%	99.5%	94.6%
HHW						
Description	Anthem	CS	MDwise	MHS	UHC	Total
Total Claims	100%	100%	100%	100%	N/A	100%
Matched Encounters	99.5%	95.1%	98.9%	86.1%	N/A	95.7%
HIP						
Description	Anthem	CS	MDwise	MHS	UHC	Total
Total Claims	100%	100%	100%	100%	N/A	100%
Matched Encounters	99.7%	92.4%	99.3%	83.1%	N/A	96.0%

Table D-2. Non-Rx Completion Percentages – Paid Amounts

HCC						
Description	Anthem	CS	MDwise	MHS	UHC	Total
Total Claims	100%	N/A	N/A	100%	100%	100%
Matched Encounters	99.7%	N/A	N/A	93.9%	102.6%	98.4%
HHW						
Description	Anthem	CS	MDwise	MHS	UHC	Total
Total Claims	100%	100%	100%	100%	N/A	100%
Matched Encounters	99.5%	91.4%	98.5%	95.5%	N/A	97.6%
HIP						
Description	Anthem	CS	MDwise	MHS	UHC	Total
Total Claims	100%	100%	100%	100%	N/A	100%
Matched Encounters	99.5%	88.2%	98.8%	99.7%	N/A	98.4%

Table D-3. Rx Completion Percentages

Counts						
Description	Anthem	CS	MDwise	MHS	UHC	Total
Total Claims	100%	100%	100%	100%	100%	100%
Matched Encounters	99.6%	61.7%	100%	100%	98.2%	96.9%
Paid Amounts						
Description	Anthem	CS	MDwise	MHS	UHC	Total
Total Claims	100%	100%	100%	100%	100%	100%
Matched Encounters	109.4%	106.4%	100%	119.4%	106.0%	107.3%

Cash Disbursements Journal (CDJ) Completeness

Table D-4. All MCEs Combined by Program

	HCC			HHW			HIP		
	March 2022	September 2022	Total	March 2022	September 2022	Total	March 2022	September 2022	Total
CDJ Data									
CDJ Paid Amount Total	\$124,548,163	\$123,347,837	\$247,896,000	\$178,302,956	\$188,364,401	\$366,667,357	\$456,248,794	\$495,999,154	\$952,247,948
Reconciling Adjustment	\$1,442,540	\$1,785,029	\$3,227,569	\$794,918	\$1,074,153	\$1,869,071	\$3,491,792	\$4,368,782	\$7,860,575
Net CDJ Data Paid Amount Total	\$125,990,703	\$125,132,866	\$251,123,568	\$179,097,873	\$189,438,554	\$368,536,428	\$459,740,586	\$500,367,936	\$960,108,522
Encounter Data									
Encounter Paid Amount Total	\$135,083,763	\$134,758,188	\$269,841,951	\$191,816,498	\$200,674,175	\$392,490,673	\$495,901,338	\$540,014,773	\$1,035,916,111
Payment Adjustments	(\$10,255,055)	(\$10,449,114)	(\$20,704,168)	(\$13,627,073)	(\$12,326,902)	(\$25,953,975)	(\$39,046,903)	(\$42,393,014)	(\$81,439,917)
Net Encounter Paid Amount Total	\$124,828,709	\$124,309,074	\$249,137,783	\$178,189,425	\$188,347,273	\$366,536,698	\$456,854,435	\$497,621,759	\$954,476,194
Encounter Completeness Percentage	99.1%	99.3%	99.2%	99.5%	99.4%	99.5%	99.4%	99.5%	99.4%

Table D-5. Anthem by Program

	HCC			HHW			HIP		
	March 2022	September 2022	Total	March 2022	September 2022	Total	March 2022	September 2022	Total
CDJ Data									
CDJ Paid Amount Total	\$78,208,943	\$78,129,724	\$156,338,667	\$65,350,062	\$69,897,543	\$135,247,605	\$233,141,855	\$229,704,459	\$462,846,314

Table D-5. Anthem by Program

	HCC			HHW			HIP		
	March 2022	September 2022	Total	March 2022	September 2022	Total	March 2022	September 2022	Total
Reconciling Adjustment	\$1,186,796	\$1,463,219	\$2,650,015	\$705,320	\$834,674	\$1,539,994	\$3,372,695	\$3,839,961	\$7,212,656
Net CDJ Data Paid Amount Total	\$79,395,740	\$79,592,943	\$158,988,682	\$66,055,382	\$70,732,216	\$136,787,599	\$236,514,550	\$233,544,420	\$470,058,970
Encounter Data									
Encounter Paid Amount Total	\$81,815,601	\$79,805,730	\$161,621,332	\$68,613,878	\$71,740,544	\$140,354,422	\$243,158,284	\$239,335,170	\$482,493,454
Payment Adjustments	(\$2,988,906)	(\$712,629)	(\$3,701,535)	(\$2,870,219)	(\$1,530,310)	(\$4,400,528)	(\$8,016,932)	(\$7,278,266)	(\$15,295,198)
Net Encounter Paid Amount Total	\$78,826,695	\$79,093,102	\$157,919,797	\$65,743,660	\$70,210,234	\$135,953,893	\$235,141,352	\$232,056,904	\$467,198,256
Encounter Completeness Percentage	99.3%	99.4%	99.3%	99.5%	99.3%	99.4%	99.4%	99.4%	99.4%

Table D-6. CS by Program

	HCC			HHW			HIP		
	March 2022	September 2022	Total	March 2022	September 2022	Total	March 2022	September 2022	Total
CDJ Data									
CDJ Paid Amount Total	N/A	N/A	N/A	\$14,604,577	\$15,971,978	\$30,576,554	\$40,445,856	\$40,726,572	\$81,172,428
Reconciling Adjustment	N/A	N/A	N/A	\$7,591	\$28,845	\$36,436	-\$1,070	\$49,603	\$48,533
Net CDJ Data Paid Amount Total	N/A	N/A	N/A	\$14,612,168	\$16,000,823	\$30,612,991	\$40,444,786	\$40,776,174	\$81,220,961
Encounter Data									
Encounter Paid Amount Total	N/A	N/A	N/A	\$16,699,871	\$19,123,827	\$35,823,698	\$46,217,159	\$52,462,208	\$98,679,367
Payment Adjustments	N/A	N/A	N/A	(\$2,064,114)	(\$3,154,135)	(\$5,218,249)	(\$5,789,054)	(\$11,891,597)	(\$17,680,652)
Net Encounter Paid Amount Total	N/A	N/A	N/A	\$14,635,757	\$15,969,692	\$30,605,449	\$40,428,105	\$40,570,611	\$80,998,716
Encounter Completeness Percentage	N/A	N/A	N/A	100.2%	99.8%	100%	100%	99.5%	99.7%

Table D-7. MDWise by Program

	HCC			HHW			HIP		
	March 2022	September 2022	Total	March 2022	September 2022	Total	March 2022	September 2022	Total
CDJ Data									
CDJ Paid Amount Total	N/A	N/A	N/A	\$55,602,048	\$59,941,888	\$115,543,936	\$95,968,891	\$144,199,880	\$240,168,772
Reconciling Adjustment	N/A	N/A	N/A	-\$76,501	\$54,878	-\$21,623	-\$314,055	\$19,600	-\$294,455
Net CDJ Data Paid Amount Total	N/A	N/A	N/A	\$55,525,547	\$59,996,766	\$115,522,313	\$95,654,836	\$144,219,480	\$239,874,316
Encounter Data									
Encounter Paid Amount Total	N/A	N/A	N/A	\$55,764,610	\$59,473,112	\$115,237,722	\$95,926,400	\$143,978,157	\$239,904,557
Payment Adjustments	N/A	N/A	N/A	(\$629,469)	\$312,174	(\$317,295)	(\$1,274,634)	(\$199,536)	(\$1,474,169)
Net Encounter Paid Amount Total	N/A	N/A	N/A	\$55,135,141	\$59,785,286	\$114,920,427	\$94,651,766	\$143,778,621	\$238,430,388
Encounter Completeness Percentage	N/A	N/A	N/A	99.3%	99.6%	99.5%	99.0%	99.7%	99.4%

Table D-8. MHS by Program

	HCC			HHW			HIP		
	March 2022	September 2022	Total	March 2022	September 2022	Total	March 2022	September 2022	Total
CDJ Data									
CDJ Paid Amount Total	\$42,077,911	\$39,359,308	\$81,437,220	\$42,746,269	\$42,552,993	\$85,299,262	\$86,692,191	\$81,368,243	\$168,060,434
Reconciling Adjustment	\$209,255	\$204,667	\$413,923	\$158,508	\$155,756	\$314,263	\$434,222	\$459,619	\$893,841
Net CDJ Data Paid Amount Total	\$42,287,167	\$39,563,976	\$81,851,143	\$42,904,777	\$42,708,748	\$85,613,525	\$87,126,413	\$81,827,862	\$168,954,275
Encounter Data									
Encounter Paid Amount Total	\$47,875,868	\$48,325,805	\$96,201,673	\$50,738,138	\$50,336,693	\$101,074,831	\$110,599,495	\$104,239,238	\$214,838,732
Payment Adjustments	(\$6,134,668)	(\$9,044,902)	(\$15,179,570)	(\$8,063,270)	(\$7,954,632)	(\$16,017,902)	(\$23,966,283)	(\$23,023,614)	(\$46,989,897)
Net Encounter Paid Amount Total	\$41,741,200	\$39,280,903	\$81,022,102	\$42,674,868	\$42,382,061	\$85,056,929	\$86,633,212	\$81,215,623	\$167,848,835
Encounter Completeness Percentage	98.7%	99.3%	99.0%	99.5%	99.2%	99.3%	99.4%	99.3%	99.3%

Table D.9. UHC by Program

	HCC			HHW			HIP		
	March 2022	September 2022	Total	March 2022	September 2022	Total	March 2022	September 2022	Total
CDJ Data									
CDJ Paid Amount Total	\$4,261,308	\$5,858,805	\$10,120,113	N/A	N/A	N/A	N/A	N/A	N/A
Reconciling Adjustment	\$46,489	\$117,142	\$163,631	N/A	N/A	N/A	N/A	N/A	N/A
Net CDJ Data Paid Amount Total	\$4,307,797	\$5,975,947	\$10,283,744	N/A	N/A	N/A	N/A	N/A	N/A
Encounter Data									
Encounter Paid Amount Total	\$5,392,294	\$6,626,653	\$12,018,947	N/A	N/A	N/A	N/A	N/A	N/A
Payment Adjustments	(\$1,131,480)	(\$691,583)	(\$1,823,063)	N/A	N/A	N/A	N/A	N/A	N/A
Net Encounter Paid Amount Total	\$4,260,814	\$5,935,070	\$10,195,884	N/A	N/A	N/A	N/A	N/A	N/A
Encounter Completeness Percentage	98.9%	99.3%	99.1%	N/A	N/A	N/A	N/A	N/A	N/A

Appendix E | EDV Documentation

Per Enrollee Utilization and Paid Amounts

Table E-1. Total Volume and Per Enrollee Utilization by Program

	HCC				HHW				HIP			
Enrollees												
Total Enrollee Months	1,231,170				10,154,361				9,015,365			
Average Number of Enrollees ¹	102,598				846,197				751,280			
Service Type	Count	PEPY ² Count	Paid Amount	PEPY ² Amount	Count	PEPY ² Count	Paid Amount	PEPY ² Amount	Count	PEPY ² Count	Paid Amount	PEPY ² Amount
Ancillary	1,446,638	14.1	\$164,644,961	\$1,605	2,430,263	2.9	\$198,729,052	\$235	6,812,833	9.1	\$415,069,201	\$552
Dental	211,674	2.1	\$11,428,589	\$111	2,648,082	3.1	\$115,230,358	\$136	1,019,753	1.4	\$75,830,027	\$101
Inpatient	22,810	0.2	\$249,703,204	\$2,434	61,444	0.1	\$414,889,513	\$490	111,939	0.1	\$797,945,350	\$1,062
Outpatient	1,866,798	18.2	\$267,498,388	\$2,607	3,441,606	4.1	\$387,926,418	\$458	9,714,222	12.9	\$1,228,309,446	\$1,635
Primary Care	1,287,397	12.5	\$55,385,015	\$540	6,857,155	8.1	\$216,422,724	\$256	7,973,711	10.6	\$390,386,875	\$520
Specialty	727,399	7.1	\$55,341,776	\$539	1,243,831	1.5	\$86,085,011	\$102	3,383,562	4.5	\$290,879,434	\$387
Transportation	157,966	1.5	\$3,142,829	\$31	26,678	0.0	\$820,162	\$1	400,955	0.5	\$10,220,154	\$14
Vision	96,523	0.9	\$3,199,044	\$31	553,780	0.7	\$18,510,363	\$22	484,732	0.6	\$26,363,094	\$35
Rx	2,571,681	25.1	\$464,872,744	\$4,531	3,574,081	4.2	\$351,408,371	\$415	11,336,709	15.1	\$1,641,561,885	\$2,185
Total Services³	8,388,886	81.7	\$1,275,216,549	\$12,429	20,836,920	24.7	\$1,790,021,972	\$2,115	41,238,416	54.8	\$4,876,565,466	\$6,491

¹Total enrollee months divided by the number of months.

²Per enrollee per year counts and/or paid amount divided by the average number of enrollees.

³Differences are due to rounding.

