FINAL REPORT
2016 External Quality Review of Indiana's Health Coverage Programs:
Hoosier Healthwise, Hoosier Care Connect and Healthy Indiana Plan 2.0

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ABBREVIATIONS LIST

Abbreviation	Meaning
ACOG	American College of Obstetricians & Gynecologists
ALOS	Average Length of Stay
AOD	Alcohol or Other Drug Dependence
ASAM	American Society of Addiction Medicine
AWC	Adolescent Well Care Visit
B&A	Burns & Associates, Inc.
BH	Behavioral Health
CHIP	Children's Health Insurance Program
CM	Care Management/Case Management
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CY	Calendar Year
DRG	Diagnosis-Related Group
E&M	Evaluation and Management
ED	Emergency Department
EDW	Enterprise Data Warehouse
EPSDT	Early Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FFS	Fee-for-Service
FPC	Frequency of Prenatal Care
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FSSA	Family and Social Services Administration
FUH	Follow-Up Visit After Inpatient Hospitalization
HCPCS	Healthcare Common Procedure Coding System
HPE	Hewlett Packard Enterprise
H S A	Health Savings Account
HEDIS	Healthcare Effectiveness Data and Information Set
HCC	Hoosier Care Connect
HHW	Hoosier Healthwise
HIP	Healthy Indiana Plan
HNS	Health Needs Screening
IESD	Index Episode Start Date
IET	Initiation and Engagement of Drug Dependence Treatment

Abbreviation	Meaning
IHCP	Indiana Health Coverage Program
IOP	Intensive Outpatient Service
IOT	Intensive Outpatient Therapy
IVR	Interactive Voice Response
LCSW	Licensed Clinical Social Workers
LMFT	Licensed Marriage and Family Therapist
MAT	Medication-Assisted Treatment
MCE	Managed Care Entity
MCO	Managed Care Organization
MHS	Managed Health Solutions
MRO	Medicaid Rehabilitation Option
NEMT	Non-Emergency Medical Transportation
NCQA	National Committee on Quality Assurance
NICU	Neonatal Intensive Care Unit
NPI	National Provider Identifier
OG/GYN	Obstetrician/Gynecologist
OMPP	Office of Medicaid Policy and Planning
P4O	Pay For Outcomes
PA	Prior Authorization
PCCM	Primary Care Case Management
PE	Presumptive Eligibility
PIH	Pregnancy-Induced Hypertension
PIHPs	Prepaid Inpatient Health Plans
PIPs	Performance Improvement Projects
PMP	Primary Medical Provider
PMPM	Per Member Per Month
POWER	Personal Wellness and Responsibility Acct
PPC	Prenatal Care or Postpartum Care
QI	Quality Improvement
QIP	Quality Improvement Project
RCP	Right Choices Program
SAS	Statistical Analysis System
SMA	State Medicaid Agency
TAT	Turnaround Time
W15	Well Care Child Visit, First 15 Months of Life
W34	Well Care Child Visit, Third through Sixth Years of Life

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EXECUTIVE SUMMARY

Indiana's Medicaid program saw substantial change in Calendar Year (CY) 2015 in the delivery system models used, in the movement of populations across programs, and a substantial net growth in the Medicaid enrollment itself. The Family and Social Services Administration (FSSA) and the Indiana Office of Medicaid Policy and Planning (OMPP)[1] have responsibility for the administration and oversight of Indiana's Medicaid program under two different Section 1115 demonstration waiver authorities. At the end of CY 2015, three risk-based managed care programs were in place and each serves a targeted population—Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) 2.0, and Hoosier Care Connect (HCC).

The **Hoosier Healthwise (HHW)** program began in 1994 with optional enrollment for Medicaid enrollees. Mandatory enrollment became effective in 2005 for select populations, namely, low income families, pregnant women, and children. These enrollees have the option to choose both their primary medical provider (PMP) and the managed care entity (MCEs)[2] to enroll with.

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

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

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

There are three MCEs that are contracted with Indiana's Medicaid managed care programs. Anthem Insurance Companies, Inc. (Anthem) has been under contract with Indiana Medicaid since 2007. Coordinated Care Corporation, Inc. d/b/a Managed Health Services (MHS) is a subsidiary of the Centene Corporation and has been under contract with Indiana Medicaid since the inception of HHW in 1994. MDwise, Inc. has also been participating in HHW since its inception. MDwise subcontracts the management of services to nine delivery systems. All three MCEs have members enrolled in HHW, HIP and HCC.

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

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

Net enrollment in Indiana Medicaid's program grew by more than 200,000 most directly due to the rapid expansion of HIP 2.0. In addition to this, the managed care enrollment growth from December 2014 to December 2015 was even larger (up 322,707 members) due to the expiration of the Care Select program and the introduction of the HCC program. Enrollment in HHW went down because most all of the adults that had been enrolled in the program were moved to HIP 2.0. The child enrollment in HHW actually saw a slight increase from December 2014 to December 2015. Among the 1,052,953 enrollees in Indiana's Medicaid managed care programs as of December 31, 2015, 600,452 (57.0%) were enrolled in HHW, 354,879 (33.7%) were enrolled in HIP 2.0, and 97,622 (9.3%) were enrolled in HCC[3].

EQRO Activities in CY 2016

Burns & Associates (B&A) has served as the External Quality Review Organization (EQRO) and has conducted External Quality Reviews (EQRs) for Indiana Medicaid each year since 2007. For our reviews, we have relied on the protocols defined by CMS. This year was no exception. B&A utilized the new protocols released by CMS in September 2012 to serve as the basis for the format of the EQR this year.

B&A has worked with the OMPP on the topics to cover in each annual review. This year, in cooperation with the OMPP, B&A developed focus studies in addition to the mandatory activities. This year's topics include the following:

- Validation of Performance Measures
- Validation of Performance Improvement Projects
- Focus Study on the Audit of Provider Directories
- Focus Study on Beneficiary Access to Providers
- Focus Study on the Utilization and Access to Dental Services
- Focus Study on the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Focus Study on the Delivery of Prenatal Care Services
- Focus Study on the Delivery of Well Care and Primary Care to Children

Validation of Performance Measures

B&A selected performance measures to validate from among the various reports that the MCEs submit to the OMPP on a regular (usually quarterly) basis. Each of this year's performance measures are based on Healthcare Effectiveness Data and Information Set (HEDIS)®[4] measures. Whereas the annual HEDIS results are tabulated and reported to the OMPP by external certified HEDIS auditors, the OMPP requires the MCEs to submit quarterly updates throughout the year using a "HEDIS-like" approach. There are two key differences between a pure HEDIS annual result and the quarterly submissions. One is that the anchor date for the measurement period changes with each quarterly submission. The second is that the quarterly submissions rely only on claims data (the administrative approach) whereas the annual HEDIS submission may use a hybrid approach (claims data and medical records).

The measures that were validated in this year's EQR were from the quarterly submissions that the MCEs delivered to the OMPP on April 30, 2016. Each of the measures examined allows for a 90-day claims lag submission; therefore, the measurement period examined encompassed enrollee utilization for the time period throughout CY 2015. Measures were selected to be validated from each of the health coverage programs in Indiana's Medicaid program.

[3] Source: Optum, OMPP's data warehouse vendor, provided enrollment data to B&A on May 31, 2016.

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

Measure	HEDIS Definition	HHW	HCC	HIP
Well Child Visits, First 15 Months of Life	W15	X		
Well Child Visits, Third through Sixth Years of Life	W34	X	X	
Adolescent Well Care Visits	AWC	X	X	
Adolescent Well Care Visits, 19-21 year olds	AWC			X
Prenatal Care	PPC	X		
Postpartum Care	PPC	X		

B&A received data from the OMPP Enterprise Data Warehouse (EDW) with the transfer of data facilitated by OMPP's EDW vendor, Optum. This included enrollment data and encounter claims which the MCEs are required to submit to the OMPP. All data used to validate this year's performance measures came from the OMPP's EDW.

B&A could validate to Anthem's results on five of the six well care measures reviewed; for MHS, two of the six; for MDwise, four of the six. The measure that could not be validated for any MCE was the AWC measure in HIP. However, this may be due to data limitations for B&A more than MCE calculations.

In the HIP, the OMPP requires the MCEs to report results for three different products under HIP: HIP Plus, HIP Basic and HIP State Plan. The measure that B&A was validating against was the result for the HIP Plus product, since each MCE indicated that the majority of their HIP population was enrolled in this product line. B&A did not have the ability to segregate the HIP enrollees by product line. Therefore, B&A's results are for all HIP eligible members in AWC whereas the MCEs' results are for the HIP Plus members in AWC. Furthermore, the total sample that could be considered for the HEDIS measure AWC in HIP 2.0 was small (n=6,081) due to the age restriction of age 19 to 21 in the measure when compared to the total HIP 2.0 enrollment of 355,000 members at the end of CY 2015.

B&A could validate to Anthem's results on both the prenatal and postpartum measures; for MHS, on the prenatal measure only; for MDwise, on the postpartum measure only. The reason why all measures could not be fully validated by B&A may also be a limitation in the data.