Table E-2. Anthem Volume and Per Enrollee Utilization by Program

	HCC				HHW				HIP			
Enrollees												
Total Enrollee Months	744,706				3,989,015				4,336,409			
Average Number of Enrollees ¹	62,059				332,418				361,367			
Service Type	Count	PEPY ² Count	Paid Amount	PEPY ² Amount	Count	PEPY ² Count	Paid Amount	PEPY ² Amount	Count	PEPY ² Count	Paid Amount	PEPY ² Amount
Ancillary	929,512	15.0	\$87,035,756	\$1,402	1,013,818	3.0	\$70,338,785	\$212	3,503,363	9.7	\$206,758,193	\$572
Dental	124,114	2.0	\$6,960,257	\$112	1,018,591	3.1	\$44,546,089	\$134	507,048	1.4	\$37,105,056	\$103
Inpatient	14,848	0.2	\$148,137,381	\$2,387	25,676	0.1	\$188,042,459	\$566	56,720	0.2	\$468,550,962	\$1,297
Outpatient	1,200,462	19.3	\$176,029,532	\$2,836	1,342,577	4.0	\$139,693,023	\$420	4,775,991	13.2	\$575,938,763	\$1,594
Primary Care	837,397	13.5	\$36,019,969	\$580	2,826,047	8.5	\$87,387,165	\$263	4,143,549	11.5	\$198,246,358	\$549
Specialty	482,817	7.8	\$36,365,466	\$586	514,274	1.5	\$33,223,949	\$100	1,777,487	4.9	\$145,033,571	\$401
Transportation	118,455	1.9	\$2,624,583	\$42	13,258	0.0	\$406,370	\$1	257,584	0.7	\$6,466,691	\$18
Vision	60,167	1.0	\$1,859,939	\$30	212,761	0.6	\$5,924,845	\$18	244,169	0.7	\$12,717,720	\$35
Rx	1,666,970	26.9	\$283,589,119	\$4,570	1,465,434	4.4	\$107,029,565	\$322	5,788,946	16.0	\$730,834,174	\$2,022
Total Services³	5,434,742	87.6	\$778,622,002	\$12,545	8,432,436	25.2	\$676,592,248	\$2,036	21,054,857	58.3	\$2,381,651,488	\$6,591

¹Total enrollee months divided by the number of months.

²Per enrollee per year counts and/or paid amount divided by the average number of enrollees.

³Differences are due to rounding.

Table E-3. CS Volume and Per Enrollee Utilization by Program

	HCC				HHW				HIP			
Enrollees												
Total Enrollee Months	N/A				971,175				935,517			
Average Number of Enrollees ¹	N/A				80,931				77,960			
Service Type	Count	PEPY ² Count	Paid Amount	PEPY ² Amount	Count	PEPY ² Count	Paid Amount	PEPY ² Amount	Count	PEPY ² Count	Paid Amount	PEPY ² Amount
Ancillary	N/A	N/A	N/A	N/A	208,537	2.6	\$16,227,774	\$201	621,311	8.0	\$40,643,014	\$521
Dental	N/A	N/A	N/A	N/A	217,687	2.7	\$7,579,375	\$94	88,439	1.1	\$5,721,089	\$73
Inpatient	N/A	N/A	N/A	N/A	6,452	0.1	\$56,621,838	\$700	11,867	0.2	\$118,119,647	\$1,515
Outpatient	N/A	N/A	N/A	N/A	313,602	3.9	\$39,930,382	\$493	876,693	11.2	\$117,304,986	\$1,505
Primary Care	N/A	N/A	N/A	N/A	641,853	7.9	\$20,218,222	\$250	691,071	8.9	\$34,437,774	\$442
Specialty	N/A	N/A	N/A	N/A	106,037	1.3	\$8,051,756	\$99	286,889	3.7	\$26,439,157	\$339
Transportation	N/A	N/A	N/A	N/A	2,203	0.0	\$82,584	\$1	36,030	0.5	\$1,018,310	\$13
Vision	N/A	N/A	N/A	N/A	42,714	0.5	\$1,266,380	\$16	43,668	0.6	\$2,390,420	\$31
Rx	N/A	N/A	N/A	N/A	299,183	3.7	\$22,232,862	\$275	953,468	12.2	\$133,829,711	\$1,717
Total Services³	N/A	N/A	N/A	N/A	1,838,268	22.7	\$172,211,172	\$2,129	3,609,436	46.4	\$479,904,109	\$6,156

¹Total enrollee months divided by the number of months.

²Per enrollee per year counts and/or paid amount divided by the average number of enrollees.

³Differences are due to rounding.

Table E-4. MDWise Volume and Per Enrollee Utilization by Program

	HCC				HHW				HIP			
Enrollees												
Total Enrollee Months	N/A				2,858,667				2,088,038			
Average Number of Enrollees ¹	N/A				238,222				174,003			
Service Type	Count	PEPY ² Count	Paid Amount	PEPY ² Amount	Count	PEPY ² Count	Paid Amount	PEPY ² Amount	Count	PEPY ² Count	Paid Amount	PEPY ² Amount
Ancillary	N/A	N/A	N/A	N/A	648,570	2.7	\$59,500,249	\$250	1,454,533	8.4	\$92,523,008	\$532
Dental	N/A	N/A	N/A	N/A	776,411	3.3	\$34,915,924	\$147	232,496	1.3	\$18,394,028	\$106
Inpatient	N/A	N/A	N/A	N/A	15,742	0.1	\$56,521,807	\$237	24,061	0.1	\$7,633,776	\$44
Outpatient	N/A	N/A	N/A	N/A	1,018,365	4.3	\$119,110,266	\$500	2,319,181	13.3	\$318,841,097	\$1,832
Primary Care	N/A	N/A	N/A	N/A	1,811,588	7.6	\$59,404,933	\$249	1,758,907	10.1	\$90,516,750	\$520
Specialty	N/A	N/A	N/A	N/A	350,604	1.5	\$24,517,823	\$103	772,749	4.4	\$69,896,827	\$402
Transportation	N/A	N/A	N/A	N/A	6,461	0.0	\$194,293	\$1	52,557	0.3	\$1,790,126	\$10
Vision	N/A	N/A	N/A	N/A	165,405	0.7	\$6,489,510	\$27	107,472	0.6	\$6,138,286	\$35
Rx	N/A	N/A	N/A	N/A	952,869	4.0	\$133,252,789	\$559	2,514,683	14.5	\$483,938,105	\$2,781
Total Services³	N/A	N/A	N/A	N/A	5,746,015	24.2	\$493,907,593	\$2,073	9,236,639	53.0	\$1,089,672,003	\$6,262

¹Total enrollee months divided by the number of months.

²Per enrollee per year counts and/or paid amount divided by the average number of enrollees.

³Differences are due to rounding.

Table E-5. MHS Volume and Per Enrollee Utilization by Program

	HCC				HHW				HIP			
Enrollees												
Total Enrollee Months	424,114				2,335,504				1,655,401			
Average Number of Enrollees ¹	35,343				194,625				137,950			
Service Type	Count	PEPY ² Count	Paid Amount	PEPY ² Amount	Count	PEPY ² Count	Paid Amount	PEPY ² Amount	Count	PEPY ² Count	Paid Amount	PEPY ² Amount
Ancillary	446,509	12.6	\$68,953,655	\$1,951	559,338	2.9	\$52,662,244	\$271	1,233,626	8.9	\$75,144,986	\$545
Dental	78,772	2.2	\$4,020,507	\$114	635,393	3.3	\$28,188,971	\$145	191,770	1.4	\$14,609,854	\$106
Inpatient	6,875	0.2	\$87,957,851	\$2,489	13,574	0.1	\$113,703,410	\$584	19,291	0.1	\$203,640,965	\$1,476
Outpatient	576,854	16.3	\$77,456,278	\$2,192	767,062	3.9	\$89,192,747	\$458	1,742,357	12.6	\$216,224,600	\$1,567
Primary Care	390,808	11.1	\$17,172,835	\$486	1,577,667	8.1	\$49,412,405	\$254	1,380,184	10.0	\$67,185,993	\$487
Specialty	209,420	5.9	\$17,068,886	\$483	272,916	1.4	\$20,291,483	\$104	546,437	4.0	\$49,509,878	\$359
Transportation	35,134	1.0	\$428,786	\$12	4,756	0.0	\$136,916	\$1	54,784	0.4	\$945,028	\$7
Vision	32,703	0.9	\$1,240,167	\$35	132,900	0.7	\$4,829,628	\$25	89,423	0.6	\$5,116,668	\$37
Rx	806,778	22.8	\$165,867,469	\$4,693	856,595	4.4	\$88,893,156	\$457	2,079,612	15.1	\$292,959,894	\$2,124
Total Services³	2,583,853	73.0	\$440,166,434	\$12,455	4,820,201	24.8	\$447,310,958	\$2,299	7,337,484	53.1	\$925,337,866	\$6,708

¹Total enrollee months divided by the number of months.

²Per enrollee per year counts and/or paid amount divided by the average number of enrollees.

³Differences are due to rounding.

Table E-6. UHC Volume and Per Enrollee Utilization by Program

HCC													HHW				HIP			
Enrollees																				
Total Enrollee Months	62,350												N/A				N/A			
Average Number of Enrollees ¹	5,196												N/A				N/A			
Service Type	Count	PEPY ² Count	Paid Amount	PEPY ² Amount	Count	PEPY ² Count	Paid Amount	PEPY ² Amount	Count	PEPY ² Count	Paid Amount	PEPY ² Amount								
Ancillary	70,617	13.6	\$8,655,550	\$1,666	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A								
Dental	8,788	1.7	\$447,824	\$86	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A								
Inpatient	1,087	0.2	\$13,607,972	\$2,619	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A								
Outpatient	89,482	17.2	\$14,012,577	\$2,697	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A								
Primary Care	59,192	11.4	\$2,192,211	\$422	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A								
Specialty	35,162	6.8	\$1,907,425	\$367	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A								
Transportation	4,377	0.8	\$89,460	\$17	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A								
Vision	3,653	0.7	\$98,938	\$19	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A								
Rx	97,933	18.8	\$15,416,156	\$2,967	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A								
Total Services³	370,291	71.2	\$56,428,113	\$10,860	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A								

¹Total enrollee months divided by the number of months.

²Per enrollee per year counts and/or paid amount divided by the average number of enrollees.

³Differences are due to rounding.

Key Data Element Comparison

Table E-7. Key Data Element Comparison – HCC																		
Key Data Element	March 2022						September 2022						Total					
	Valid		Missing		Erroneous		Valid		Missing		Erroneous		Valid		Missing		Erroneous	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Non-Rx																		
Admission Date	2,694	60.3%	1,752	39.2%	21	0.5%	4,406	77.9%	1,221	21.6%	30	0.5%	7,100	70.1%	2,973	29.4%	51	0.5%
Bill Type	46,116	71.9%	12,232	19.1%	5,752	9.0%	39,726	81.9%	2,495	5.1%	6,293	13.0%	85,842	76.2%	14,727	13.1%	12,045	10.7%
Billed Charges	304,931	97.6%	0	0.0%	6,746	2.2%	270,502	97.4%	0	0.0%	7,263	2.6%	575,433	97.5%	0	0.0%	14,009	2.4%
Billing Provider NPI	252,208	80.7%	24,240	7.8%	36,115	11.6%	243,121	87.5%	18,895	6.8%	15,756	5.7%	495,329	83.9%	43,135	7.3%	51,871	8.8%
Date of Service (First)	312,539	100%	0	0.0%	24	0.0%	277,764	100%	0	0.0%	8	0.0%	590,303	100%	0	0.0%	32	0.0%
Date of Service (Last)	305,524	100%	0	0.0%	21	0.0%	271,591	100%	0	0.0%	11	0.0%	577,115	100%	0	0.0%	32	0.0%
Diagnosis Code	286,719	93.8%	0	0.0%	18,826	6.2%	251,651	92.7%	0	0.0%	19,950	7.3%	538,370	93.3%	0	0.0%	38,776	6.7%
Former ICN	305,593	97.8%	0	0.0%	6,970	2.2%	272,052	97.9%	0	0.0%	5,720	2.1%	577,645	97.9%	0	0.0%	12,690	2.1%
Health Plan Paid Amount	307,420	98.4%	3,089	1.0%	2,054	0.7%	275,799	99.3%	116	0.0%	1,857	0.7%	583,219	98.8%	3,205	0.5%	3,911	0.7%
Health Plan Paid Date	126,174	40.4%	33,175	10.6%	153,214	49.0%	108,777	39.2%	23,686	8.5%	145,309	52.3%	234,951	39.8%	56,861	9.6%	298,523	50.6%
MMIS ICN	283,535	90.7%	0	0.0%	29,028	9.3%	276,964	99.7%	0	0.0%	808	0.3%	560,499	94.9%	0	0.0%	29,836	5.1%
MMIS Enrollee ID	308,837	98.8%	0	0.0%	3,726	1.2%	274,404	98.8%	0	0.0%	3,368	1.2%	583,241	98.8%	0	0.0%	7,094	1.2%
Place of Service	243,145	97.9%	5	0.0%	5,313	2.1%	224,037	97.7%	0	0.0%	5,221	2.3%	467,182	97.8%	5	0.0%	10,534	2.2%
Procedure Code	301,586	97.9%	1	0.0%	6,509	2.1%	267,130	98.2%	0	0.0%	4,985	1.8%	568,716	98.0%	1	0.0%	11,494	2.0%
Procedure Modifier	301,078	100%	0	0.0%	0	0.0%	265,945	100%	0	0.0%	0	0.0%	567,023	100%	0	0.0%	0	0.0%
Revenue Code	64,094	100%	5	0.0%	1	0.0%	48,508	100%	3	0.0%	3	0.0%	112,602	100%	8	0.0%	4	0.0%
Service Provider NPI	269,047	86.1%	21,628	6.9%	21,888	7.0%	248,087	89.3%	16,028	5.8%	13,657	4.9%	517,134	87.6%	37,656	6.4%	35,545	6.0%
Surgical Procedure Code	3,606	80.7%	0	0.0%	861	19.3%	5,080	89.8%	0	0.0%	577	10.2%	8,686	85.8%	0	0.0%	1,438	14.2%
Tooth Number	6,811	97.1%	0	0.0%	207	2.9%	5,986	97.0%	0	0.0%	184	3.0%	12,797	97.0%	0	0.0%	391	3.0%
Tooth Surface	7,016	100%	0	0.0%	2	0.0%	6,168	100%	0	0.0%	2	0.0%	13,184	100%	0	0.0%	4	0.0%
Total	4,038,673	91.1%	96,127	2.2%	297,278	6.7%	3,637,698	92.5%	62,444	1.6%	231,002	5.9%	7,676,371	91.8%	158,571	1.9%	528,280	6.3%
Rx																		
Billed Charges	264,719	72.5%	0	0.0%	100,408	27.5%	257,551	74.6%	0	0.0%	87,559	25.4%	522,270	73.5%	0	0.0%	187,967	26.5%
Date Filled	365,127	100%	0	0.0%	0	0.0%	345,110	100%	0	0.0%	0	0.0%	710,237	100%	0	0.0%	0	0.0%
Days Supply	365,127	100%	0	0.0%	0	0.0%	345,107	100%	0	0.0%	3	0.0%	710,234	100%	0	0.0%	3	0.0%
Former ICN	131,292	36.0%	0	0.0%	233,835	64.0%	119,552	34.6%	0	0.0%	225,558	65.4%	250,844	35.3%	0	0.0%	459,393	64.7%
Health Plan Paid Amount	358,838	98.3%	4,876	1.3%	1,413	0.4%	339,800	98.5%	4,570	1.3%	740	0.2%	698,638	98.4%	9,446	1.3%	2,153	0.3%
Health Plan Paid Date	348,759	95.5%	0	0.0%	16,368	4.5%	327,568	94.9%	0	0.0%	17,542	5.1%	676,327	95.2%	0	0.0%	33,910	4.8%
MMIS ICN	349,245	95.7%	0	0.0%	15,882	4.3%	328,393	95.2%	0	0.0%	16,717	4.8%	677,638	95.4%	0	0.0%	32,599	4.6%
MMIS Enrollee ID	349,207	95.6%	0	0.0%	15,920	4.4%	328,358	95.1%	0	0.0%	16,752	4.9%	677,565	95.4%	0	0.0%	32,672	4.6%
NDC	365,080	100%	0	0.0%	47	0.0%	345,072	100%	0	0.0%	38	0.0%	710,152	100%	0	0.0%	85	0.0%
Prescriber NPI	364,968	100%	111	0.0%	48	0.0%	345,005	100%	59	0.0%	46	0.0%	709,973	100%	170	0.0%	94	0.0%
Prescription Number	365,127	100%	0	0.0%	0	0.0%	345,110	100%	0	0.0%	0	0.0%	710,237	100%	0	0.0%	0	0.0%
Quantity Dispensed	365,127	100%	0	0.0%	0	0.0%	345,107	100%	0	0.0%	3	0.0%	710,234	100%	0	0.0%	3	0.0%

Table E-7. Key Data Element Comparison – HCC

Key Data Element	March 2022						September 2022						Total					
	Valid		Missing		Erroneous		Valid		Missing		Erroneous		Valid		Missing		Erroneous	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Refill Number	365,127	100%	0	0.0%	0	0.0%	345,110	100%	0	0.0%	0	0.0%	710,237	100%	0	0.0%	0	0.0%
Total	4,357,743	91.8%	4,987	0.1%	383,921	8.1%	4,116,843	91.8%	4,629	0.1%	364,958	8.1%	8,474,586	91.8%	9,616	0.1%	748,879	8.1%

Table E-8. Key Data Element Comparison – HHW

Key Data Element	March 2022						September 2022						Total					
	Valid		Missing		Erroneous		Valid		Missing		Erroneous		Valid		Missing		Erroneous	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Non-Rx																		
Admission Date	3,822	55.3%	3,076	44.5%	10	0.1%	2,818	55.1%	2,285	44.7%	11	0.2%	6,640	55.2%	5,361	44.6%	21	0.2%
Bill Type	93,296	81.4%	3,076	2.7%	18,206	15.9%	85,974	80.0%	2,285	2.1%	19,274	17.9%	179,270	80.7%	5,361	2.4%	37,480	16.9%
Billed Charges	767,682	98.1%	0	0.0%	14,422	1.8%	670,465	98.4%	0	0.0%	10,939	1.6%	1,438,147	98.3%	0	0.0%	25,361	1.7%
Billing Provider NPI	745,050	95.3%	5,175	0.7%	31,947	4.1%	647,201	95.0%	6,061	0.9%	28,142	4.1%	1,392,251	95.1%	11,236	0.8%	60,089	4.1%
Date of Service (First)	782,148	100%	0	0.0%	24	0.0%	681,392	100%	0	0.0%	12	0.0%	1,463,540	100%	0	0.0%	36	0.0%
Date of Service (Last)	708,909	100%	0	0.0%	90	0.0%	617,729	100%	0	0.0%	102	0.0%	1,326,638	100%	0	0.0%	192	0.0%
Diagnosis Code	707,091	99.7%	0	0.0%	1,905	0.3%	615,573	99.6%	0	0.0%	2,252	0.4%	1,322,664	99.7%	0	0.0%	4,157	0.3%
Former ICN	751,149	96.0%	0	0.0%	31,023	4.0%	669,019	98.2%	0	0.0%	12,385	1.8%	1,420,168	97.0%	0	0.0%	43,408	3.0%
Health Plan Paid Amount	776,426	99.3%	4,290	0.5%	1,456	0.2%	678,907	99.6%	543	0.1%	1,954	0.3%	1,455,333	99.4%	4,833	0.3%	3,410	0.2%
Health Plan Paid Date	487,891	62.4%	58,805	7.5%	235,476	30.1%	398,378	58.5%	50,017	7.3%	233,009	34.2%	886,269	60.6%	108,822	7.4%	468,485	32.0%
MMIS ICN	746,913	95.5%	0	0.0%	35,259	4.5%	654,963	96.1%	0	0.0%	26,441	3.9%	1,401,876	95.8%	0	0.0%	61,700	4.2%
MMIS Enrollee ID	739,258	94.5%	0	0.0%	42,914	5.5%	647,913	95.1%	0	0.0%	33,491	4.9%	1,387,171	94.8%	0	0.0%	76,405	5.2%
Place of Service	665,821	99.7%	0	0.0%	1,773	0.3%	571,946	99.7%	0	0.0%	1,925	0.3%	1,237,767	99.7%	0	0.0%	3,698	0.3%
Procedure Code	766,295	98.8%	0	0.0%	8,969	1.2%	667,571	98.7%	0	0.0%	8,719	1.3%	1,433,866	98.8%	0	0.0%	17,688	1.2%
Procedure Modifier	702,091	100%	0	0.0%	0	0.0%	612,717	100%	0	0.0%	0	0.0%	1,314,808	100%	0	0.0%	0	0.0%
Revenue Code	114,569	100%	6	0.0%	3	0.0%	107,527	100%	6	0.0%	0	0.0%	222,096	100%	12	0.0%	3	0.0%
Service Provider NPI	776,227	99.2%	2,382	0.3%	3,563	0.5%	674,310	99.0%	2,840	0.4%	4,254	0.6%	1,450,537	99.1%	5,222	0.4%	7,817	0.5%
Surgical Procedure Code	5,546	80.3%	0	0.0%	1,362	19.7%	4,444	86.9%	0	0.0%	670	13.1%	9,990	83.1%	0	0.0%	2,032	16.9%
Tooth Number	72,731	99.4%	0	0.0%	442	0.6%	63,163	99.4%	0	0.0%	410	0.6%	135,894	99.4%	0	0.0%	852	0.6%
Tooth Surface	73,171	100%	0	0.0%	2	0.0%	63,570	100%	0	0.0%	3	0.0%	136,741	100%	0	0.0%	5	0.0%
Total	10,486,086	95.4%	76,810	0.7%	428,846	3.9%	9,135,580	95.3%	64,037	0.7%	383,993	4.0%	19,621,666	95.4%	140,847	0.7%	812,839	4.0%
Rx																		
Billed Charges	332,665	85.2%	18	0.0%	57,791	14.8%	364,390	86.2%	15	0.0%	58,116	13.8%	697,055	85.7%	33	0.0%	115,907	14.3%
Date Filled	390,474	100%	0	0.0%	0	0.0%	422,521	100%	0	0.0%	0	0.0%	812,995	100%	0	0.0%	0	0.0%
Days Supply	390,471	100%	0	0.0%	3	0.0%	422,521	100%	0	0.0%	0	0.0%	812,992	100%	0	0.0%	3	0.0%
Former ICN	97,523	25.0%	0	0.0%	292,951	75.0%	106,927	25.3%	0	0.0%	315,594	74.7%	204,450	25.1%	0	0.0%	608,545	74.9%
Health Plan Paid Amount	389,362	99.7%	8	0.0%	1,104	0.3%	421,525	99.8%	18	0.0%	978	0.2%	810,887	99.7%	26	0.0%	2,082	0.3%

Table E-8. Key Data Element Comparison – HHW

Key Data Element	March 2022						September 2022						Total					
	Valid		Missing		Erroneous		Valid		Missing		Erroneous		Valid		Missing		Erroneous	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Health Plan Paid Date	304,600	78.0%	0	0.0%	85,874	22.0%	299,981	71.0%	0	0.0%	122,540	29.0%	604,581	74.4%	0	0.0%	208,414	25.6%
MMIS ICN	390,468	100%	0	0.0%	6	0.0%	422,520	100%	0	0.0%	1	0.0%	812,988	100%	0	0.0%	7	0.0%
MMIS Enrollee ID	390,362	100%	0	0.0%	112	0.0%	422,447	100%	0	0.0%	74	0.0%	812,809	100%	0	0.0%	186	0.0%
NDC	389,854	99.8%	2	0.0%	618	0.2%	421,948	99.9%	0	0.0%	573	0.1%	811,802	99.9%	2	0.0%	1,191	0.1%
Prescriber NPI	390,329	100%	69	0.0%	76	0.0%	422,424	100%	56	0.0%	41	0.0%	812,753	100%	125	0.0%	117	0.0%
Prescription Number	381,773	97.8%	0	0.0%	8,701	2.2%	422,521	100%	0	0.0%	0	0.0%	804,294	98.9%	0	0.0%	8,701	1.1%
Quantity Dispensed	390,474	100%	0	0.0%	0	0.0%	422,520	100%	0	0.0%	1	0.0%	812,994	100%	0	0.0%	1	0.0%
Refill Number	390,474	100%	0	0.0%	0	0.0%	422,521	100%	0	0.0%	0	0.0%	812,995	100%	0	0.0%	0	0.0%
Total	4,628,829	91.2%	97	0.0%	447,236	8.8%	4,994,766	90.9%	89	0.0%	497,918	9.1%	9,623,595	91.1%	186	0.0%	945,154	8.9%

Table E-9. Key Data Element Comparison – HIP

Key Data Element	March 2022						September 2022						Total					
	Valid		Missing		Erroneous		Valid		Missing		Erroneous		Valid		Missing		Erroneous	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Non-Rx																		
Admission Date	5,250	39.6%	7,945	59.9%	63	0.5%	4,767	44.7%	5,836	54.7%	60	0.6%	10,017	41.9%	13,781	57.6%	123	0.5%
Bill Type	157,603	66.4%	7,945	3.3%	71,853	30.3%	197,374	72.3%	5,834	2.1%	69,768	25.6%	354,977	69.6%	13,779	2.7%	141,621	27.7%
Billed Charges	1,451,111	98.7%	0	0.0%	18,292	1.2%	1,333,859	98.4%	0	0.0%	22,270	1.6%	2,784,970	98.5%	0	0.0%	40,562	1.4%
Billing Provider NPI	1,369,167	93.1%	49,251	3.3%	52,314	3.6%	1,260,754	93.0%	42,887	3.2%	52,494	3.9%	2,629,921	93.0%	92,138	3.3%	104,808	3.7%
Date of Service (First)	1,470,705	100%	0	0.0%	27	0.0%	1,356,112	100%	0	0.0%	23	0.0%	2,826,817	100%	0	0.0%	50	0.0%
Date of Service (Last)	1,429,784	100%	0	0.0%	360	0.0%	1,320,306	100%	0	0.0%	479	0.0%	2,750,090	100%	0	0.0%	839	0.0%
Diagnosis Code	1,379,275	96.4%	0	0.0%	50,864	3.6%	1,270,458	96.2%	0	0.0%	50,327	3.8%	2,649,733	96.3%	0	0.0%	101,191	3.7%
Former ICN	1,418,699	96.5%	0	0.0%	52,033	3.5%	1,309,300	96.5%	0	0.0%	46,835	3.5%	2,727,999	96.5%	0	0.0%	98,868	3.5%
Health Plan Paid Amount	1,452,224	98.7%	13,957	0.9%	4,551	0.3%	1,342,582	99.0%	4,347	0.3%	9,206	0.7%	2,794,806	98.9%	18,304	0.6%	13,757	0.5%
Health Plan Paid Date	733,487	49.9%	146,273	9.9%	590,972	40.2%	639,402	47.1%	128,323	9.5%	588,410	43.4%	1,372,889	48.6%	274,596	9.7%	1,179,382	41.7%
MMIS ICN	1,444,642	98.2%	0	0.0%	26,090	1.8%	1,326,379	97.8%	0	0.0%	29,756	2.2%	2,771,021	98.0%	0	0.0%	55,846	2.0%
MMIS Enrollee ID	1,439,734	97.9%	0	0.0%	30,998	2.1%	1,326,536	97.8%	0	0.0%	29,599	2.2%	2,766,270	97.9%	0	0.0%	60,597	2.1%
Place of Service	1,223,115	99.2%	6	0.0%	10,210	0.8%	1,071,054	98.9%	0	0.0%	12,105	1.1%	2,294,169	99.0%	6	0.0%	22,315	1.0%
Procedure Code	1,443,511	99.0%	3	0.0%	13,960	1.0%	1,333,829	99.1%	0	0.0%	11,643	0.9%	2,777,340	99.1%	3	0.0%	25,603	0.9%
Procedure Modifier	1,416,886	100%	0	0.0%	0	0.0%	1,310,122	100%	0	0.0%	0	0.0%	2,727,008	100%	0	0.0%	0	0.0%
Revenue Code	237,362	100%	16	0.0%	23	0.0%	272,944	100%	15	0.0%	17	0.0%	510,306	100%	31	0.0%	40	0.0%
Service Provider NPI	1,406,442	95.6%	40,592	2.8%	23,698	1.6%	1,288,665	95.0%	38,542	2.8%	28,928	2.1%	2,695,107	95.3%	79,134	2.8%	52,626	1.9%
Surgical Procedure Code	10,970	82.7%	0	0.0%	2,288	17.3%	8,563	80.3%	0	0.0%	2,100	19.7%	19,533	81.7%	0	0.0%	4,388	18.3%
Tooth Number	39,413	97.1%	0	0.0%	1,175	2.9%	34,244	96.9%	0	0.0%	1,106	3.1%	73,657	97.0%	0	0.0%	2,281	3.0%
Tooth Surface	40,588	100%	0	0.0%	0	0.0%	35,344	100%	0	0.0%	6	0.0%	75,932	100%	0	0.0%	6	0.0%
Total	19,569,968	94.1%	265,988	1.3%	949,771	4.6%	18,042,594	93.9%	225,784	1.2%	955,132	5.0%	37,612,562	94.0%	491,772	1.2%	1,904,903	4.8%