For the prenatal measure, the type of visits considered for numerator compliance is dependent upon the time period the mother is enrolled with the MCE. In particular, one test is 280 days prior to birth and another is within 42 days of enrollment. The issue is with respect to the actual enrollment start date. B&A obtained information on each member's enrollment with an MCE rounded to the nearest month, not day. If a woman did not start to actively engage with an MCE until the 6th day of the month, B&A would have counted the first five days toward a 280 day test or 42 day test since the assumption had to be that the member was "actively engaged" in every day of the month based on the member month record.

For the postpartum measure, B&A discovered (and the MCEs confirmed) that there are sometimes conflicting delivery dates when comparing the hospital claim and the physician's claim for the mother. To the extent that the dates are mismatched, this could influence the postpartum care results since the service is date sensitive.

Despite these data limitations, the variance between the computed rates for each measure by the MCE and by B&A was not significant. Therefore, B&A has determined that many of the measures are validated with the caveats discussed above.

Validation of Performance Improvement Projects

The OMPP uses the term "Quality Improvement Project" (QIP) to describe the projects in this review. In this report, references to "QIPs" means the same thing as "PIPs" in CMS EQR Protocol 3. The OMPP implemented a new QIP Report template which was constructed with MCE input on January 1, 2015.

The MCEs are required to have QIPs for all three programs that it administers (HHW, HCC and HIP 2.0). The MCEs have the option to conduct the same QIP across programs. For this year's EQR, B&A selected the following QIPs for validation from each MCE:

Anthem

- New Member Health Needs Screening (HHW, HCC and HIP programs)
- Appropriate Use of Emergency Department Services (HHW only)
- Follow-up Visit after Inpatient Psychiatric Hospitalization (HCC only)
- Adult Preventive Care (HIP only)

MHS

- Follow-up Visit after Inpatient Psychiatric Hospitalization (HHW, HCC and HIP programs)
- Appropriate Use of Emergency Department Services (HHW and HIP)
- Alcohol and Other Drug Dependence Treatment (HCC and HIP)

MDwise

- Follow-up Visit after Inpatient Psychiatric Hospitalization (HHW, HCC and HIP programs)
- Adolescent Well Care (HCC and HIP)
- Post-partum Care (HHW only)

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

It was apparent to the EQR Review Team after the onsite meetings that each MCE had implemented and, in many cases, documented the effectiveness of their interventions more than what had been submitted on the QIP Reports. It should be noted that the results on MHS's QIP reports were more comprehensive than the other two MCEs. A recommendation to all MCEs is to improve the reporting on the effectiveness of interventions in the QIP report.

The MCEs all indicated that after using the QIP Reporting tool for two years now, they found it useful. However, when B&A cited the lack of reporting on some elements in the tool back to the MCEs, the feedback was that the MCEs needed more clarity on the method to submit documentation and the level of detail expected. Therefore, B&A recommends that the OMPP reconvene the team of representatives from all MCEs that originally participated in the development of the QIP Reporting tool (or the individuals at the MCEs that are filling it out today). This should be conducted prior to the due date when the MCEs are to submit their QIPs for CY 2017. The meeting should center on what elements of the tool are working, what could be improved, and how the tool should be modified so that it is useful to both the MCEs and to the OMPP.

Focus Study on the Audit of Provider Directories

With the introduction of HCC and HIP 2.0 in CY 2015, the OMPP saw significant growth in the managed care portion of its Medicaid delivery system. Providers have the option to contract with one, two or all three MCEs. Providers also have the option to contract with just the HHW, HCC or HIP program or any combination of programs.

In order for a provider to contract with any MCE or program, however, the provider must first be enrolled in Indiana's Health Coverage Program (IHCP). The application and enrollment process in the IHCP is administered for the OMPP by its fiscal agent, Hewlett Packard Enterprise (HPE). The MCEs receive file notifications of additions, deletions and changes to the IHCP from HPE.

The large influx of providers, the multitude of contracting options a provider can choose from, and the need to continually transfer current provider information between HPE and the MCEs suggests the possibility that provider information may vary across MCEs, across programs and between the MCEs and HPE.

The purpose of the study, therefore, was to:

- Assess the reliability of the information provided by the MCE to its members enrolled in HHW, HCC and HIP about contracted providers;
- Assess the consistency of provider information within a program but across MCEs; and
- Assess the consistency of provider information between the MCEs and HPE.

B&A used multiple approaches to conduct the study:

1. Tests were completed to simulate from the member's perspective how he/she would query the MCE's "find a doctor" online tool.
2. A sample of providers that contracted with one or more MCEs was tested using the MCE's online query tool to see how results were the same or different across the MCEs as well with HPE's online query for IHCP.
3. A full review of all providers contracted with multiple MCEs was reviewed to compare the consistency of the provider's street address and office phone number.
4. A sample of 720 outbound calls was made to provider offices to verify key information about the provider against what is stored in the MCE's provider directory.

The results of the provider directory phone audit were disappointing. All calls were placed during normal business hours and 196 of the calls were conducted twice because of no answer or voice mail required on the first attempt. Of the 720 calls to provider offices, only 58 percent were designated "complete" while 38 percent were "incomplete" and four percent of providers refused to participate. Reasons were documented for incomplete calls, which included disconnected phone number, no answer, on hold for more than three minutes with no option to leave a voice mail, required to leave a voice mail, or office closed. These results were tallied after the second round of calls was made.

When calls were deemed complete, specific information that was provided to B&A from each MCE in their provider directory database was validated with the provider's office. Results showed that:

- The provider's correct office phone number was valid 89 percent of the time
- The provider's address and group practice name were valid 83 percent of the time
- The provider's specialty was valid 79 percent of the time

- The provider's location was valid 63 percent of the time
- Verification that the provider contracted with a program (HHW, HCC or HIP) occurred 71 percent of the time
- Verification that the provider contracted with an MCE (Anthem, MHS or MDwise) occurred 75 percent of the time
- Among those that confirmed their contractual relationship, 82 percent confirmed that they were accepting new patients (out of the total that the MCE believed were accepting new patients)

The results shown above reflect the averages across all three MCEs. However, these rates were also similar for each MCE individually.

When the providers who contracted with more than one MCE were reviewed for address and phone number information side-by-side, the addresses matched 55 percent of the time and the phone numbers matched 46 percent of the time. B&A recognized that this could be because providers may serve in multiple locations, so the low match rate may not be absolute. To test this further, B&A looked up 100 random providers that did not match across MCEs to learn what a member would see if they queried each MCE's "find a doctor" website. There was significant inconsistency in the number of times that the same provider appeared on each MCE's website or the IHCP website. This could be an artifact of differing contract arrangements the provider has with each MCE. But even within an MCE, when matching the number of times the provider appeared in the online database against the number of unique addresses or phone numbers for that provider, there was not always a one-to-one match (meaning that the same address/phone number could be listed for more than one entry for a provider). The one exception was Anthem's addresses matched one-for-one with the number of times the provider was listed.

There are a number of opportunities for improving the provider directories among the MCEs and the alignment of data between the MCEs and IHCP (managed by HPE for the OMPP). B&A offers specific recommendations to improve the information at the end of Section V in this report.

Focus Study on Beneficiary Access to Providers

One mechanism that the OMPP monitors access to providers is through the review of geoaccess reports that the MCEs submit to the OMPP for each program. Geoaccess reports plot the location of individual providers for a particular specialty on a map to visualize where providers are located within the state for the population served. Additionally, analytics in the geoaccess reports compute the shortest distance for each member in the population to a provider, the shortest distance to the second-closest provider, etc.

The OMPP has developed contractual requirements for the MCEs to meet that set the maximum distance requirements for members to access over two dozen specialties. For example, the threshold for primary medical providers (PMPs) is a minimum of one provider within 30 miles of every member. The MCEs are required to submit geoaccess reports for each of the three OMPP programs (HHW, HCC and HIP) and to report on access for each provider specialty separately. Specific elements that are required to be included in each report are:

- Member count by region, county and zip code;
- Provider specialty count by region, county and zip code; and
- Member-to-specialist ratio by region, county and zip code.

The purpose of this study was to evaluate member access to providers within HHW, HCC and HIP by validating the geoaccess reports submitted by the MCEs for each program

B&A compiled the geoaccess reports submitted to the OMPP by the MCEs for the period ending 4th Quarter of CY 2015 for 23 different provider specialties. We also compiled information from the electronic provider directories that each MCE provided to B&A for this EQR. B&A also tabulated the utilization that members had with each of the 23 specialties for services rendered in CY 2015. This information was tabulated separately for each MCE as well as separately for each program (HHW, HCC and HIP) as well as across eight geographic regions of the state and for each of Indiana's 92 counties (based on the member's home county).

With respect to the geoaccess reports specifically, B&A used member-to-provider ratios to calibrate potential access across the eight regions of the state for each specialty. Anthem met the standards in every specialty category for all three programs with a few exceptions. The exceptions where it was not met are one region for primary care in HHW (Southwest) and multiple regions for dermatology, neurosurgeon and speech therapist in HHW and HIP. MHS and MDwise also had member-to-provider thresholds above the standard set by B&A for dermatology, neurosurgeon and speech therapist, but each had other specialties above the standard as well. In total, MHS had 17 specialties in HHW where at least one region exceeded the threshold, 19 specialties in HCC and 21 specialties in HIP. MDwise had 15 specialties in HHW where at least one region exceeded the threshold, 14 specialties in HCC and 22 specialties in HIP.

With respect to meeting the access standards set by the OMPP, however, the MCEs are almost always meeting the standard. Out of 207 possibilities (23 specialties x 3 MCEs x 3 programs), there are only 10 instances where at least one county was found where the standard was not met. In these cases, the standard is usually two providers within 60 miles. For most, the distance was above 60 but under 70 miles.

B&A also measured the available providers as self-reported by the MCEs against the number of unique providers reported in each MCE's provider directory for each of the 23 specialties reviewed. We also examined the ratio between the number of providers listed in the directory (on the roster) against the number of providers that members used (available). For the comparison of providers reported on the geoaccess reports, a tolerance level was built in for duplication since many providers can serve members across multiple counties provided that they are within the OMPP access standard (e.g., primary care providers within a 30 mile radius). Even when accounting for this duplication, there was a high degree of variability between the provider counts on the geoaccess reports and the provider counts in the MCE's own database for MHS and MDwise. Anthem's results appear to be more in line between the two data sources.

The count of unique providers on the MCE's roster versus the count of unique providers used by members was also highly variable. For some specialties, more providers in the specialty served members than were reported on the roster. In other cases, there were a far greater number of providers on the roster than those that serve members.

The most significant finding of this study is that the reporting on the geoaccess reports that are submitted to the OMPP by the MCEs is inconsistent. Without further research, it is premature to assess if each MCE's geoaccess reports are not valid. What has been determined is that the OMPP cannot compare MCE network adequacy the same across the MCEs and potentially even across programs within the same MCE. This is likely due to different definitions used by the MCEs to assign providers to specialty categories. With this in mind, B&A offers recommendations to the OMPP on the methodology and design of the geoaccess reports that are submitted by the MCEs. Some MCE-specific recommendations are also provided based on the evaluation of MCE-specific findings at the end of Section VI of this report.

Focus Study on the Utilization and Access to Dental Services

Currently, the management of dental services is the responsibility of the MCEs for HCC and HIP 2.0. In a new contract period beginning in January 2017, the MCEs will also be responsible for managing dental services in HHW. The purpose of this study was to assess the adequacy of coverage for the provision of dental services throughout the state for HCC and HIP members and to set a baseline of the utilization of this service for future monitoring.

B&A used encounter claims with dates of service in CY 2015 to identify the dentists who delivered services to HCC and HIP members as well as utilization of dental services within each program. Because both the HCC and HIP 2.0 began in CY 2015, B&A limited the study to encounters from April through December 2015 for the HCC program and February through December for HIP 2.0. B&A also used geocoding software to measure the driving distance from the member's home to the dental provider and computed average driving distances at the discrete program / MCE / county level. Currently, the OMPP sets a threshold of two dentists within 60 miles of each member as the access standard.

Using claims, B&A computed the number of unique dental providers that members went to see in each program by county. There are 14 counties that had less than 50 or fewer providers that delivered dental services to the members in their county (HCC and HIP combined). Among these, eight are in the Southwest Region of the state.

When comparing utilization across the HCC and HIP programs, the average utilization per 1,000 member months statewide was identical for HCC and HIP at 76 visits per 1,000 member months. There are six counties with a utilization per 1,000 member months statistic that is less than 50. One of these counties (Dearborn) is common to both HCC and HIP. The rates of utilization per 1,000 member months were similar between Anthem and MDwise among HCC members but lower for MHS members. In HIP, the utilization across the three MCEs was similar.

When comparing the average distance travelled by members in the HCC and HIP programs, there are eight counties where the average distance was less than 10 miles and 20 counties where the average distance was greater than 30 miles for HCC members. Among the HCC population exclusively, there were 16 of the 92 counties that had an average distance of greater than 30 miles in at least two of the MCEs. The greatest distance for any county was White County (52 miles) for MHS members. Among the HIP population exclusively, there were 15 of the 92 counties that had an average distance of greater than 30 miles in at least two of the MCEs. The greatest distance for any county was Starke County (50 miles) for both Anthem and MHS members.

The use of dental services was also compared across many demographic features within HCC and HIP and across the MCEs. For the HCC population, it was found that the percent of members who received a dental service closely aligned with the population overall when examined by gender, race/ethnicity and region. The only variance seen was by age group where it was not surprising to see higher utilization among children than adults. In the HIP program, dental usage was found to be similar to enrollment by region and by race/ethnicity, but more females used dental services than males.

B&A is making recommendations to the MCEs to direct resources for strengthening dental provider coverage in targeted counties that either had few providers serving members, a lower utilization rate per 1,000 member months, or higher average distance travelled for members in the county to seek services. Of greatest importance are the counties that met more than one of these criteria, Dearborn and Ohio.

Focus Study on the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

The epidemic of opiate addiction nationally has been covered widely in the past year. Medicaid beneficiaries are disproportionately affected by the epidemic since they are prescribed painkillers at twice the rate of non-Medicaid patients and are at three to six times the risk of overdose on prescription painkillers.

There were five objectives to this focus study:

1. To collect baseline data on the prevalence of the initiation and engagement of alcohol and other drug dependence treatment;
2. To identify the base of providers delivering services to these beneficiaries;
3. To gain an understanding of how services are being delivered today through face-to-face interviews with providers;
4. To learn about the MCEs' efforts to facilitate and manage members receiving these services; and
5. To provide recommendations to the OMPP and the MCEs about opportunities to leverage resources and improve outcomes for members.

B&A used the HEDIS 2016 specification for its measure Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) as the basis for the analytics in this study. The HEDIS measure identifies the percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following:

- *Initiation of AOD Treatment* - The percent of members who initiate treatment for AOD through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

- *Engagement of AOD Treatment* – The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

B&A added an additional measure to the study which we call *Continuation of AOD Treatment*, which is the percent of members with initiation that become engaged.

Among the total study sample of 19,391 individuals, the statewide initiation rate for Indiana's Medicaid programs is 40 percent (the national Medicaid average is 38 percent). The engagement rate for Indiana Medicaid is 11 percent (equal to the national Medicaid average). The continuation rate computed by B&A is 27 percent (no national benchmark value available). Among high-volume providers, the continuation rate was found to be much higher where the initiation phase occurred at community mental health centers (51%) than psychiatric hospitals (38%) or acute care hospitals (16%).

A key part of the focus study was to gain a better understanding of how the MCEs approach AOD treatment and the factors that lead to effective treatment by visiting providers that serve the most members with AOD diagnoses. After initial meetings with each MCE individually, B&A conducted 17 field interviews with high-volume providers. This feedback was synthesized and then shared in one-on-one meetings with each MCE. The feedback can be generally classified as items that relate to MCE processes (e.g., prior authorization, billing, forms), items that relate to impacting access to patient care (e.g., wait times for appointments, services that are not covered, timely notification of patient eligibility), innovative models currently being conducted in the field, and recommendations to either the MCEs or to the OMPP.

Although much work is being done in the field to address the rapid increase in the demand for services, there is much that can be done to reduce administrative burdens on AOD treatment providers and mitigate misunderstandings related to the coverage of AOD treatment in the HHW, HCC and HIP programs. This focus study was intended more to level set the current situation and to offer recommendations for continued quality improvement. To this end, B&A offers recommendations related to the delivery of treatment to this vulnerable population at the end of Section VIII of this report.

Focus Study on the Delivery of Prenatal Care Services

The timeliness and frequency of prenatal and postpartum visits for pregnant women in HHW was one of the OMPP's quality strategy objectives for CY 2015. Timely prenatal care can help to mitigate pre-term births, complicated deliveries, low birth weight babies and infant death. With the introduction of the HCC and HIP 2.0 programs in CY 2015, there will be an emphasis on this quality objective in these programs as well. In HHW, the OMPP goal was to achieve at or above the 90th percentile among Medicaid managed care plans nationally on the frequency of prenatal care (HEDIS FPC), specifically, the percent of women who had 81 percent or more of their expected visits.

The American College of Obstetricians and Gynecologists (ACOG) recommends that women with an uncomplicated pregnancy receive visits every four weeks for the first 28 weeks of pregnancy, every two to three weeks until 36 weeks of pregnancy, and weekly thereafter. The study in this EQR focused on examining the ratio of prenatal visits per weeks that the mother was enrolled during her pregnancy. In addition to understanding the overall trend in HHW and HCC, the study examined the prenatal visit rate among cohorts within the population stratified by: the MCE she is enrolled with, the age of the mother, her race/ethnicity, the region where she lives, the type of delivery (vaginal or Cesarean) and the outcome of the baby's birth (normal newborn or complications). The subpopulations were examined for the HHW cohort only due to the low sample size in CY 2015 in HCC. In future years, it is anticipated that this study would also include the HIP population as more mothers become enrolled in this program.