Table E-9. Key Data Element Comparison – HIP

Key Data Element	March 2022						September 2022						Total					
	Valid		Missing		Erroneous		Valid		Missing		Erroneous		Valid		Missing		Erroneous	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Rx																		
Billed Charges	1,240,651	82.1%	12	0.0%	271,289	17.9%	1,270,999	83.5%	18	0.0%	251,006	16.5%	2,511,650	82.8%	30	0.0%	522,295	17.2%
Date Filled	1,511,952	100%	0	0.0%	0	0.0%	1,522,023	100%	0	0.0%	0	0.0%	3,033,975	100%	0	0.0%	0	0.0%
Days Supply	1,511,948	100%	0	0.0%	4	0.0%	1,522,022	100%	0	0.0%	1	0.0%	3,033,970	100%	0	0.0%	5	0.0%
Former ICN	410,373	27.1%	0	0.0%	1,101,579	72.9%	407,975	26.8%	0	0.0%	1,114,048	73.2%	818,348	27.0%	0	0.0%	2,215,627	73.0%
Health Plan Paid Amount	1,507,714	99.7%	34	0.0%	4,204	0.3%	1,519,026	99.8%	45	0.0%	2,952	0.2%	3,026,740	99.8%	79	0.0%	7,156	0.2%
Health Plan Paid Date	1,228,140	81.2%	0	0.0%	283,812	18.8%	1,142,103	75.0%	0	0.0%	379,920	25.0%	2,370,243	78.1%	0	0.0%	663,732	21.9%
MMIS ICN	1,511,923	100%	0	0.0%	29	0.0%	1,522,011	100%	0	0.0%	12	0.0%	3,033,934	100%	0	0.0%	41	0.0%
MMIS Enrollee ID	1,511,656	100%	0	0.0%	296	0.0%	1,521,811	100%	0	0.0%	212	0.0%	3,033,467	100%	0	0.0%	508	0.0%
NDC	1,511,517	100%	0	0.0%	435	0.0%	1,521,683	100%	1	0.0%	339	0.0%	3,033,200	100%	1	0.0%	774	0.0%
Prescriber NPI	1,510,783	99.9%	292	0.0%	877	0.1%	1,521,557	100%	190	0.0%	276	0.0%	3,032,340	99.9%	482	0.0%	1,153	0.0%
Prescription Number	1,483,840	98.1%	0	0.0%	28,112	1.9%	1,522,023	100%	0	0.0%	0	0.0%	3,005,863	99.1%	0	0.0%	28,112	0.9%
Quantity Dispensed	1,511,946	100%	0	0.0%	6	0.0%	1,522,020	100%	0	0.0%	3	0.0%	3,033,966	100%	0	0.0%	9	0.0%
Refill Number	1,511,950	100%	0	0.0%	2	0.0%	1,522,021	100%	0	0.0%	2	0.0%	3,033,971	100%	0	0.0%	4	0.0%
Total	17,964,393	91.4%	338	0.0%	1,690,645	8.6%	18,037,274	91.2%	254	0.0%	1,748,771	8.8%	36,001,667	91.3%	592	0.0%	3,439,416	8.7%

Table E-10. Key Data Element Comparison – Anthem

Key Data Element	March 2022						September 2022						Total					
	Valid		Missing		Erroneous		Valid		Missing		Erroneous		Valid		Missing		Erroneous	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Non-Rx																		
Admission Date	4,810	46.7%	5,490	53.3%	5	0.0%	4,596	48.2%	4,923	51.6%	25	0.3%	9,406	47.4%	10,413	52.5%	30	0.2%
Bill Type	147,586	80.8%	5,490	3.0%	29,646	16.2%	150,881	79.9%	4,921	2.6%	33,050	17.5%	298,467	80.3%	10,411	2.8%	62,696	16.9%
Billed Charges	1,204,494	99.7%	0	0.0%	755	0.1%	1,191,214	99.9%	0	0.0%	717	0.1%	2,395,708	99.8%	0	0.0%	1,472	0.1%
Billing Provider NPI	1,077,327	89.2%	66,043	5.5%	64,162	5.3%	1,066,610	89.5%	66,296	5.6%	59,038	5.0%	2,143,937	89.4%	132,339	5.5%	123,200	5.1%
Date of Service (First)	1,207,518	100%	0	0.0%	14	0.0%	1,191,938	100%	0	0.0%	6	0.0%	2,399,456	100%	0	0.0%	20	0.0%
Date of Service (Last)	1,153,240	100%	0	0.0%	33	0.0%	1,147,469	100%	0	0.0%	23	0.0%	2,300,709	100%	0	0.0%	56	0.0%
Diagnosis Code	1,087,251	94.3%	0	0.0%	66,021	5.7%	1,084,240	94.5%	0	0.0%	63,252	5.5%	2,171,491	94.4%	0	0.0%	129,273	5.6%
Former ICN	1,198,794	99.3%	0	0.0%	8,738	0.7%	1,189,138	99.8%	0	0.0%	2,806	0.2%	2,387,932	99.5%	0	0.0%	11,544	0.5%
Health Plan Paid Amount	1,204,773	99.8%	1,787	0.1%	972	0.1%	1,187,691	99.6%	3,275	0.3%	978	0.1%	2,392,464	99.7%	5,062	0.2%	1,950	0.1%
Health Plan Paid Date	142,167	11.8%	149,819	12.4%	915,546	75.8%	125,539	10.5%	144,956	12.2%	921,449	77.3%	267,706	11.2%	294,775	12.3%	1,836,995	76.6%
MMIS ICN	1,202,565	99.6%	0	0.0%	4,967	0.4%	1,184,501	99.4%	0	0.0%	7,443	0.6%	2,387,066	99.5%	0	0.0%	12,410	0.5%
MMIS Enrollee ID	1,186,364	98.2%	0	0.0%	21,168	1.8%	1,172,958	98.4%	0	0.0%	18,986	1.6%	2,359,322	98.3%	0	0.0%	40,154	1.7%
Place of Service	1,023,690	99.9%	11	0.0%	1,109	0.1%	1,002,200	99.9%	0	0.0%	892	0.1%	2,025,890	99.9%	11	0.0%	2,001	0.1%
Procedure Code	1,194,702	99.8%	4	0.0%	2,521	0.2%	1,182,102	100%	0	0.0%	298	0.0%	2,376,804	99.9%	4	0.0%	2,819	0.1%
Procedure Modifier	1,142,968	100%	0	0.0%	0	0.0%	1,137,948	100%	0	0.0%	0	0.0%	2,280,916	100%	0	0.0%	0	0.0%

Table E-10. Key Data Element Comparison – Anthem

Key Data Element	March 2022						September 2022						Total					
	Valid		Missing		Erroneous		Valid		Missing		Erroneous		Valid		Missing		Erroneous	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Revenue Code	182,680	100%	27	0.0%	15	0.0%	188,817	100%	24	0.0%	11	0.0%	371,497	100%	51	0.0%	26	0.0%
Service Provider NPI	1,127,067	93.3%	53,159	4.4%	27,306	2.3%	1,112,871	93.4%	51,735	4.3%	27,338	2.3%	2,239,938	93.4%	104,894	4.4%	54,644	2.3%
Surgical Procedure Code	7,186	69.7%	0	0.0%	3,119	30.3%	6,800	71.2%	0	0.0%	2,744	28.8%	13,986	70.5%	0	0.0%	5,863	29.5%
Tooth Number	53,118	97.9%	0	0.0%	1,141	2.1%	43,264	97.3%	0	0.0%	1,188	2.7%	96,382	97.6%	0	0.0%	2,329	2.4%
Tooth Surface	54,258	100%	0	0.0%	1	0.0%	44,441	100%	0	0.0%	11	0.0%	98,699	100%	0	0.0%	12	0.0%
Total	15,602,558	91.6%	281,830	1.7%	1,147,239	6.7%	15,415,218	91.6%	276,130	1.6%	1,140,255	6.8%	31,017,776	91.6%	557,960	1.6%	2,287,494	6.8%
Rx																		
Billed Charges	1,237,774	75.1%	0	0.0%	409,620	24.9%	1,291,034	77.5%	0	0.0%	374,435	22.5%	2,528,808	76.3%	0	0.0%	784,055	23.7%
Date Filled	1,647,394	100%	0	0.0%	0	0.0%	1,665,469	100%	0	0.0%	0	0.0%	3,312,863	100%	0	0.0%	0	0.0%
Days Supply	1,647,362	100%	1	0.0%	31	0.0%	1,665,414	100%	0	0.0%	55	0.0%	3,312,776	100%	1	0.0%	86	0.0%
Former ICN	639,327	38.8%	0	0.0%	1,008,067	61.2%	634,621	38.1%	0	0.0%	1,030,848	61.9%	1,273,948	38.5%	0	0.0%	2,038,915	61.5%
Health Plan Paid Amount	1,640,456	99.6%	48	0.0%	6,890	0.4%	1,660,516	99.7%	85	0.0%	4,868	0.3%	3,300,972	99.6%	133	0.0%	11,758	0.4%
Health Plan Paid Date	1,603,568	97.3%	0	0.0%	43,826	2.7%	1,618,464	97.2%	0	0.0%	47,005	2.8%	3,222,032	97.3%	0	0.0%	90,831	2.7%
MMIS ICN	1,647,116	100%	0	0.0%	278	0.0%	1,665,158	100%	0	0.0%	311	0.0%	3,312,274	100%	0	0.0%	589	0.0%
MMIS Enrollee ID	1,646,864	100%	0	0.0%	530	0.0%	1,665,123	100%	0	0.0%	346	0.0%	3,311,987	100%	0	0.0%	876	0.0%
NDC	1,647,380	100%	2	0.0%	12	0.0%	1,665,459	100%	1	0.0%	9	0.0%	3,312,839	100%	3	0.0%	21	0.0%
Prescriber NPI	1,646,031	99.9%	472	0.0%	891	0.1%	1,664,861	100%	305	0.0%	303	0.0%	3,310,892	99.9%	777	0.0%	1,194	0.0%
Prescription Number	1,647,394	100%	0	0.0%	0	0.0%	1,665,469	100%	0	0.0%	0	0.0%	3,312,863	100%	0	0.0%	0	0.0%
Quantity Dispensed	1,647,372	100%	0	0.0%	22	0.0%	1,665,426	100%	0	0.0%	43	0.0%	3,312,798	100%	0	0.0%	65	0.0%
Refill Number	1,647,345	100%	0	0.0%	49	0.0%	1,665,420	100%	0	0.0%	49	0.0%	3,312,765	100%	0	0.0%	98	0.0%
Total	19,945,383	93.1%	523	0.0%	1,470,216	6.9%	20,192,434	93.3%	391	0.0%	1,458,272	6.7%	40,137,817	93.2%	914	0.0%	2,928,488	6.8%

Table E-11. Key Data Element Comparison – CS

Key Data Element	March 2022						September 2022						Total					
	Valid		Missing		Erroneous		Valid		Missing		Erroneous		Valid		Missing		Erroneous	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Non-Rx																		
Admission Date	1,027	67.9%	486	32.1%	0	0.0%	874	68.4%	403	31.6%	0	0.0%	1,901	68.1%	889	31.9%	0	0.0%
Bill Type	23,256	79.1%	486	1.7%	5,660	19.3%	31,677	87.7%	403	1.1%	4,036	11.2%	54,933	83.8%	889	1.4%	9,696	14.8%
Billed Charges	162,553	98.6%	0	0.0%	2,256	1.4%	157,975	97.1%	0	0.0%	4,650	2.9%	320,528	97.9%	0	0.0%	6,906	2.1%
Billing Provider NPI	151,447	91.9%	30	0.0%	13,332	8.1%	153,719	94.5%	19	0.0%	8,887	5.5%	305,166	93.2%	49	0.0%	22,219	6.8%
Date of Service (First)	164,809	100%	0	0.0%	0	0.0%	162,625	100%	0	0.0%	0	0.0%	327,434	100%	0	0.0%	0	0.0%
Date of Service (Last)	156,467	99.8%	0	0.0%	247	0.2%	153,374	99.7%	0	0.0%	417	0.3%	309,841	99.8%	0	0.0%	664	0.2%
Diagnosis Code	156,711	100%	0	0.0%	3	0.0%	153,780	100%	0	0.0%	11	0.0%	310,491	100%	0	0.0%	14	0.0%
Former ICN	156,033	94.7%	0	0.0%	8,776	5.3%	158,023	97.2%	0	0.0%	4,602	2.8%	314,056	95.9%	0	0.0%	13,378	4.1%
Health Plan Paid Amount	162,255	98.5%	1,713	1.0%	841	0.5%	159,302	98.0%	0	0.0%	3,323	2.0%	321,557	98.2%	1,713	0.5%	4,164	1.3%

Table E-11. Key Data Element Comparison – CS

Key Data Element	March 2022						September 2022						Total					
	Valid		Missing		Erroneous		Valid		Missing		Erroneous		Valid		Missing		Erroneous	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Health Plan Paid Date	135,956	82.5%	25,824	15.7%	3,029	1.8%	141,548	87.0%	19,790	12.2%	1,287	0.8%	277,504	84.8%	45,614	13.9%	4,316	1.3%
MMIS ICN	146,436	88.9%	0	0.0%	18,373	11.1%	146,772	90.3%	0	0.0%	15,853	9.7%	293,208	89.5%	0	0.0%	34,226	10.5%
MMIS Enrollee ID	158,231	96.0%	0	0.0%	6,578	4.0%	159,755	98.2%	0	0.0%	2,870	1.8%	317,986	97.1%	0	0.0%	9,448	2.9%
Place of Service	131,809	97.3%	0	0.0%	3,598	2.7%	122,306	96.7%	0	0.0%	4,203	3.3%	254,115	97.0%	0	0.0%	7,801	3.0%
Procedure Code	163,282	100%	0	0.0%	14	0.0%	161,336	100%	0	0.0%	12	0.0%	324,618	100%	0	0.0%	26	0.0%
Procedure Modifier	155,201	100%	0	0.0%	0	0.0%	152,514	100%	0	0.0%	0	0.0%	307,715	100%	0	0.0%	0	0.0%
Revenue Code	29,402	100%	0	0.0%	0	0.0%	36,114	100%	0	0.0%	2	0.0%	65,516	100%	0	0.0%	2	0.0%
Service Provider NPI	164,504	99.8%	2	0.0%	303	0.2%	162,532	99.9%	0	0.0%	93	0.1%	327,036	99.9%	2	0.0%	396	0.1%
Surgical Procedure Code	1,182	78.1%	0	0.0%	331	21.9%	1,031	80.7%	0	0.0%	246	19.3%	2,213	79.3%	0	0.0%	577	20.7%
Tooth Number	8,089	99.9%	0	0.0%	6	0.1%	8,831	100%	0	0.0%	3	0.0%	16,920	99.9%	0	0.0%	9	0.1%
Tooth Surface	8,095	100%	0	0.0%	0	0.0%	8,834	100%	0	0.0%	0	0.0%	16,929	100%	0	0.0%	0	0.0%
Total	2,236,745	96.1%	28,541	1.2%	63,347	2.7%	2,232,922	96.9%	20,615	0.9%	50,495	2.2%	4,469,667	96.5%	49,156	1.1%	113,842	2.5%
Rx																		
Billed Charges	135,814	100%	0	0.0%	5	0.0%	169,054	100%	0	0.0%	0	0.0%	304,868	100%	0	0.0%	5	0.0%
Date Filled	135,819	100%	0	0.0%	0	0.0%	169,054	100%	0	0.0%	0	0.0%	304,873	100%	0	0.0%	0	0.0%
Days Supply	135,818	100%	0	0.0%	1	0.0%	169,054	100%	0	0.0%	0	0.0%	304,872	100%	0	0.0%	1	0.0%
Former ICN	0	0.0%	0	0.0%	135,819	100%	0	0.0%	0	0.0%	169,054	100%	0	0.0%	0	0.0%	304,873	100%
Health Plan Paid Amount	134,089	98.7%	123	0.1%	1,607	1.2%	166,729	98.6%	193	0.1%	2,132	1.3%	300,818	98.7%	316	0.1%	3,739	1.2%
Health Plan Paid Date	102,573	75.5%	0	0.0%	33,246	24.5%	124,778	73.8%	0	0.0%	44,276	26.2%	227,351	74.6%	0	0.0%	77,522	25.4%
MMIS ICN	0	0.0%	0	0.0%	135,819	100%	0	0.0%	0	0.0%	169,054	100%	0	0.0%	0	0.0%	304,873	100%
MMIS Enrollee ID	135,819	100%	0	0.0%	0	0.0%	169,054	100%	0	0.0%	0	0.0%	304,873	100%	0	0.0%	0	0.0%
NDC	135,819	100%	0	0.0%	0	0.0%	169,054	100%	0	0.0%	0	0.0%	304,873	100%	0	0.0%	0	0.0%
Prescriber NPI	0	0.0%	23	0.0%	135,796	100%	0	0.0%	39	0.0%	169,015	100%	0	0.0%	62	0.0%	304,811	100%
Prescription Number	135,819	100%	0	0.0%	0	0.0%	169,054	100%	0	0.0%	0	0.0%	304,873	100%	0	0.0%	0	0.0%
Quantity Dispensed	135,817	100%	0	0.0%	2	0.0%	169,054	100%	0	0.0%	0	0.0%	304,871	100%	0	0.0%	2	0.0%
Refill Number	65,331	48.1%	0	0.0%	70,488	51.9%	81,138	48.0%	0	0.0%	87,916	52.0%	146,469	48.0%	0	0.0%	158,404	52.0%
Total	1,252,718	70.9%	146	0.0%	512,783	29.0%	1,556,023	70.8%	232	0.0%	641,447	29.2%	2,808,741	70.9%	378	0.0%	1,154,230	29.1%

Table E-12. Key Data Element Comparison – MDwise

Key Data Element	March 2022						September 2022						Total					
	Valid		Missing		Erroneous		Valid		Missing		Erroneous		Valid		Missing		Erroneous	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Non-Rx																		
Admission Date	1,156	16.8%	5,744	83.2%	0	0.0%	269	7.3%	3,409	92.7%	0	0.0%	1,425	13.5%	9,153	86.5%	0	0.0%
Bill Type	41,240	41.2%	5,744	5.7%	53,221	53.1%	66,625	55.0%	3,409	2.8%	51,080	42.2%	107,865	48.7%	9,153	4.1%	104,301	47.1%
Billed Charges	664,492	99.9%	0	0.0%	468	0.1%	504,431	99.9%	0	0.0%	302	0.1%	1,168,923	99.9%	0	0.0%	770	0.1%

Table E-12. Key Data Element Comparison – MDwise

Key Data Element	March 2022						September 2022						Total					
	Valid		Missing		Erroneous		Valid		Missing		Erroneous		Valid		Missing		Erroneous	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Billing Provider NPI	655,239	98.5%	356	0.1%	9,365	1.4%	496,916	98.5%	153	0.0%	7,664	1.5%	1,152,155	98.5%	509	0.0%	17,029	1.5%
Date of Service (First)	664,958	100%	0	0.0%	2	0.0%	504,729	100%	0	0.0%	4	0.0%	1,169,687	100%	0	0.0%	6	0.0%
Date of Service (Last)	631,629	100%	0	0.0%	173	0.0%	480,456	100%	0	0.0%	142	0.0%	1,112,085	100%	0	0.0%	315	0.0%
Diagnosis Code	626,233	99.1%	0	0.0%	5,567	0.9%	471,339	98.1%	0	0.0%	9,259	1.9%	1,097,572	98.7%	0	0.0%	14,826	1.3%
Former ICN	629,338	94.6%	0	0.0%	35,622	5.4%	474,001	93.9%	0	0.0%	30,732	6.1%	1,103,339	94.3%	0	0.0%	66,354	5.7%
Health Plan Paid Amount	651,066	97.9%	13,797	2.1%	97	0.0%	501,625	99.4%	1,490	0.3%	1,618	0.3%	1,152,691	98.5%	15,287	1.3%	1,715	0.1%
Health Plan Paid Date	581,396	87.4%	47,964	7.2%	35,600	5.4%	445,397	88.2%	31,009	6.1%	28,327	5.6%	1,026,793	87.8%	78,973	6.8%	63,927	5.5%
MMIS ICN	626,239	94.2%	0	0.0%	38,721	5.8%	471,354	93.4%	0	0.0%	33,379	6.6%	1,097,593	93.8%	0	0.0%	72,100	6.2%
MMIS Enrollee ID	625,798	94.1%	0	0.0%	39,162	5.9%	471,250	93.4%	0	0.0%	33,483	6.6%	1,097,048	93.8%	0	0.0%	72,645	6.2%
Place of Service	564,214	99.9%	0	0.0%	541	0.1%	383,183	99.9%	0	0.0%	436	0.1%	947,397	99.9%	0	0.0%	977	0.1%
Procedure Code	657,510	99.9%	0	0.0%	550	0.1%	501,037	100%	0	0.0%	18	0.0%	1,158,547	100%	0	0.0%	568	0.0%
Procedure Modifier	624,902	100%	0	0.0%	0	0.0%	476,920	100%	0	0.0%	0	0.0%	1,101,822	100%	0	0.0%	0	0.0%
Revenue Code	100,197	100%	0	0.0%	8	0.0%	121,113	100%	0	0.0%	1	0.0%	221,310	100%	0	0.0%	9	0.0%
Service Provider NPI	664,507	99.9%	14	0.0%	439	0.1%	497,972	98.7%	5,079	1.0%	1,682	0.3%	1,162,479	99.4%	5,093	0.4%	2,121	0.2%
Surgical Procedure Code	6,415	93.0%	0	0.0%	485	7.0%	3,655	99.4%	0	0.0%	23	0.6%	10,070	95.2%	0	0.0%	508	4.8%
Tooth Number	32,490	98.0%	0	0.0%	668	2.0%	23,634	97.9%	0	0.0%	501	2.1%	56,124	98.0%	0	0.0%	1,169	2.0%
Tooth Surface	33,157	100%	0	0.0%	1	0.0%	24,135	100%	0	0.0%	0	0.0%	57,292	100%	0	0.0%	1	0.0%
Total	9,082,176	96.9%	73,619	0.8%	220,690	2.4%	6,920,041	96.6%	44,549	0.6%	198,651	2.8%	16,002,217	96.8%	118,168	0.7%	419,341	2.5%
Rx																		
Billed Charges	599,298	99.1%	30	0.0%	5,368	0.9%	600,796	98.8%	33	0.0%	7,104	1.2%	1,200,094	99.0%	63	0.0%	12,472	1.0%
Date Filled	604,696	100%	0	0.0%	0	0.0%	607,933	100%	0	0.0%	0	0.0%	1,212,629	100%	0	0.0%	0	0.0%
Days Supply	604,696	100%	0	0.0%	0	0.0%	607,933	100%	0	0.0%	0	0.0%	1,212,629	100%	0	0.0%	0	0.0%
Former ICN	0	0.0%	0	0.0%	604,696	100%	0	0.0%	0	0.0%	607,933	100%	0	0.0%	0	0.0%	1,212,629	100%
Health Plan Paid Amount	604,694	100%	0	0.0%	2	0.0%	607,933	100%	0	0.0%	0	0.0%	1,212,627	100%	0	0.0%	2	0.0%
Health Plan Paid Date	271,520	44.9%	0	0.0%	333,176	55.1%	145,102	23.9%	0	0.0%	462,831	76.1%	416,622	34.4%	0	0.0%	796,007	65.6%
MMIS ICN	604,667	100%	0	0.0%	29	0.0%	607,933	100%	0	0.0%	0	0.0%	1,212,600	100%	0	0.0%	29	0.0%
MMIS Enrollee ID	604,684	100%	0	0.0%	12	0.0%	607,904	100%	0	0.0%	29	0.0%	1,212,588	100%	0	0.0%	41	0.0%
NDC	603,651	99.8%	0	0.0%	1,045	0.2%	607,025	99.9%	0	0.0%	908	0.1%	1,210,676	99.8%	0	0.0%	1,953	0.2%
Prescriber NPI	604,584	100%	0	0.0%	112	0.0%	607,872	100%	0	0.0%	61	0.0%	1,212,456	100%	0	0.0%	173	0.0%
Prescription Number	567,883	93.9%	0	0.0%	36,813	6.1%	607,933	100%	0	0.0%	0	0.0%	1,175,816	97.0%	0	0.0%	36,813	3.0%
Quantity Dispensed	604,694	100%	0	0.0%	2	0.0%	607,933	100%	0	0.0%	0	0.0%	1,212,627	100%	0	0.0%	2	0.0%
Refill Number	604,696	100%	0	0.0%	0	0.0%	607,933	100%	0	0.0%	0	0.0%	1,212,629	100%	0	0.0%	0	0.0%
Total	6,879,763	87.5%	30	0.0%	981,255	12.5%	6,824,230	86.3%	33	0.0%	1,078,866	13.7%	13,703,993	86.9%	63	0.0%	2,060,121	13.1%

Table E-13. Key Data Element Comparison – MHS

Key Data Element	March 2022						September 2022						Total					
	Valid		Missing		Erroneous		Valid		Missing		Erroneous		Valid		Missing		Erroneous	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Non-Rx																		
Admission Date	3,321	86.5%	429	11.2%	89	2.3%	2,969	85.4%	433	12.4%	76	2.2%	6,290	86.0%	862	11.8%	165	2.3%
Bill Type	78,739	91.0%	429	0.5%	7,324	8.5%	71,739	90.3%	433	0.5%	7,242	9.1%	150,478	90.7%	862	0.5%	14,566	8.8%
Billed Charges	463,793	92.9%	0	0.0%	35,611	7.1%	405,114	92.1%	0	0.0%	34,690	7.9%	868,907	92.5%	0	0.0%	70,301	7.5%
Billing Provider NPI	480,964	96.3%	10,596	2.1%	7,844	1.6%	419,147	95.3%	325	0.1%	20,332	4.6%	900,111	95.8%	10,921	1.2%	28,176	3.0%
Date of Service (First)	499,363	100%	0	0.0%	41	0.0%	439,775	100%	0	0.0%	29	0.0%	939,138	100%	0	0.0%	70	0.0%
Date of Service (Last)	474,415	100%	0	0.0%	0	0.0%	412,431	100%	0	0.0%	2	0.0%	886,846	100%	0	0.0%	2	0.0%
Diagnosis Code	474,391	100%	0	0.0%	4	0.0%	412,420	100%	0	0.0%	6	0.0%	886,811	100%	0	0.0%	10	0.0%
Former ICN	463,413	92.8%	0	0.0%	35,991	7.2%	414,124	94.2%	0	0.0%	25,680	5.8%	877,537	93.4%	0	0.0%	61,671	6.6%
Health Plan Paid Amount	489,305	98.0%	3,952	0.8%	6,147	1.2%	432,501	98.3%	229	0.1%	7,074	1.6%	921,806	98.1%	4,181	0.4%	13,221	1.4%
Health Plan Paid Date	467,019	93.5%	7,478	1.5%	24,907	5.0%	423,436	96.3%	1,712	0.4%	14,656	3.3%	890,455	94.8%	9,190	1.0%	39,563	4.2%
MMIS ICN	499,361	100%	0	0.0%	43	0.0%	439,779	100%	0	0.0%	25	0.0%	939,140	100%	0	0.0%	68	0.0%
MMIS Enrollee ID	488,557	97.8%	0	0.0%	10,847	2.2%	428,617	97.5%	0	0.0%	11,187	2.5%	917,174	97.7%	0	0.0%	22,034	2.3%
Place of Service	400,902	97.1%	0	0.0%	12,010	2.9%	346,670	96.2%	0	0.0%	13,720	3.8%	747,572	96.7%	0	0.0%	25,730	3.3%
Procedure Code	469,180	94.7%	0	0.0%	26,385	5.3%	411,270	94.3%	0	0.0%	25,056	5.7%	880,450	94.5%	0	0.0%	51,441	5.5%
Procedure Modifier	470,576	100%	0	0.0%	0	0.0%	408,955	100%	0	0.0%	0	0.0%	879,531	100%	0	0.0%	0	0.0%
Revenue Code	86,488	100%	0	0.0%	4	0.0%	79,406	100%	0	0.0%	8	0.0%	165,894	100%	0	0.0%	12	0.0%
Service Provider NPI	483,145	96.7%	10,595	2.1%	5,664	1.1%	423,959	96.4%	310	0.1%	15,535	3.5%	907,104	96.6%	10,905	1.2%	21,199	2.3%
Surgical Procedure Code	3,587	93.4%	0	0.0%	252	6.6%	3,211	92.3%	0	0.0%	267	7.7%	6,798	92.9%	0	0.0%	519	7.1%
Tooth Number	24,984	100%	0	0.0%	5	0.0%	27,364	100%	0	0.0%	7	0.0%	52,348	100%	0	0.0%	12	0.0%
Tooth Surface	24,989	100%	0	0.0%	0	0.0%	27,371	100%	0	0.0%	0	0.0%	52,360	100%	0	0.0%	0	0.0%
Total	6,846,492	97.1%	33,479	0.5%	173,168	2.5%	6,030,258	97.1%	3,442	0.1%	175,592	2.8%	12,876,750	97.1%	36,921	0.3%	348,760	2.6%
Rx																		
Billed Charges	545,656	77.9%	0	0.0%	154,421	22.1%	571,681	80.9%	0	0.0%	134,722	19.1%	1,117,337	79.4%	0	0.0%	289,143	20.6%
Date Filled	700,077	100%	0	0.0%	0	0.0%	706,403	100%	0	0.0%	0	0.0%	1,406,480	100%	0	0.0%	0	0.0%
Days Supply	700,075	100%	0	0.0%	2	0.0%	706,400	100%	0	0.0%	3	0.0%	1,406,475	100%	0	0.0%	5	0.0%
Former ICN	260,592	37.2%	0	0.0%	439,485	62.8%	255,395	36.2%	0	0.0%	451,008	63.8%	515,987	36.7%	0	0.0%	890,493	63.3%
Health Plan Paid Amount	698,555	99.8%	3	0.0%	1,519	0.2%	705,405	99.9%	3	0.0%	995	0.1%	1,403,960	99.8%	6	0.0%	2,514	0.2%
Health Plan Paid Date	671,366	95.9%	0	0.0%	28,711	4.1%	675,642	95.6%	0	0.0%	30,761	4.4%	1,347,008	95.8%	0	0.0%	59,472	4.2%
MMIS ICN	700,077	100%	0	0.0%	0	0.0%	706,403	100%	0	0.0%	0	0.0%	1,406,480	100%	0	0.0%	0	0.0%
MMIS Enrollee ID	699,807	100%	0	0.0%	270	0.0%	706,188	100%	0	0.0%	215	0.0%	1,405,995	100%	0	0.0%	485	0.0%
NDC	700,069	100%	7	0.0%	1	0.0%	706,398	100%	5	0.0%	0	0.0%	1,406,467	100%	12	0.0%	1	0.0%
Prescriber NPI	699,598	99.9%	190	0.0%	289	0.0%	706,069	100%	87	0.0%	247	0.0%	1,405,667	99.9%	277	0.0%	536	0.0%
Prescription Number	700,077	100%	0	0.0%	0	0.0%	706,403	100%	0	0.0%	0	0.0%	1,406,480	100%	0	0.0%	0	0.0%
Quantity Dispensed	700,076	100%	0	0.0%	1	0.0%	706,400	100%	0	0.0%	3	0.0%	1,406,476	100%	0	0.0%	4	0.0%
Refill Number	700,077	100%	0	0.0%	0	0.0%	706,403	100%	0	0.0%	0	0.0%	1,406,480	100%	0	0.0%	0	0.0%
Total	8,476,102	93.1%	200	0.0%	624,699	6.9%	8,565,190	93.3%	95	0.0%	617,954	6.7%	17,041,292	93.2%	295	0.0%	1,242,653	6.8%