Among the study population, the overall average visits per week enrolled were consistent across subpopulations and across MCEs, including in the weeks just before giving birth. In fact, the average visits per week result of 1.0 in the weeks just prior to birth is line with the ACOG recommendations for all cohorts of the population examined in this study. Recommendations from B&A related to this study, therefore, are more focused on potential opportunities aimed towards continuous quality improvement rather than remediation.

Focus Study on the Delivery of Well Care and Primary Care to Children

The OMPP has a Pay for Outcomes (P4O) program in its contracts with the MCEs, part of which relates to the three HEDIS measures pertaining to well care visits—visits in the first 15 months of life (W15), annual visits in the third through sixth years of life (W34), and annual visits for adolescents (AWC). The study in this EQR focused on examining the utilization of both well care visits (as defined by the HEDIS measures) as well as other primary care visits to the children and adolescents in the HHW, HCC and HIP 2.0 programs in CY 2015. Analyses were conducted to examine who delivers well care and primary care services to the members, the differences in the rate of well care and primary care visit utilization, and the percentage of members in each program that received neither well care nor primary care services in CY 2015. Variances in these trends were also examined by gender, by region in the state, by race/ethnicity and by age.

The main distinction between well care and primary care is that well care is indicative of a routine checkup and primary care includes sick visits. Also, well care visits include immunizations. This is why

the standard for the W15 population is six well care visits the first 15 months of life and only one well care visit for the other populations.

B&A analyzed claims for the members in each cohort population across program and MCE. The values shown below represent the average visits in CY 2015.

In the W15 population, members had, on average, 24.1 well care *services* (including immunizations), 5.8 well care visits and 2.7 primary care visits. Well care services could be duplicated in the same visit (e.g., multiple vaccinations). Fifty-one percent of well care visits overall are delivered by physicians (office-based setting) and 50 percent of primary care visits are delivered by physicians. Clinics deliver 43 percent of well care visits and 47 percent of primary care visits. Approximately five percent of visits are delivered by other provider types (hospitals and public health agencies usually).

The average number of well care services delivered to the W34 population is 3.0 per HHW member and 1.4 per HCC member; for primary care visits, the averages are 0.5 per HHW member and 1.0 per HCC member. For the AWC population, the average number of well care services delivered is 2.2 in HHW and 0.8 visits in the cohort of HCC plus HIP combined. Primary care services were more prevalent among HCC and HIP members than HHW members. The average number of primary care visits among HHW members is 0.8; for the HHC and HIP members combined, 1.2.

Each of the cohort populations (W15, W34 and AWC) were analyzed to determine if there was a difference in the percentage of members with well care visits by gender, race/ethnicity and region. Overall, the disparities were limited, but some notable findings include:

- Hispanic children had a higher well care visit rate (64%) among W15 children than the statewide average, but African-American children had a lower well visit rate (55%). Caucasian children were at the statewide average of 60 percent primarily because they comprise most of the population in the study (63% of the total).

- Among the W34 population in HHW and HCC, the well care visit rate is lower in the East Central and Southeast Regions than statewide. The rate among Hispanics is higher than the statewide average and Caucasians are lower than the statewide average. African-American children have a rate at the statewide average. The well care visit rate by age group is the same for three-, four- and five-year-olds but lower for children age six.

- Among the AWC population in HHW, the rate among males and females is almost identical. By race/ethnicity, Hispanic members have a much higher well care visit rate of 62 percent and Caucasians are lowest at 50 percent. In HCC, the trend of similar well care visit rates by gender, by region and by age are similar to what was seen among HHW members. The exception to this is that the much higher well care visit rate among Hispanics is not as pronounced in HCC as it was in HHW. Among the AWC population in HIP, which is only 19-21 year olds, there is a difference in the well care visit rate by gender (13% for males, 26% for females, 21% overall). There is less disparity in the well care visit rate among race/ethnicities in HIP than was seen in HHW or HCC.

B&A offers recommendations to the MCEs at the end of Section X of this report related to opportunities to investigate ways to reduce the well care visit disparities such as the findings mentioned above.

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

Introduction

Indiana's Medicaid program saw substantial change in Calendar Year (CY) 2015 in the delivery system models used, in the movement of populations across programs, and a substantial net growth in the Medicaid enrollment itself. To understand the magnitude of this change, it is helpful to know some history of risk-based managed care in the Indiana Medicaid program.

The Family and Social Services Administration (FSSA) and the Indiana Office of Medicaid Policy and Planning (OMPP)[5] have responsibility for the administration and oversight of Indiana's Medicaid program under two different Section 1115 demonstration waiver authorities. At the end of CY 2015, three risk-based managed care programs were in place and each serves a targeted population—Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) 2.0, and Hoosier Care Connect (HCC).

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

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

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

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

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

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

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

HIP 2.0 is a State-sponsored health insurance program where monthly contributions are required of each enrolled member. The Personal Wellness and Responsibility (POWER) Account is the feature of HIP that makes it unique among programs developed nationally for the low-income uninsured. The POWER Account was used in HIP 1.0 and continues to be used in the HIP 2.0 program. A $1,100 allocation is contributed for each HIP member's POWER Account annually. These dollars are funded through contributions from the member, the State (with federal matching dollars) and, in some cases, the member's employer. The member's contribution to the $1,100 balance is calculated based upon household income.

The POWER Account is intended for members to use to purchase health care services. However, in an effort to promote preventive care, the first $500 in preventive care benefits are covered by the MCE and are not drawn from a member's POWER Account.

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

The **Hoosier Care Connect (HCC)** program was implemented April 1, 2015. Enabling state legislation in CY 2013 tasked the FSSA with managing the care for the aged, blind and disabled Medicaid enrollees. After convening a task force of key FSSA divisions, the FSSA developed the HCC program. This new program means that its predecessor program, Care Select, expired June 30, 2015. Whereas HCC is administered by MCEs, the Care Select program was administered by Care Management Organizations who were not at full risk. The MCEs who administer HCC are the same ones that administer HHW and HIP 2.0.

Traditional Medicaid is comprised of the remaining Medicaid enrollees who are not members of HHW, HIP 2.0 or HCC. Specifically, the following populations are covered under Traditional Medicaid under a fee-for-service environment:

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

Applicants to HHW, HIP 2.0 and HCC are asked to select the MCE they would like to join if determined eligible for the program. If a member does not select an MCE within 14 days of obtaining eligibility, then Indiana Medicaid auto-assigns the member to an MCE. Once assigned, the MCE then has 30 days to work with the member to select a primary medical provider (PMP). If the member does not make a selection within this time frame, the MCE will auto-assign the member to a PMP.

Currently, there are three MCEs that contract with the OMPP to administer services to the HHW, HIP 2.0 and HCC populations. Anthem Insurance Companies, Inc. (Anthem) has been under contract with Indiana Medicaid since 2007. Coordinated Care Corporation, Inc. d/b/a Managed Health Services (MHS) is a subsidiary of the Centene Corporation and has been under contract with Indiana Medicaid since the inception of HHW in 1994. MDwise, Inc. has also been participating in HHW since its inception. MDwise subcontracts the management of services to nine delivery systems.

Enrollment at a Glance

As seen in Exhibit I.1 below, net enrollment in Indiana Medicaid's program grew by more than 200,000 most directly due to the rapid expansion of HIP 2.0. In addition to this, the managed care enrollment growth from December 2014 to December 2015 was even larger (up 322,707 members) due to the expiration of the Care Select program and the introduction of the HCC program. Enrollment in HHW went down because most all of the adults that had been enrolled in the program were moved to HIP 2.0. The child enrollment in HHW actually saw a slight increase from December 2014 to December 2015.

Exhibit I.1
Change in Enrollment Across Indiana Medicaid's Programs, Dec 2014 to Dec 2015

	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect	Care Select (fee-for-service)	All Other Non Risk-Based Programs	All Combined
December 2014	669,951	60,295	0	43,040	407,662	1,180,948
December 2015	600,452	354,879	97,622	0	337,756	1,390,709
Change from Dec 14 to Dec 15	**-69,499**	**294,584**	**97,622**	**-43,040**	**-69,906**	**209,761**

	Managed Care Programs	Fee-for-Service Programs	All Combined
December 2014	730,246	450,702	1,180,948
Pct of Total	61.8%	38.2%	
December 2015	1,052,953	337,756	1,390,709
Pct of Total	75.7%	24.3%	
Change from Dec 14 to Dec 15	**322,707**	**-112,946**	**209,761**

Source: OMPP Enterprise Data Warehouse. Data provided by B&A by Optum (OMPP's vendor) on May 31, 2016.

Exhibit I.2 shows that Anthem and MDwise have a similar proportion (36%-38%) of total managed care members when considering the three programs combined, and MHS has 26 percent. Within the three programs, MDwise has a higher proportion of HHW and HCC members while Anthem has a higher proportion of HIP 2.0 members.

Exhibit I.2
Managed Care Program Enrollment by MCE
As of December 2015

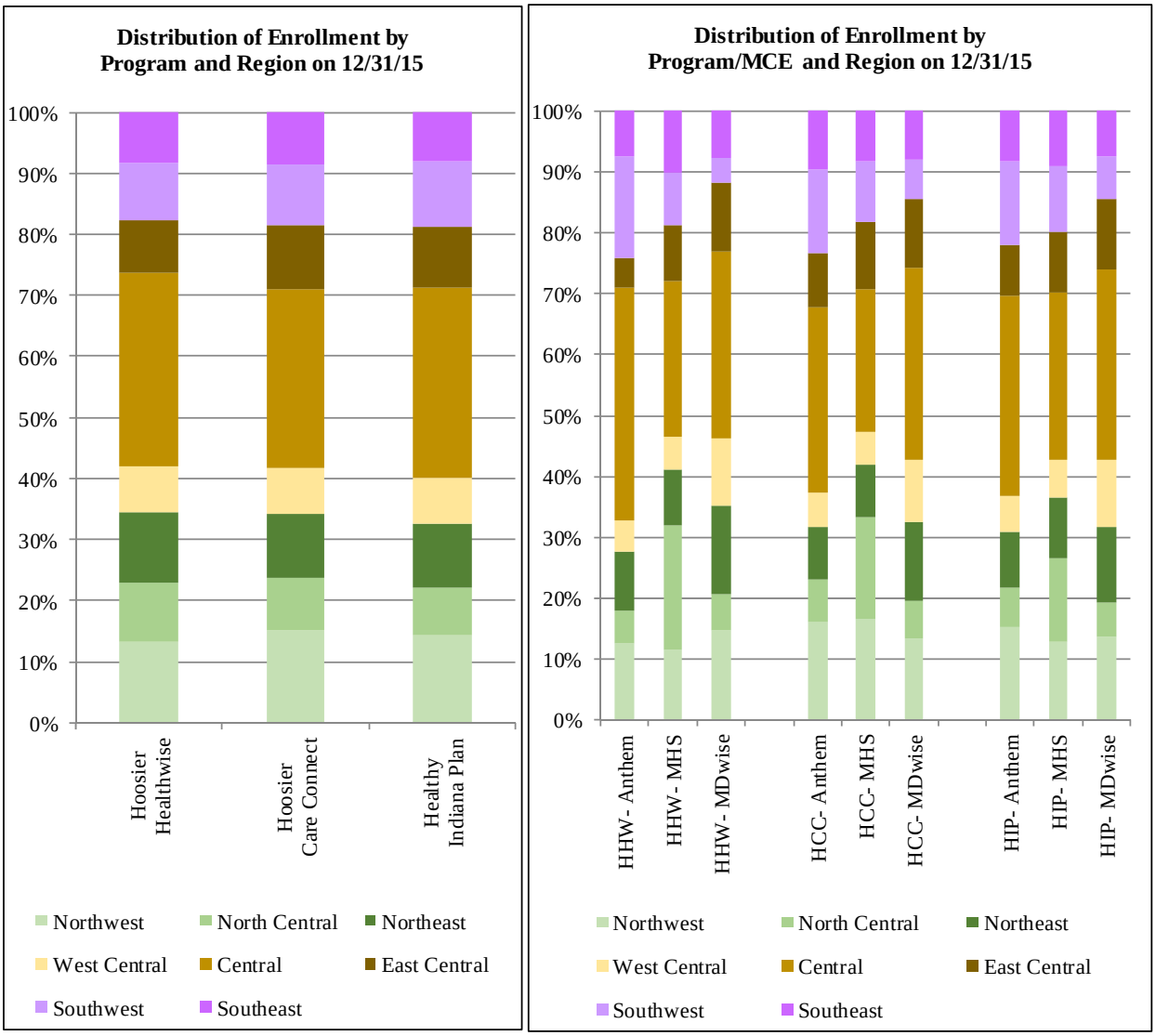
	Hoosier Healthwise	Healthy Indiana Plan	Hoosier Care Connect	All Combined
Anthem	32%	42%	36%	36%
MHS	28%	24%	21%	26%
MDwise	40%	34%	43%	38%

Source: OMPP Enterprise Data Warehouse

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

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

Exhibit I.3
Managed Care Program Enrollment by Region and MCE
As of December 2015



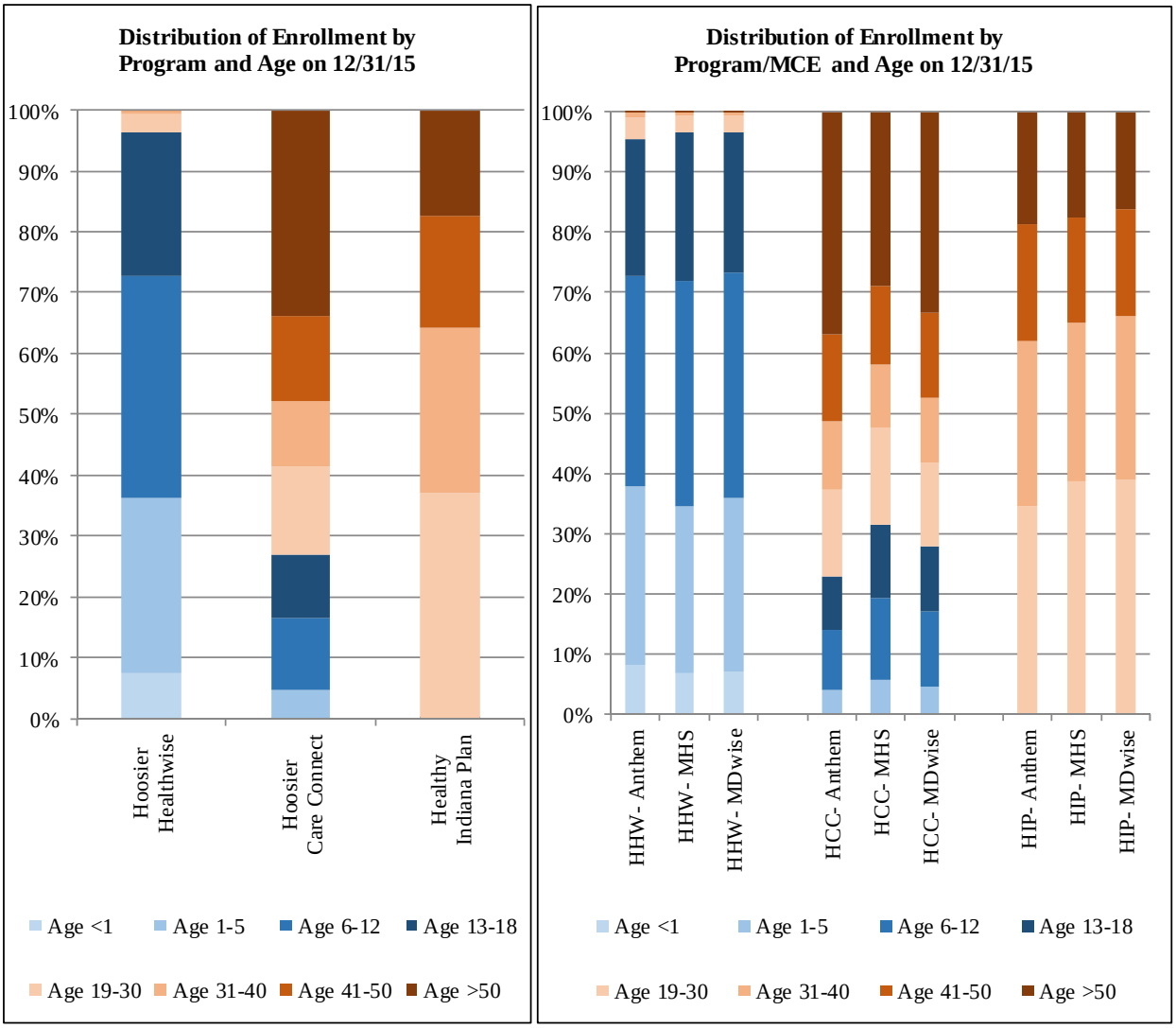
Source: OMPP Enterprise Data Warehouse

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

Exhibit I.4 illustrates the targeted populations of each of Indiana's managed care programs. As of December 2015, more than 96 percent of the HHW population is children. Conversely, all of the HIP population is adults. The HCC program is mixed with 27 percent children and 73 percent adults. Even within HCC, the children that are enrolled are mostly older children.

In the right box, the enrollment is distributed by age group and by MCE. There are no significant differences in the distribution of the enrollment by age group across the MCEs in any of the three managed care programs.

Exhibit I.4
Managed Care Program Enrollment by Age and MCE
As of December 2015



Source: OMPP Enterprise Data Warehouse

Indiana Medicaid's CY 2015 Quality Strategy Plan

Indiana Medicaid, like other State Medicaid Agencies, develops an annual Quality Strategy Plan. In its 2015 Plan, Indiana outlined specific initiatives for the HHW, HIP and HCC programs as well as the Traditional Medicaid program. The initiatives for the managed care programs are shown on the next page in Exhibit I.5.