Table E-14. Key Data Element Comparison – UHC

Key Data Element	March 2022						September 2022						Total					
	Valid		Missing		Erroneous		Valid		Missing		Erroneous		Valid		Missing		Erroneous	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Non-Rx																		
Admission Date	1,467	70.0%	628	30.0%	0	0.0%	3,289	94.8%	180	5.2%	0	0.0%	4,756	85.5%	808	14.5%	0	0.0%
Bill Type	6,332	36.3%	11,108	63.7%	0	0.0%	2,200	60.2%	1,454	39.8%	0	0.0%	8,532	40.4%	12,562	59.6%	0	0.0%
Billed Charges	29,355	98.1%	0	0.0%	564	1.9%	16,705	98.9%	0	0.0%	191	1.1%	46,060	98.4%	0	0.0%	755	1.6%
Billing Provider NPI	2,605	8.7%	1,641	5.5%	25,673	85.8%	15,375	91.0%	1,050	6.2%	471	2.8%	17,980	38.4%	2,691	5.7%	26,144	55.8%
Date of Service (First)	29,901	99.9%	0	0.0%	18	0.1%	16,892	100%	0	0.0%	4	0.0%	46,793	100%	0	0.0%	22	0.0%
Date of Service (Last)	29,623	99.9%	0	0.0%	18	0.1%	16,587	100%	0	0.0%	8	0.0%	46,210	99.9%	0	0.0%	26	0.1%
Diagnosis Code	29,641	100%	0	0.0%	0	0.0%	16,594	100%	0	0.0%	1	0.0%	46,235	100%	0	0.0%	1	0.0%
Former ICN	28,809	96.3%	0	0.0%	1,110	3.7%	15,687	92.8%	0	0.0%	1,209	7.2%	44,496	95.0%	0	0.0%	2,319	5.0%
Health Plan Paid Amount	29,811	99.6%	93	0.3%	15	0.1%	16,848	99.7%	16	0.1%	32	0.2%	46,659	99.7%	109	0.2%	47	0.1%
Health Plan Paid Date	21,719	72.6%	7,193	24.0%	1,007	3.4%	11,205	66.3%	4,566	27.0%	1,125	6.7%	32,924	70.3%	11,759	25.1%	2,132	4.6%
MMIS ICN	1,646	5.5%	0	0.0%	28,273	94.5%	16,591	98.2%	0	0.0%	305	1.8%	18,237	39.0%	0	0.0%	28,578	61.0%
MMIS Enrollee ID	29,884	99.9%	0	0.0%	35	0.1%	16,875	99.9%	0	0.0%	21	0.1%	46,759	99.9%	0	0.0%	56	0.1%
Place of Service	12,441	99.7%	0	0.0%	38	0.3%	13,242	100%	0	0.0%	0	0.0%	25,683	99.9%	0	0.0%	38	0.1%
Procedure Code	27,814	100%	0	0.0%	10	0.0%	13,424	100%	0	0.0%	3	0.0%	41,238	100%	0	0.0%	13	0.0%
Procedure Modifier	27,546	100%	0	0.0%	0	0.0%	13,126	100%	0	0.0%	0	0.0%	40,672	100%	0	0.0%	0	0.0%
Revenue Code	17,440	100%	0	0.0%	0	0.0%	3,654	100%	0	0.0%	0	0.0%	21,094	100%	0	0.0%	0	0.0%
Service Provider NPI	13,647	45.6%	832	2.8%	15,440	51.6%	14,411	85.3%	286	1.7%	2,199	13.0%	28,058	59.9%	1,118	2.4%	17,639	37.7%
Surgical Procedure Code	1,768	84.4%	0	0.0%	327	15.6%	3,399	98.0%	0	0.0%	70	2.0%	5,167	92.9%	0	0.0%	397	7.1%
Tooth Number	274	98.6%	0	0.0%	4	1.4%	300	99.7%	0	0.0%	1	0.3%	574	99.1%	0	0.0%	5	0.9%
Tooth Surface	276	99.3%	0	0.0%	2	0.7%	301	100%	0	0.0%	0	0.0%	577	99.7%	0	0.0%	2	0.3%
Total	341,999	78.4%	21,495	4.9%	72,534	16.6%	226,705	94.5%	7,552	3.1%	5,640	2.4%	568,704	84.1%	29,047	4.3%	78,174	11.6%
Rx																		
Billed Charges	963	6.1%	0	0.0%	14,919	93.9%	1,110	6.6%	0	0.0%	15,607	93.4%	2,073	6.4%	0	0.0%	30,526	93.6%
Date Filled	15,882	100%	0	0.0%	0	0.0%	16,717	100%	0	0.0%	0	0.0%	32,599	100%	0	0.0%	0	0.0%
Days Supply	15,882	100%	0	0.0%	0	0.0%	16,717	100%	0	0.0%	0	0.0%	32,599	100%	0	0.0%	0	0.0%
Former ICN	0	0.0%	0	0.0%	15,882	100%	0	0.0%	0	0.0%	16,717	100%	0	0.0%	0	0.0%	32,599	100%
Health Plan Paid Amount	11,012	69.3%	4,870	30.7%	0	0.0%	12,169	72.8%	4,548	27.2%	0	0.0%	23,181	71.1%	9,418	28.9%	0	0.0%
Health Plan Paid Date	6,490	40.9%	0	0.0%	9,392	59.1%	6,182	37.0%	0	0.0%	10,535	63.0%	12,672	38.9%	0	0.0%	19,927	61.1%
MMIS ICN	0	0.0%	0	0.0%	15,882	100%	0	0.0%	0	0.0%	16,717	100%	0	0.0%	0	0.0%	32,599	100%
MMIS Enrollee ID	4	0.0%	0	0.0%	15,878	100%	2	0.0%	0	0.0%	16,715	100%	6	0.0%	0	0.0%	32,593	100%
NDC	15,836	99.7%	0	0.0%	46	0.3%	16,680	99.8%	0	0.0%	37	0.2%	32,516	99.7%	0	0.0%	83	0.3%
Prescriber NPI	15,881	100%	0	0.0%	1	0.0%	16,715	100%	0	0.0%	2	0.0%	32,596	100%	0	0.0%	3	0.0%
Prescription Number	15,882	100%	0	0.0%	0	0.0%	16,717	100%	0	0.0%	0	0.0%	32,599	100%	0	0.0%	0	0.0%
Quantity Dispensed	15,882	100%	0	0.0%	0	0.0%	16,717	100%	0	0.0%	0	0.0%	32,599	100%	0	0.0%	0	0.0%
Refill Number	15,882	100%	0	0.0%	0	0.0%	16,717	100%	0	0.0%	0	0.0%	32,599	100%	0	0.0%	0	0.0%
Total	129,596	62.8%	4,870	2.4%	72,000	34.9%	136,443	62.8%	4,548	2.1%	76,330	35.1%	266,039	62.8%	9,418	2.2%	148,330	35.0%

Benefit Testing

Table E-15. Benefit Testing – HHW													
Category of Service	MCE Status	Anthem		CS		MDwise		MHS		UHC		Total	
		Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Chiropractic Services	Paid	151,091	90.00%	20,744	94.73%	89,557	94.83%	66,585	92.46%	N/A	N/A	327,977	92.07%
	Denied	16,792	10.00%	1155	5.27%	4,880	5.17%	5,427	7.54%	N/A	N/A	28,254	7.93%
Dental Services - Adult	Paid	139,679	1000%	75,051	1000%	36,461	1000%	38,592	1000%	N/A	N/A	289,783	1000%
	Denied	0	0.00%	0	0.00%	0	0.00%	0	0.00%	N/A	N/A	0	0.00%
Dental Services - Child	Paid	4,796,427	1000%	942,292	1000%	3,951,240	1000%	3,127,894	1000%	N/A	N/A	12,817,853	1000%
	Denied	0	0.00%	0	0.00%	0	0.00%	0	0.00%	N/A	N/A	0	0.00%
EPSDT Services	Paid	2,109,210	97.77%	546,997	98.28%	1,429,806	97.61%	1,277,968	99.40%	N/A	N/A	5,363,981	98.16%
	Denied	48053	2.23%	9600	1.72%	35015	2.39%	7731	0.60%	N/A	N/A	100399	1.84%
Eye Care and Exams	Paid	322,669	98.22%	64,454	99.64%	262,161	98.05%	176,798	99.08%	N/A	N/A	826,082	98.46%
	Denied	5838	1.78%	230	0.36%	5,212	1.95%	1649	0.92%	N/A	N/A	12,929	1.54%
Eyewear	Paid	277,414	97.20%	55,118	99.99%	262,780	97.74%	168,282	99.84%	N/A	N/A	763,594	98.16%
	Denied	7993	2.80%	7	0.01%	6064	2.26%	271	0.16%	N/A	N/A	14335	1.84%
HME/DME	Paid	53,444	94.42%	12,396	95.19%	43,697	89.40%	28,783	94.47%	N/A	N/A	138,320	92.85%
	Denied	3,158	5.58%	626	4.81%	5,180	10.60%	1686	5.53%	N/A	N/A	10,650	7.15%
Inpatient Services	Paid	55,725	89.85%	15,397	92.72%	41,575	91.38%	34,776	96.45%	N/A	N/A	147,473	92.07%
	Denied	6,298	10.15%	1209	7.28%	3,922	8.62%	1279	3.55%	N/A	N/A	12,708	7.93%
Lab Services	Paid	1,291,840	85.54%	239,504	83.76%	838,402	91.79%	809,256	90.04%	N/A	N/A	3,179,002	88.10%
	Denied	218,425	14.46%	46,453	16.24%	75,013	8.21%	89,545	9.96%	N/A	N/A	429,436	11.90%
Mental Health Services	Paid	399,765	95.27%	84,749	95.76%	324,329	96.45%	231,634	95.30%	N/A	N/A	1,040,477	95.68%
	Denied	19,843	4.73%	3751	4.24%	11,928	3.55%	11,427	4.70%	N/A	N/A	46,949	4.32%
Outpatient Services	Paid	7,904,917	94.79%	1,788,078	96.56%	6,086,039	95.89%	4,884,128	97.57%	N/A	N/A	20,663,162	95.91%
	Denied	434,836	5.21%	63,689	3.44%	261,087	4.11%	121,757	2.43%	N/A	N/A	881,369	4.09%
Physician Services	Paid	3,381,751	96.76%	747,818	97.28%	2,010,396	96.86%	1,878,251	98.21%	N/A	N/A	8,018,216	97.17%
	Denied	113,333	3.24%	20,939	2.72%	65,177	3.14%	34,274	1.79%	N/A	N/A	233,723	2.83%
Podiatrist Services	Paid	6,499	89.22%	1435	82.85%	10,945	94.08%	4,205	90.18%	N/A	N/A	23,084	91.19%
	Denied	785	10.78%	297	17.15%	689	5.92%	458	9.82%	N/A	N/A	2229	8.81%
Therapy Services - Audiology	Paid	4740	95.70%	771	94.02%	1178	92.54%	2185	94.55%	N/A	N/A	8,874	94.84%
	Denied	213	4.30%	49	5.98%	95	7.46%	126	5.45%	N/A	N/A	483	5.16%
Therapy Services - Occupational	Paid	23,385	97.04%	3902	96.49%	7,510	97.47%	9,542	95.05%	N/A	N/A	44,339	96.63%
	Denied	713	2.96%	142	3.51%	195	2.53%	497	4.95%	N/A	N/A	1547	3.37%
Therapy Services - Physical	Paid	112,711	92.34%	22,049	90.79%	98,762	94.84%	62,239	95.38%	N/A	N/A	295,761	93.67%
	Denied	9,354	7.66%	2237	9.21%	5,372	5.16%	3,014	4.62%	N/A	N/A	19,977	6.33%
Therapy Services - Respiratory	Paid	19,069	95.08%	3177	95.81%	12,027	97.67%	10,893	97.25%	N/A	N/A	45,166	96.33%
	Denied	987	4.92%	139	4.19%	287	2.33%	308	2.75%	N/A	N/A	1721	3.67%
Transportation Services	Paid	70,816	95.05%	11,111	95.16%	71,408	91.07%	26,374	95.30%	N/A	N/A	179,709	93.47%
	Denied	3691	4.95%	565	4.84%	7001	8.93%	1302	4.70%	N/A	N/A	12,559	6.53%