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

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

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

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

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

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

[8] From the Indiana Medicaid Managed Care Quality Strategy Plan 2015, page 4.
https://secure.in.gov/fssa/hip/files/2015_Indiana_Medicaid_Quality_Strategy_Plan_final.pdf

Exhibit I.5
OMPP Quality Strategy Initiatives for 2015

Area of Focus	Goal	HHW	HIP	HCC
Improvements in Children and Adolescent Well-Care	Achieve at or above the 90th percentile for improvements in children and adolescent well-child visits (HEDIS).	✓		
Early Periodic Screening, Diagnosis and Treatment (EPSDT)	Improve the EPSDT participation rate to 80% in 2014.	✓		
Improvement in Behavioral Health	Achieve at or above the 90th percentile for members who receive follow-up within 7 days of discharge from hospitalization for mental health disorders (HEDIS).	✓	✓	
Ambulatory Care	Achieve at or above the 75th percentile (for HHW, HIP is 90th percentile) of Ambulatory Outpatient Care Visits (HEDIS).	✓		
	Achieve at or above the 90th percentile.		✓	
	Establish baseline data			✓
Emergency Room Visits	Achieve at or below the 10th percentile of Ambulatory Emergency Department Care Visits (HEDIS).	✓		
	Achieve at or below 75 visits per 1000 member months.		✓	
Smoking Cessation	Achieve at or above the 50th percentile for members who are advised to quit during at least one visit with a health care provider.	✓		
Diabetes Care	Achieve at or above the 75th percentile of diabetic members who receive a LDL-C screening.	✓		
Full Term Pregnancy	Benchmark the early elective delivery rate at the 1 year mark of policy implementation.	✓		
Freqency of Prenatal and Post-Partum Care	Achieve at or above the 90th percentile for the frequency of prenatal, and at or above the 90th percentile, for post-partum care	✓		
	Establish baseline data		✓	
Notification of Pregnancy	Increase the overall number of provider submitted Notification of Pregnancy forms by 1% above the the 2013 rate.	✓		
Monitoring Presumptive Eligibility (PE) for Pregnant Women	Increase the number of submitted PE applications during the 1st trimester of pregnancy by 2%.	✓		
Right Choices Program (RCP)	Achieve at or above 96% of the RCP periodic reviews that are completed on time.	✓	✓	
Access to Care	90% of all HIP members shall have access to primary care within a minimum of 30 miles of a member's residence and at least two providers of each specialty type within 60 miles of their residence.		✓	
Access to Care	90% of all HIP members shall have access to dental and vision care within a minimum of 60 miles of a member's residence and at least two providers of each type within 60 miles of their residence.		✓	
POWER Account Rollover	Achieve at or above 85% of the number of members who receive a preventive exam during the year.		✓	
Medically Frail	Establish baseline data		✓	
Preventive Care (HEDIS AAP-like)	Establish baseline data			✓
Completion of Health Needs Screen	Percentage of newly enrolled MCE members, net of terminated members, that have had a health screen assessment completed within 90 days.			✓
Completion of Comprehensive Health Assessment Tool	Percentage of newly enrolled MCE members, net of terminated members, that have had a comprehensive health assessment completed within 150 days.			✓
Identification of Hoosier Care Connect Members	Number of members identified by stratification level, program participation length and average contacts per month.			✓
Complex Case Management	Number of CCM members by disease state, total contacts and average contacts per reporting period.			✓

Source: Indiana Medicaid Managed Care Quality Strategy Plan 2015

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

Background

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

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

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

For the first activity, B&A completed a full review of compliance with all federal Medicaid managed care regulations as well as additional contractual requirements mandated by Indiana Medicaid in its contract with the managed care entities (MCEs) in the EQR conducted in 2012 covering Calendar Year (CY) 2011. B&A utilized the CMS Protocol *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al.* to complete this review. This periodic review was completed in 2012 because the OMPP entered into new contracts with the MCEs effective January 1, 2011 in which the requirements for administering the Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) programs were subsumed under one contract.

In other years, B&A has worked with the OMPP to develop focus studies covering specific aspects of the HHW and HIP programs. This approach began with the CY 2009 review. The functional areas where focus studies have been completed in the last six years appears in Exhibit II.1 on the next page.

The OMPP released a Request for Proposals (RFP) to contract with MCEs for the HHW and HIP programs with a contract effective date of January 1, 2017. There will be new benefit coverage and other policy requirements in the new contract. Therefore, B&A will conduct the review of MCO compliance once again upon initiation of this new contract.

In the meantime, B&A continues to perform the activities related to the validation of performance measures, the validation of performance improvement projects, and targeted focus studies related to OMPP quality initiatives.

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

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

Exhibit II.1
EQR Focus Studies Conducted of MCE Operations in HHW and HIP, 2010 - 2015

Year Review Conducted	Review Year	Program	Functional Area	Review Topic
CY 2010	CY 2009	HHW, HIP	Member Services	Initiatives to Address Cultural Competency
CY 2010	CY 2009	HHW, HIP	Program Integrity	Program Integrity Functions
CY 2010	CY 2009	HHW, HIP	Provider Network	Availability and Accessibility of Providers to Members
CY 2010	CY 2009	HHW, HIP	Utilization Management	Retrospective Authorization and Claim Denial Review
CY 2011	CY 2010, Q1 2011	HHW, HIP	Disease Management	Review of Disease, Case and Care Management Practices
CY 2011	CY 2010	HHW, HIP	Clinical Practices	Clinical Review of Complicated C-sections and Hospital Readmissions
CY 2011	CY 2010	HHW, HIP	Emergency Services	ER Utilization and Payment Practices
CY 2012	CY 2011	HHW, HIP	Utilization Management Behavioral Health	Review of Inpatient Psychiatric Stays
CY 2012	CY 2011	HHW, HIP	Utilization Management	Review of the Right Choices Program
CY 2013	CY 2012	HHW, HIP	Access to Care	Review of member access to care and provider perceptions of the MCEs
CY 2013	CY 2012	HHW, HIP	Mental Health Utilization and Care Coordination	Clinical review of care plans and review of care coordination for members with co-morbid physical health and behavioral health ailments
CY 2014	CY 2013	HHW	Access to Care	Review of Non-Emergency Medical Transportation Services
CY 2014	CY 2013	HHW, HIP	Member Services	New Member Activities
CY 2014	CY 2013	HHW, HIP	Provider Relations	Review of MCE Provider Services Staff and Communication with Providers
CY 2014	CY 2013	HHW, HIP	Program Integrity	Review of Processes Related to Third Party Liability
CY 2015	CY 2014	HHW, HIP	Utilization Management	Review of Service Authorization Processes including sample review
CY 2015	CY 2014	HHW, HIP	Inpatient Hospital Readmissions	Assessment of Potentially Preventable Hospital Readmissions
CY 2015	CY 2014	HHW, HIP	Emergency Services	Assessment of Potentially Preventable Emergency Department Visits

EQRO Activities in CY 2016

B&A met with the OMPP in early 2016 and developed the following topics for this year's EQR:

- Validation of Performance Measures
- Validation of MCE Performance Improvement Projects (Quality Improvement Projects, QIPs)
- Optional EQR Activity: Focus Study on the Audit of MCE Provider Directories
- Optional EQR Activity: Focus Study on Assessing Beneficiary Access to Providers
- Optional EQR Activity: Focus Study on the Utilization and Access to Dental Services
- Optional EQR Activity: Focus Study on the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- Optional EQR Activity: Focus Study on the Delivery of Prenatal Care Services
- Optional EQR Activity: Focus Study on the Delivery of Well Care and Primary Care to Children

For the validation of performance measures and QIPs, B&A utilized the September 2012 editions of CMS Protocols EQR Protocol #2: *Validation of Performance Measures* and EQR Protocol #3: *Validating Performance Improvement Projects* for guidance in completing these mandatory activities. For the six focus studies, B&A worked with the OMPP Quality Director to develop the elements of each study.

The details pertaining to each aspect of this year's EQR were released to the MCEs in an EQR Guide on June 3, 2016. The EQR Guide appears in Appendix B of this report. It contains information about the focus of each review topic in the EQR, the expectations of MCEs in the review, a document request list, and a schedule of events. For all review topics, a desk review, onsite reviews and post-onsite follow-up occurred. All of this year's EQR tasks were conducted during May through October, 2016.

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

- An enrollment file that contained demographic information about each Medicaid enrollee
- A member month file that tracked a Medicaid member's enrollment in any of the three programs (HHW, HCC or HIP) as well as Traditional Medicaid on a monthly basis for CYs 2014 and 2015
- A provider roster file that contained demographic information about each provider enrolled with Indiana Medicaid (a provider must be enrolled with Indiana Medicaid before the provider can contract with an MCE for any Medicaid managed care program)
- A dataset of fee-for-service claims with dates of service in CYs 2014 and 2015 for individuals who moved from a fee-for-service to a managed care program (or back to fee-for-service)
- A dataset of encounters with dates of service in CYs 2014 and 2015 representing all services submitted by the MCEs to OMPP for members enrolled in HHW, HIP or HCC
- For both the fee-for-service claims and encounter data, services included institutional services, professional services, dental services and pharmacy scripts

Sections III through X of this report describes in detail the methodology and findings of each of the EQR activities stated above. Because the MCEs that contract with the OMPP serve all three programs (HHW, HCC and HIP), the review of all three programs was conducted simultaneously. This report, therefore, serves as the EQR study for all thee of Indiana's managed care programs for CY 2015. Throughout the

report, where applicable, information is presented for each program individually. In some studies, information is not shown for all three programs. This is due to one of two reasons. One reason is that the study was not specific to the population served in the program (e.g., the focus study on well care and primary care delivered to children is not applicable to the HIP). Another reason is that there has not been sufficient time since the program's implementation to collect enough information to produce findings (this is true in some cases for the HCC and HIP).

The EQR Review Team

This year's review team included the following staff:

Onsite Team

- Mark Podrazik, Project Director, Burns & Associates, Inc. Mr. Podrazik provided project oversight and participated in onsite reviews for this year's EQR. He has worked with the OMPP in various capacities since 2000. Previously, Mr. Podrazik led the EQRs of HHW in CYs 2007-2015 as well as the EQRs for the HIP in CYs 2009-2015. Although it was not required since the program was not a managed care program, Mr. Podrazik also conducted an external review of Indiana's Care Select program (the predecessor to HCC) at OMPP's request in CY 2009.

- Maureen Sharp, Project Manager/RN, Burns & Associates, Inc. Ms. Sharp joined the EQR team this year with a focus on the data analytics related to the focus study on IET as well as participating in face-to-face interviews with IET providers in the state. Ms. Sharp brings her nursing experience, consulting experience, and eight years working at a state Medicaid agency where she was responsible for managing medical policy and a data analytics team.

- Dr. Linda Gunn, AGS Consulting, Inc. Dr. Gunn participated as a team member in the audit of the MCE's provider directories by conducting calls to a sample of providers and by auditing the MCE websites for a sample of provider information. She also participated in face-to-face interviews with IET providers in the state. Dr. Gunn also participated in B&A's EQRs for Indiana programs in CYs 2009-2015.

- Debbie Saxe, Saxe Consulting, LLC under contract to AGS Consulting. Ms. Saxe joined the EQR team this year with a focus on the data analytics related to the focus study on dental services as well as participating in face-to-face interviews with IET providers in the state. Ms. Saxe brings over 25 years working at a state Medicaid agency where she was responsible for managing policy, reimbursement and, for part of her tenure, a managed care oversight unit.

- Kristy Lawrance, Lawrance Policy Consulting, LLC. Ms. Lawrence participated as a team member conducting the desk review of QIPs and led the onsite interviews related to this topic. She also participated in face-to-face interviews with IET providers in the state and was on the team conducting the audit of MCE provider directories. Ms. Lawrance also participated in B&A's EQRs for Indiana programs in CYs 2013-2015.

Analytics Team

- Steven Abele, Senior Consultant, Burns & Associates, Inc. Mr. Abele analyzed and validated the provider databases submitted by the MCEs in this year's EQR. Mr. Abele has worked on four previous EQRs for Indiana.

- Jesse Eng, SAS Programmer, Burns & Associates, Inc. Mr. Eng conducted analytical support in SAS in the validation of performance measures and the calculation of findings related to the IET study and prenatal care study. He has participated in analytical aspects of B&A's EQRs for Indiana since 2010. Mr. Eng has also served as the lead analyst on B&A's project to write an independent evaluation of Indiana's Children's Health Insurance Program (CHIP). He also assists in preparing Indiana's annual CHIP report to CMS.

- James Maedke, SAS Programmer, Burns & Associates, Inc. Mr. Maedke conducted analytical support in SAS in the validation of performance measures and the calculation of findings related to the well care/primary care utilization study. He has participated in analytical aspects of B&A's EQRs conducted in CYs 2014 and 2015 and he has also served as the lead analyst on B&A's project to write an independent evaluation of Indiana's CHIP. He also assists in preparing Indiana's annual CHIP report to CMS.

- Ryan Sandhaus, SAS Programmer, Burns & Associates, Inc. Mr. Sandhaus conducted analytical support in SAS in the validation of performance measures and the calculation of findings related to the well care/primary care utilization study, the prenatal care study, the dental access study and the access to providers study. Prior to his work on this EQR, he has participated in analytical aspects of a B&A project for another state that analyzed beneficiary access to care across a variety of provider specialties.

- Tina Brezenski, Analyst, Burns & Associates, Inc. Ms. Brezenski used her geocoding and mapping software skills to assist the team in the focus study related to the utilization and access to dental services.

- Sakina Pasha, Analyst, Burns & Associates, Inc. Ms. Pasha participated as a team member in the audit of the MCE's provider directories by conducting calls to a sample of providers.

- Barry Smith, Analyst, Burns & Associates, Inc. Mr. Smith participated as a team member in the audit of the MCE's provider directories by conducting calls to a sample of providers. He also built and maintained the Microsoft Access database used to tabulate results from the sample phone audit. Mr. Smith also assisted in the tabulation of information related to the validation of performance measures and he summarized the results of the geoaccess reports submitted by the MCEs to the OMPP across 23 provider specialties. Mr. Smith has previously worked on the Data Analysis Team for the EQRs conducted in CYs 2009-2015.

SECTION III: VALIDATION OF PERFORMANCE MEASURES

Introduction

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

For this year's EQR, B&A selected five performance measures from among the many in the MCE Reporting Manual for review. Additionally, a more comprehensive evaluation of geoaccess reports that are submitted by the MCEs was also conducted. The geoaccess evaluation will be discussed more fully in Section VI of this report.

Each of this year's performance measures are based on Healthcare Effectiveness Data and Information Set (HEDIS)®[9] measures. The MCEs are required to submit annual HEDIS results as compiled by an independent certified HEDIS auditor. Among this year's measures, the annual submissions that were tabulated by the HEDIS auditor used the hybrid approach—that is, a combination of administrative (claims) data and medical record abstraction.

The validation exercise for this EQR, however, is based solely on the administrative method. For the measures that were reviewed, the MCEs are required to submit information on a quarterly basis for a 12-month period each quarter. As subsequent quarters occur, the 12-month period for reporting advances. Therefore, the definitions for each measure as instructed by the OMPP are "HEDIS-like" in that they follow the HEDIS specifications for the measure with the exception that the anchor date for the measure continually changes with each reporting cycle.

B&A has followed the steps in the Centers for Medicare and Medicaid's (CMS's) EQR Protocol #2, *Validation of Performance Measures*, with some slight adjustments discussed with the OMPP. The sections below describe our validation activities in this protocol. At the end of this section, the results of our validation are shown for each measure.

Activity 1: Pre-Onsite Visit Activities

In cooperation with the OMPP, B&A selected the following measures for validation in this year's EQR.

Report Number	Report Name	HEDIS Definition	HHW	HCC	HIP
QR-CA1	Well Child Visits, First 15 Months of Life	W15	X	X	
QR-CA2	Well Child Visits, Third through Sixth Years of Life	W34	X	X	
QR-CA3	Adolescent Well Care Visits	AWC	X	X	
QR-PCC10	Adolescent Well Care Visits, 19-21 year olds	AWC			X
QR-MN3	Prenatal Care	PPC	X		
QR-MN3	Postpartum Care	PPC	X		

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

Since some measures are required to be submitted for multiple programs, B&A validated the results of the measures reported for each program separately.

Although these measures are reported quarterly by the MCEs, B&A validated the results reported by the MCEs in their 1st Quarter 2016 report submissions. Since the OMPP quarterly report specifications require a 90-day claims lag period, this means that:

- The measurement year of study for W15, W34 and AWC is Calendar Year (CY) 2015.
- The measurement period for deliveries for the PPC measure is deliveries between November 6, 2014 and November 5, 2015.

As previously mentioned in Section II, B&A received data from the OMPP Enterprise Data Warehouse (EDW) with the transfer of data facilitated by OMPP's EDW vendor, Optum. This included enrollment data and encounter claims which the MCEs are required to submit to the OMPP. All data used to validate this year's performance measures came from the OMPP's EDW.

Preparing the Dataset for Each Measure

B&A used the HEDIS 2016 specifications as the basis for validating the results submitted by the MCEs. By selecting the 1st Quarter 2016 report submissions, B&A effectively was replicating the HEDIS parameters for an annual HEDIS submission if the administrative method only was used.

The following criteria were used in calculating the results for each *well care measure*:

	W15	**W34**	**AWC**
Age	15 months old during the measurement period	3 to 6 Years as of the end of the measurement period	12 to 21 Years as of the end of the measurement period
Measurement Period	Analyzed claims from 10/1/13 – 12/31/15, as needed, based on the date the member turned 15 months old during the measurement period	Analyzed claims from 1/1/15 – 12/31/15	Analyzed claims from 1/1/15 – 12/31/15
Continuous Enrollment	From 31 days after birth to 15 months of age	The entire measurement year	The entire measurement year
Allowable Gap*	No more than one monthly segment within the MCE during the continuous enrollment period	No more than one monthly segment within the MCE during the continuous enrollment period	No more than one monthly segment within the MCE during the continuous enrollment period
Anchor Date	The day the child turns 15 months old	December 31, 2015	December 31, 2015

*One limitation of the data is that B&A received member month data from the EDW. This identifies a member's enrollment in an MCE for an entire month. Whereas HEDIS generally uses a 30-day gap in enrollment, B&A used a monthly segment, which means that gaps are rounded to the nearest month, not to the day.