Table E-16. Benefit Testing – HCC													
Category of Service	MCE Status	Anthem		CS		MDwise		MHS		UHC		Total	
		Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Chiropractic Services	Paid	43,744	88.02%	N/A	N/A	N/A	N/A	19,589	94.75%	2,100	1000%	65,433	90.29%
	Denied	5,954	11.98%	N/A	N/A	N/A	N/A	1086	5.25%	0	0.00%	7,040	9.71%
Dental Services - Adult	Paid	173,037	1000%	N/A	N/A	N/A	N/A	87,584	1000%	7,625	1000%	268,246	1000%

Dental Services - Child	Denied	0	0.00%	N/A	N/A	N/A	N/A	0	0.00%	0	0.00%	0	0.00%
	Paid	303,774	1000%	N/A	N/A	N/A	N/A	247,750	1000%	14,651	1000%	566,175	1000%
EPSDT Services	Denied	0	0.00%	N/A	N/A	N/A	N/A	0	0.00%	0	0.00%	0	0.00%
	Paid	67,377	97.31%	N/A	N/A	N/A	N/A	49,811	99.06%	9,023	1000%	126,211	98.19%
Eye Care and Exams	Denied	1862	2.69%	N/A	N/A	N/A	N/A	471	0.94%	0	0.00%	2333	1.81%
	Paid	106,571	98.00%	N/A	N/A	N/A	N/A	47,943	98.67%	4,230	1000%	158,744	98.26%
Eyewear	Denied	2170	2.00%	N/A	N/A	N/A	N/A	647	1.33%	0	0.00%	2817	1.74%
	Paid	61,523	98.05%	N/A	N/A	N/A	N/A	34,599	99.82%	2,668	1000%	98,790	98.71%
HME/DME	Denied	1225	1.95%	N/A	N/A	N/A	N/A	61	0.18%	0	0.00%	1286	1.29%
	Paid	177,079	95.54%	N/A	N/A	N/A	N/A	63,381	95.03%	7,538	1000%	247,998	95.54%
Inpatient Services	Denied	8,264	4.46%	N/A	N/A	N/A	N/A	3,315	4.97%	0	0.00%	11,579	4.46%
	Paid	109,605	90.66%	N/A	N/A	N/A	N/A	55,767	97.17%	5,685	1000%	171,057	92.98%
Lab Services	Denied	11,289	9.34%	N/A	N/A	N/A	N/A	1,623	2.83%	0	0.00%	12,912	7.02%
	Paid	1,007,437	88.69%	N/A	N/A	N/A	N/A	504,545	89.32%	42,315	1000%	1,554,297	89.17%
Mental Health Services	Denied	128,515	11.31%	N/A	N/A	N/A	N/A	60,336	10.68%	0	0.00%	188,851	10.83%
	Paid	303,739	96.50%	N/A	N/A	N/A	N/A	166,778	95.38%	19,282	1000%	489,799	96.25%
Outpatient Services	Denied	11,030	3.50%	N/A	N/A	N/A	N/A	8,073	4.62%	0	0.00%	19,103	3.75%
	Paid	10,875,987	96.49%	N/A	N/A	N/A	N/A	5,554,928	98.21%	516,234	1000%	16,947,149	97.15%
Physician Services	Denied	395,457	3.51%	N/A	N/A	N/A	N/A	101,230	1.79%	0	0.00%	496,687	2.85%
	Paid	1,182,124	96.37%	N/A	N/A	N/A	N/A	524,225	97.50%	51,655	1000%	1,758,004	96.80%
Podiatrist Services	Denied	44,567	3.63%	N/A	N/A	N/A	N/A	13,456	2.50%	0	0.00%	58,023	3.20%
	Paid	20,235	88.80%	N/A	N/A	N/A	N/A	9,681	91.42%	620	1000%	30,536	89.82%
Therapy Services - Audiology	Denied	2,552	11.20%	N/A	N/A	N/A	N/A	909	8.58%	0	0.00%	3,461	10.18%
	Paid	2610	94.77%	N/A	N/A	N/A	N/A	1140	93.14%	80	1000%	3,830	94.38%
Therapy Services - Occupational	Denied	144	5.23%	N/A	N/A	N/A	N/A	84	6.86%	0	0.00%	228	5.62%
	Paid	17,634	97.29%	N/A	N/A	N/A	N/A	8,065	95.67%	1,157	1000%	26,856	96.91%
Therapy Services - Physical	Denied	492	2.71%	N/A	N/A	N/A	N/A	365	4.33%	0	0.00%	857	3.09%
	Paid	94,249	91.77%	N/A	N/A	N/A	N/A	38,526	94.30%	3,360	1000%	136,135	92.66%
Therapy Services - Respiratory	Denied	8,449	8.23%	N/A	N/A	N/A	N/A	2,328	5.70%	0	0.00%	10,777	7.34%
	Paid	9,376	93.40%	N/A	N/A	N/A	N/A	4,172	97.57%	511	1000%	14,059	94.83%
Transportation Services	Denied	663	6.60%	N/A	N/A	N/A	N/A	104	2.43%	0	0.00%	767	5.17%
	Paid	244,290	97.98%	N/A	N/A	N/A	N/A	91,640	98.88%	9,127	1000%	345,057	98.27%
	Denied	5,037	2.02%	N/A	N/A	N/A	N/A	1038	1.12%	0	0.00%	6,075	1.73%

Table E-17. Benefit Testing – HIP

Category of Service	MCE Status	Anthem		CS		MDwise		MHS		UHC		Total	
		Count	Percent	Count	Percent	Count	Percent	Count	Percent			Count	Percent
Chiropractic Services	Paid	707,188	89.69%	96,190	1000%	307,813	93.96%	211,836	91.67%	N/A	N/A	1,323,027	91.66%
	Denied	81,325	10.31%	0	0.00%	19,793	6.04%	19,256	8.33%	N/A	N/A	120,374	8.34%
Dental Services - Adult	Paid	1,710,357	1000%	292,476	1000%	867,617	1000%	731,462	1000%	N/A	N/A	3,601,912	1000%
	Denied	0	0.00%	0	0.00%	0	0.00%	0	0.00%	N/A	N/A	0	0.00%
Dental Services - Child	Paid	11,459	1000%	1,981	1000%	6,747	1000%	7,561	1000%	N/A	N/A	27,748	1000%
	Denied	0	0.00%	0	0.00%	0	0.00%	0	0.00%	N/A	N/A	0	0.00%
EPSDT Services	Paid	0	0.00%	0	0.00%	11	1000%	0	0.00%	N/A	N/A	11	1000%
	Denied	0	0.00%	0	0.00%	0	0.00%	0	0.00%	N/A	N/A	0	0.00%
Eye Care and Exams	Paid	444,694	97.26%	82,675	1000%	186,942	97.83%	133,048	98.21%	N/A	N/A	847,359	97.79%
	Denied	12,525	2.74%	0	0.00%	4,156	2.17%	2,428	1.79%	N/A	N/A	19,109	2.21%
Eyewear	Paid	247,024	96.76%	47,458	1000%	130,119	94.99%	94,113	99.79%	N/A	N/A	518,714	97.13%
	Denied	8278	3.24%	0	0.00%	6865	5.01%	196	0.21%	N/A	N/A	15339	2.87%
HME/DME	Paid	414,299	92.13%	63,933	1000%	225,516	93.36%	116,934	95.19%	N/A	N/A	820,682	93.47%

Inpatient Services	Denied	35,367	7.87%	0	0.00%	16,044	6.64%	5,905	4.81%	N/A	N/A	57,316	6.53%
	Paid	446,550	89.60%	101,643	1000%	197,836	92.91%	162,758	94.74%	N/A	N/A	908,787	92.29%
Lab Services	Denied	51,819	10.40%	0	0.00%	15,098	7.09%	9,030	5.26%	N/A	N/A	75,947	7.71%
	Paid	6,826,900	85.78%	1,390,802	1000%	2,992,616	89.89%	2,493,260	84.34%	N/A	N/A	13,703,578	87.65%
Mental Health Services	Denied	1,131,282	14.22%	0	0.00%	336,669	10.11%	462,903	15.66%	N/A	N/A	1,930,854	12.35%
	Paid	1,102,124	94.58%	227,548	1000%	814,924	94.39%	372,555	94.08%	N/A	N/A	2,517,151	94.91%
Outpatient Services	Denied	63,204	5.42%	0	0.00%	48,459	5.61%	23,427	5.92%	N/A	N/A	135,090	5.09%
	Paid	44,748,016	94.29%	8,499,164	1000%	21,506,347	96.37%	17,173,116	97.06%	N/A	N/A	91,926,643	95.79%
Physician Services	Denied	2,711,500	5.71%	0	0.00%	811,156	3.63%	520,433	2.94%	N/A	N/A	4,043,089	4.21%
	Paid	5,651,477	95.44%	1,123,187	1000%	2,366,068	96.43%	1,890,543	97.36%	N/A	N/A	11,031,275	96.42%
Podiatrist Services	Denied	270,290	4.56%	0	0.00%	87,567	3.57%	51,290	2.64%	N/A	N/A	409,147	3.58%
	Paid	64,829	89.73%	10,081	1000%	33,433	91.74%	24,118	90.93%	N/A	N/A	132,461	91.17%
Therapy Services - Audiology	Denied	7,418	10.27%	0	0.00%	3010	8.26%	2406	9.07%	N/A	N/A	12,834	8.83%
	Paid	3492	95.02%	610	1000%	1505	94.59%	1159	96.42%	N/A	N/A	6,766	95.59%
Therapy Services - Occupational	Denied	183	4.98%	0	0.00%	86	5.41%	43	3.58%	N/A	N/A	312	4.41%
	Paid	12,873	94.40%	1851	1000%	6007	98.31%	6139	97.71%	N/A	N/A	26,870	96.38%
Therapy Services - Physical	Denied	763	5.60%	0	0.00%	103	1.69%	144	2.29%	N/A	N/A	1,010	3.62%
	Paid	438,913	90.10%	80,079	1000%	238,545	96.41%	154,690	94.25%	N/A	N/A	912,227	93.20%
Therapy Services - Respiratory	Denied	48,238	9.90%	0	0.00%	8,894	3.59%	9,438	5.75%	N/A	N/A	66,570	6.80%
	Paid	33,452	90.34%	4455	1000%	12,027	93.33%	11,559	97.09%	N/A	N/A	61,493	92.79%
Transportation Services	Denied	3575	9.66%	0	0.00%	859	6.67%	346	2.91%	N/A	N/A	4780	7.21%
	Paid	640,849	98.53%	116,076	1000%	342,038	94.71%	183,062	98.36%	N/A	N/A	1,282,025	97.58%
	Denied	9,588	1.47%	0	0.00%	19,111	5.29%	3055	1.64%	N/A	N/A	31,754	2.42%

Service Limitations

Table E-18. Service Limitations – Home Health Services

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
HCC			
Anthem	622	0	0.00%
CS	N/A	N/A	N/A
MDwise	N/A	N/A	N/A
MHS	269	0	0.00%
UHC	17	0	0.00%
HHW			
Anthem	46	0	0.00%
CS	5	0	0.00%
MDwise	27	0	0.00%

MHS	23	0	0.00%
UHC	N/A	N/A	N/A
HIP			
Anthem	1,229	0	0.00%
CS	154	0	0.00%
MDwise	430	0	0.00%
MHS	359	0	0.00%
UHC	N/A	N/A	N/A

Table E-19. Service Limitations – Therapy Services			
MCE	Total Services Used	Services Over Limitation	
		Count	Percent
HCC			
Anthem	3,153	0	0.00%
CS	N/A	N/A	N/A
MDwise	N/A	N/A	N/A
MHS	1,615	0	0.00%
UHC	153	0	0.00%
HHW			
Anthem	6,768	126	1.86%
CS	1,108	31	2.80%
MDwise	4,050	53	1.31%
MHS	3,708	64	1.73%
UHC	N/A	N/A	N/A
HIP			
Anthem	11,225	15	0.13%

Table E-19. Service Limitations – Therapy Services

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
CS	1,792	5	0.28%
MDwise	4,841	15	0.31%
MHS	4,184	2	0.05%
UHC	N/A	N/A	N/A

Table E-20. Service Limitations – Chiropractic Services

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
HCC			
Anthem	923	1	0.11%
CS	N/A	N/A	N/A
MDwise	N/A	N/A	N/A
MHS	462	0	0.00%
UHC	37	0	0.00%
HHW			
Anthem	4,288	0	0.00%
CS	670	0	0.00%
MDwise	2,752	2	0.07%
MHS	2,155	0	0.00%
UHC	N/A	N/A	N/A
HIP			
Anthem	12,335	11	0.09%
CS	1,600	0	0.00%
MDwise	5,574	2,041	36.62%

Table E-20. Service Limitations – Chiropractic Services

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
MHS	4,192	1,601	38.19%
UHC	N/A	N/A	N/A

Table E-21. Service Limitations – Podiatry Services

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
HCC			
Anthem	1,447	93	6.43%
CS	N/A	N/A	N/A
MDwise	N/A	N/A	N/A
MHS	707	0	0.00%
UHC	49	0	0.00%
HHW			
Anthem	1,025	10	0.98%
CS	223	3	1.35%
MDwise	1,196	0	0.00%
MHS	708	0	0.00%
UHC	N/A	N/A	N/A
HIP			
Anthem	5,301	287	5.41%
CS	861	45	5.23%
MDwise	2,733	0	0.00%
MHS	1,899	0	0.00%
UHC	N/A	N/A	N/A

Table E-22. Service Limitations – Dental Services - No Age Limit

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
HCC			
Anthem	3,225	5	0.16%
CS	N/A	N/A	N/A
MDwise	N/A	N/A	N/A
MHS	1,306	2	0.15%
UHC	98	0	0.00%
HHW			
Anthem	3,841	2	0.05%
CS	1,494	0	0.00%
MDwise	1,095	1	0.09%
MHS	980	0	0.00%
UHC	N/A	N/A	N/A
HIP			
Anthem	38,713	55	0.14%
CS	5,587	6	0.11%
MDwise	18,091	37	0.20%
MHS	13,347	15	0.11%
UHC	N/A	N/A	N/A

Table E-23. Service Limitations – Dental Services – Ages 19-20

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
HCC			
Anthem	18	0	0.00%

Table E-23. Service Limitations – Dental Services – Ages 19-20

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
CS	N/A	N/A	N/A
MDwise	N/A	N/A	N/A
MHS	1	0	0.00%
UHC	1	0	0.00%
HHW			
Anthem	352	0	0.00%
CS	110	0	0.00%
MDwise	32	0	0.00%
MHS	27	0	0.00%
UHC	N/A	N/A	N/A
HIP			
Anthem	13	0	0.00%
CS	4	0	0.00%
MDwise	0	0	N/A
MHS	2	0	0.00%
UHC	N/A	N/A	N/A

Table E-24. Service Limitations – Dental Services – Ages 21+

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
HCC			
Anthem	3,075	5	0.16%
CS	N/A	N/A	N/A
MDwise	N/A	N/A	N/A

Table E-24. Service Limitations – Dental Services – Ages 21+

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
MHS	1,279	2	0.16%
UHC	84	0	0.00%
HHW			
Anthem	1,247	2	0.16%
CS	548	0	0.00%
MDwise	882	1	0.11%
MHS	677	0	0.00%
UHC	N/A	N/A	N/A
HIP			
Anthem	38,700	55	0.14%
CS	5,583	6	0.11%
MDwise	18,091	37	0.20%
MHS	13,344	15	0.11%
UHC	N/A	N/A	N/A

Table E-25. Service Limitations – Eye Exams - No Age Limit

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
HCC			
Anthem	8,710	154	1.77%
CS	N/A	N/A	N/A
MDwise	N/A	N/A	N/A
MHS	5,383	45	0.84%
UHC	295	3	1.02%

Table E-25. Service Limitations – Eye Exams - No Age Limit

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
HHW			
Anthem	23,662	454	1.92%
CS	3,618	51	1.41%
MDwise	21,029	183	0.87%
MHS	16,927	142	0.84%
UHC	N/A	N/A	N/A
HIP			
Anthem	21,853	435	1.99%
CS	2,791	51	1.83%
MDwise	9,401	98	1.04%
MHS	7,405	57	0.77%
UHC	N/A	N/A	N/A

Table E-26. Service Limitations – Eye Exams – Ages 19-20

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
HCC			
Anthem	250	4	1.60%
CS	N/A	N/A	N/A
MDwise	N/A	N/A	N/A
MHS	173	1	0.58%
UHC	8	0	0.00%
HHW			
Anthem	953	15	1.57%

Table E-26. Service Limitations – Eye Exams – Ages 19-20

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
CS	129	2	1.55%
MDwise	862	6	0.70%
MHS	655	4	0.61%
UHC	N/A	N/A	N/A
HIP			
Anthem	592	0	0.00%
CS	55	1	1.82%
MDwise	390	0	0.00%
MHS	319	0	0.00%
UHC	N/A	N/A	N/A

Table E-27. Service Limitations – Eye Exams – Ages 21+

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
HCC			
Anthem	5,651	99	1.75%
CS	N/A	N/A	N/A
MDwise	N/A	N/A	N/A
MHS	2,679	26	0.97%
UHC	147	1	0.68%
HHW			
Anthem	1,319	9	0.68%
CS	229	1	0.44%
MDwise	979	5	0.51%

Table E-27. Service Limitations – Eye Exams – Ages 21+

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
MHS	818	1	0.12%
UHC	N/A	N/A	N/A
HIP			
Anthem	39,284	435	1.11%
CS	6,478	50	0.77%
MDwise	18,463	98	0.53%
MHS	15,123	57	0.38%
UHC	N/A	N/A	N/A

Table E-28. Service Limitations – Eyeglasses – No Age Limit

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
HCC			
Anthem	7,190	506	7.04%
CS	N/A	N/A	N/A
MDwise	N/A	N/A	N/A
MHS	4,497	307	6.83%
UHC	243	22	9.05%
HHW			
Anthem	33,131	2,308	6.97%
CS	6,102	451	7.39%
MDwise	27,554	2,129	7.73%
MHS	21,371	1,501	7.02%
UHC	N/A	N/A	N/A

Table E-28. Service Limitations – Eyeglasses – No Age Limit

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
HIP			
Anthem	30,568	1,180	3.86%
CS	5,450	239	4.39%
MDwise	14,254	647	4.54%
MHS	12,737	521	4.09%
UHC	N/A	N/A	N/A

Table E-29. Service Limitations – Eyeglasses – Ages 19-20

MCE	Total Services Used	Services Over Limitation	
		Count	Percent
HCC			
Anthem	252	18	7.14%
CS	N/A	N/A	N/A
MDwise	N/A	N/A	N/A
MHS	155	9	5.81%
UHC	7	1	14.29%
HHW			
Anthem	2,666	129	4.84%
CS	448	23	5.13%
MDwise	2,357	105	4.45%
MHS	1,795	81	4.51%
UHC	N/A	N/A	N/A
HIP			
Anthem	96	6	6.25%

CS	16	1	6.25%
MDwise	67	2	2.99%
MHS	48	1	2.08%
UHC	N/A	N/A	N/A

Table E-30. Service Limitations – Eyeglasses – Ages 21+			
MCE	Total Services Used	Services Over Limitation	
		Count	Percent
HCC			
Anthem	4,468	248	5.55%
CS	N/A	N/A	N/A
MDwise	N/A	N/A	N/A
MHS	2,459	122	4.96%
UHC	130	5	3.85%
HHW			
Anthem	1,182	55	4.65%
CS	186	7	3.76%
MDwise	837	28	3.35%
MHS	688	27	3.92%
UHC	N/A	N/A	N/A
HIP			
Anthem	30,472	1,174	3.85%
CS	5,434	238	4.38%
MDwise	14,187	645	4.55%
MHS	12,689	520	4.10%
UHC	N/A	N/A	N/A

Appendix F | Focus Study Documentation

Table F-1. Document Requests

Transitions of Care	
1	All MCE policies and procedures regarding inpatient facility discharge processes, inclusive of primary and behavioral health inpatient discharges, for HCC's patient population.
2	All MCE policies and procedures regarding communication with patients or caregiver(s) at discharge/following discharge for HCCs patient population.
3	All MCE policies and procedures regarding transitions of care between health plans and IN programs, for HCCs patient population.
4	CY 2022 Report #0514: Care and Complex Case Management Report—Physical and Behavioral Health Conditions of Interest.
5	CY 2022 Report #0402: HEDIS Other Measures
6	CY 2022 Report #0512: New Member Health Screener Report
7	A copy of any relevant transitions of care training materials (in-house staff training and/or provider materials).
8	Documentation regarding initiatives, if any, in place to support transitions of care.
Health Related Social Needs	
1	All MCE policies, procedures, and contract requirements, regarding health-related social needs and/or social determinants of health for HCC, HIP, and HHW's patient populations.
2	All MCE policies, procedures, and contract requirements, regarding the use of Z codes for HCC, HIP, and HHW's patient populations.
3	A list, if any, of MCE-supported systems and/or software utilized to support closed loop HRSN referrals (e.g., 211, Aunt Bertha, UniteUs, etc.).
4	A copy of any relevant HRSN, SDOH, and/or Z codes training materials (in-house staff training and/or provider materials).
5	The total number of members who completed the New Member Health Needs Screen in CY 2022, indicated separately for the HCC, HIP, and HHW patient populations
6	The total number of members in CY 2022 that selected "yes" on question 10 of the New Member Health Needs Screen, ("Do you worry about things like where you live? Getting food every day? Getting to the grocery store or doctors' appointments? Feeling safe?") indicated separately for the HCC, HIP, and HHW patient populations.
7	All written MCE protocols, if any, for activities when members select "yes" on Question 10 of the New Member Health Needs Screen.

8	Documentation regarding initiatives, if any, in place to support collection, utilization, improvement, and/or reporting of HRSN, SDOH, and/or Z codes.
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Table F-2. Z Code Sub-Codes

Code	Summary	Description	Count
Z550	Z55	Illiteracy and low-level literacy	16
Z552	Z55	Failed school examinations	4
Z553	Z55	Underachievement in school	136
Z554	Z55	Educational maladjustment & discord w teachers & classmates	2
Z555	Z55	Education less than high school diploma	9
Z556	Z55	Problems related to health literacy	0
Z558	Z55	Other problems related to education and literacy	105
Z559	Z55	Problems related to education and literacy, unspecified	618
Z560	Z56	Unemployment, unspecified	313
Z561	Z56	Change of job	2
Z562	Z56	Threat of job loss	0
Z563	Z56	Stressful work schedule	10
Z564	Z56	Discord with boss and workmates	3
Z565	Z56	Uncongenial work environment	0
Z566	Z56	Other physical and mental strain related to work	47
Z5681	Z56	Sexual harassment on the job	1
Z5689	Z56	Other problems related to employment	33
Z569	Z56	Unspecified problems related to employment	73
Z570	Z57	Occupational exposure to noise	2
Z571	Z57	Occupational exposure to radiation	0
Z572	Z57	Occupational exposure to dust	1
Z5731	Z57	Occupational exposure to environmental tobacco smoke	0
Z5739	Z57	Occupational exposure to other air contaminants	0
Z575	Z57	Occupational exposure to toxic agents in other industries	0

Table F-2. Z Code Sub-Codes			
Code	Summary	Description	Count
Z577	Z57	Occupational exposure to vibration	0
Z578	Z57	Occupational exposure to other risk factors	2
Z579	Z57	Occupational exposure to unspecified risk factor	3
Z5889	Z58	Other problems related to physical environment	0
Z590	Z59	Homelessness	0
Z5900	Z59	Homelessness, unspecified	726
Z5901	Z59	Sheltered homelessness	58
Z5902	Z59	Unsheltered Homelessness	39
Z591	Z59	Inadequate housing	481
Z5910	Z59	Inadequate housing, unspecified	0
Z592	Z59	Discord with neighbors, lodgers, and landlord	5
Z593	Z59	Problems related to living in residential institution	13
Z594	Z59	Lack of adequate food and safe drinking water	0
Z5941	Z59	Food insecurity	582
Z5948	Z59	Other specified lack of food	23
Z595	Z59	Extreme poverty	3
Z596	Z59	Low income	60
Z597	Z59	Insufficient social insurance and welfare support	8
Z598	Z59	Other problems related to housing and economic circumstances	0
Z59811	Z59	Housing instability, housed, with risk of homelessness	11
Z59812	Z59	Housing instability, housed, homelessness in past 12 months	9
Z59819	Z59	Housing instability, housed unspecified	19
Z5982	Z59	Transportation insecurity	14
Z5986	Z59	Financial insecurity	6
Z5989	Z59	Other problems related to housing and economic circumstances	76
Z599	Z59	Problem related to housing and economic circumstances	226
Z600	Z60	Problems of adjustment to life-cycle transitions	49

Table F-2. Z Code Sub-Codes

Code	Summary	Description	Count
Z602	Z60	Problems related to living alone	10
Z603	Z60	Acculturation difficulty	37
Z604	Z60	Social exclusion and rejection	44
Z605	Z60	Target of (perceived) adverse discrimination and persecution	7
Z608	Z60	Other problems related to social environment	58
Z609	Z60	Problem related to social environment, unspecified	238
Z620	Z62	Inadequate parental supervision and control	10
Z621	Z62	Parental overprotection	0
Z6221	Z62	Child in welfare custody	545
Z6222	Z62	Institutional upbringing	2
Z6229	Z62	Other upbringing away from parents	116
Z626	Z62	Inappropriate (excessive) parental pressure	1
Z62810	Z62	Personal history of physical and sexual abuse in childhood	837
Z62811	Z62	Personal history of psychological abuse in childhood	166
Z62812	Z62	Personal history of neglect in childhood	231
Z62813	Z62	Personal history of forced labor or sexual exploitation in childhood	0
Z62819	Z62	Personal history of unspecified abuse in childhood	177
Z6282	Z62	Parent-child conflict	0
Z62820	Z62	Parent-biological child conflict	1993
Z62821	Z62	Parent-adopted child conflict	11
Z62822	Z62	Parent-foster child conflict	11
Z62890	Z62	Parent-child estrangement NEC	3
Z62891	Z62	Sibling rivalry	246
Z62898	Z62	Other specified problems related to upbringing	106
Z629	Z62	Problem related to upbringing, unspecified	24
Z630	Z63	Problems in relationship with spouse or partner	812
Z631	Z63	Problems in relationship with in-laws	1

Table F-2. Z Code Sub-Codes			
Code	Summary	Description	Count
Z6331	Z63	Absence of family member due to military deployment	6
Z6332	Z63	Other absence of family member	81
Z634	Z63	Disappearance and death of family member	1369
Z635	Z63	Disruption of family by separation and divorce	336
Z636	Z63	Dependent relative needing care at home	65
Z6372	Z63	Alcoholism and drug addiction in family	149
Z6379	Z63	Other stressful life events affecting family and household	283
Z638	Z63	Other specified problems related to primary support group	706
Z639	Z63	Problem related to primary support group, unspecified	282
Z640	Z64	Problems related to unwanted pregnancy	16
Z641	Z64	Problems related to multiparity	89
Z644	Z64	Discord with counselors	0
Z650	Z65	Conviction in civil & criminal proceedings w/o imprisonment	5
Z651	Z65	Imprisonment and other incarceration	71
Z652	Z65	Problems related to release from prison	14
Z653	Z65	Problems related to other legal circumstances	306
Z654	Z65	Victim of crime and terrorism	13
Z655	Z65	Exposure to disaster, war, and other hostilities	0
Z658	Z65	Other problems related to psychosocial circumstances	216
Z659	Z65	Problem related to unspecified psychosocial circumstances	222