The following criteria were used in calculating the results for the *prenatal and postpartum measures*:

- Continuous enrollment 43 days prior to delivery and 56 days after delivery
- No allowable gap during the time period above
- Anchor date is the date of delivery
- If a woman had more than one delivery during the study period and
  - The multiple births were on the same day, then the woman was counted once in the study
  - The multiple births were on different days (9 or more months apart), then the woman was counted twice in the study

For all five measures, the following additional rules applied:

- All fee-for-service (FFS) members and their claims were excluded from consideration.
- If a member moved from FFS to an MCE in the study period, the member's FFS information was excluded from consideration.
- If a member stayed within an MCE but moved across programs (e.g., from HHW to HIP or vice-versa) in the study period, the member's information for the entire measurement period "carried with them" and the member was assigned to the program that they were enrolled with at the end of the measurement period.

Since the entire dataset of administrative data was used for the study period, there was no need to assess any sampling process.

Trending Previously Submitted Data to Use as a Benchmark

Although only one quarterly submission for each measure was validated, B&A also collected the reports submitted to the OMPP by the MCEs that contained the values submitted over four quarterly report submissions for each measure. B&A tabulated the results from these reports into a report for the purpose of (a) comparing data submitted by the MCE over time and (b) to serve as a benchmark for comparison to B&A's independent calculations.

Exhibit III.1 on the next page shows the trends reported by the MCEs for the well care visit measures. Although there are differences in the results across the MCEs, the results within an MCE across the four reporting periods are generally consistent in the HHW program. There is more volatility reported across MCEs and within an MCE over time in the well care visit reports for HCC and HIP. This is not unexpected, because the well care measures look back over a 12-month period for visit use. The HIP 2.0 program did not start until February 1, 2015 and the HCC program did not start until April 1, 2015. Therefore, even the Q1 2016 report submission (experience through December 31, 2015) did not have a full 12 months of experience to report for either the HCC or HIP. For W15 and W34, the trends are moving as expected in that the compliance rate for a well care visit is increasing with each new reporting quarter once more experience is included in the study. The AWC data for HIP is more volatile because the sample size is small.

Exhibit III.2 appears on page III-5 and shows the trends reported by the MCEs for the PPC measures (prenatal and postpartum care). For both the prenatal care and postpartum care measures, the trend shows very consistent results across the four reporting periods for each MCE. In fact, the results are also consistent across MCEs on both of these measures as well.

Exhibit III.1
Trend Report on Well Care Visit Performance Measures

	As reported by MCE to the OMPP			
Reporting Period >>	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Experience Period Ends on Last Day of >>	Q1 2015	Q2 2015	Q3 2015	Q4 2015

MCE	Program	Result	Result	Result	Result
Measure:	**W15**	**Percentage of members with 6 or more well-child visits in past 15 months, ages 0-15 months**			
Anthem	HHW	58.8%	58.2%	62.6%	59.2%
	HCC			0.0%	0.0%
MHS	HHW	55.2%	53.9%	53.5%	53.0%
	HCC			33.3%	40.0%
MDwise	HHW	61.5%	61.0%	65.8%	64.9%
	HCC			0.0%	0.0%
Measure:	**W34**	**Percentage of members with 1 or more well-child visits in past 12 months, ages 3-6 years**			
Anthem	HHW	67.9%	66.8%	67.4%	66.5%
	HCC			22.0%	38.4%
MHS	HHW	69.5%	67.5%	66.7%	69.8%
	HCC			70.7%	70.3%
MDwise	HHW	70.1%	68.2%	70.3%	72.6%
	HCC			22.4%	37.1%
Measure:	**AWC**	**Percentage of members with 1 or more well-child visits in past 12 months, ages 12-21 years**			
Anthem	HHW	52.0%	51.2%	49.6%	48.7%
	HCC			14.9%	24.7%
	HIP Plus			20.0%	12.7%
MHS	HHW	55.1%	53.3%	51.4%	53.8%
	HCC			49.1%	42.4%
	HIP Plus			29.8%	28.8%
MDwise	HHW	55.5%	54.4%	53.4%	56.2%
	HCC			15.5%	24.0%
	HIP Plus			32.0%	28.9%

Notes:

1. HCC began April 1, 2015 and HIP 2.0 began February 1, 2015. Therefore, only data from experience periods starting in Q2 2015 are shown.

2. These reports are rolling 12-month results. Therefore, the results shown for HCC and HIP are incomplete even for the Q1 2016 reporting period because a full 12 months of experience had not yet commenced.

3. The OMPP requires the MCEs to report results for three different products under HIP: HIP Plus, HIP Basic and HIP State Plan. Since the majority of the membership is in the HIP Plus product, only this service line is shown.

Exhibit III.2
Trend Report on Prenatal and Postpartum Performance Measures
Hoosier Healthwise Program Only

	As reported by MCE to the OMPP			
Reporting Period >>	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Experience Period Ends on Last Day of >>	Q1 2015	Q2 2015	Q3 2015	Q4 2015

MCE	Measure	Result	Result	Result	Result
Anthem	Prenatal	75.4%	75.0%	74.5%	77.1%
	Postpartum	59.0%	58.8%	58.5%	59.8%
MHS	Prenatal	76.2%	75.5%	76.9%	75.3%
	Postpartum	61.4%	60.9%	61.7%	60.6%
MDwise	Prenatal	74.6%	74.6%	74.5%	74.8%
	Postpartum	58.5%	58.9%	58.2%	58.6%

Measure:	PPC - Prenatal	Percentage of deliveries that received a prenatal care visit as a member of the MCO in the first trimester OR within 42 days of enrollment
Measure:	PPC - Postpartum	Percentage of deliveries that received a postpartum care visit on or between 21 and 56 days after delivery

Step-by-Step Process to Validate HEDIS Specifications

Upon review of each HEDIS 2016 specification, B&A built SAS programs to tabulate members meeting numerator or denominator compliance. To validate our work in following the specifications in a step-by-step manner, B&A ran reports to assess data validity throughout the process. Examples include:

- For the well care measures
  - Count of ever enrolled members in the program (HHW, HCC or HIP) and then the count of excluded members either because the member was too young or too old during the measurement period or because the member did not have continuous enrollment with the MCE during the measurement period.
  - Once a count of the eligible population was established (the denominator for the measure), a count of eligible members by age within each MCE was performed.
  - To assess the potential count of well care visits (the numerator in the measure), frequencies were run on the denominator member's claims by provider type, provider specialty and place of service
  - To validate numerator compliance using the HEDIS well care visit value set, frequencies were run on the count of visits by the allowable CPT/HCPCS in the value set and the diagnosis codes in the value set.
  - To further validate the total count of members with numerator compliance, a count of eligible numerator members by age within each MCE was completed.

- For the prenatal and postpartum measures
  - Count of women with a trigger event (e.g., an encounter with a delivery CPT, a delivery surgical procedure code on an inpatient claim, or a delivery diagnosis code) by MCE
  - Count of women excluded for non-live birth or non-continuous enrollment by MCE
  - Count of women in the eligible population by MCE based on the number of trimesters enrolled
  - Count of women meeting numerator compliance based on each of the HEDIS prenatal value sets (the value sets differ depending upon the trimesters that the member was enrolled and the count of days since enrollment began)
  - Count of women meeting numerator compliance based on each of the HEDIS postpartum value sets

Activity 2: Onsite Visit Activities

On July 27 and 28, 2016, B&A walked through the computed results for each performance measure in the validation study with the MCE staff who are responsible for the tabulation and submission of the measures to OMPP on the quarterly reports. Questions were asked by B&A that were specific to each MCE/measure in an effort to understand the potential root cause of differences between the MCE and B&A results. To help facilitate this discussion, B&A provided the reports from the step-by-step process discussed above as supporting documentation of B&A's calculation for each measure.

During the onsite meeting, the preliminary findings were reviewed and a focus was directed on areas where there were the differences between how the MCE reported the measure and how B&A reported the measure. The MCEs were asked to identify or clarify items that could be reviewed on their end to help assist in identifying the root cause of difference or if adjustments were needed to be made to either parties' figures.

Activity 3: Post-Onsite Visit Activities and Results of the Validation

After the onsite meeting with the MCEs, B&A incorporated adjustments made either by suggestions from the MCEs or through our own validation process. This report serves as the submission of the validation report to the State

The results of B&A's validation appear in Exhibit III.3 on the next page.

The reason why B&A made the assessment of "Validated, with caveat" is because the differences between the MCE's result and B&A's result were minor but most likely explained by differences in member enrollment due to retroactive eligibility. B&A was able to compute all of the measures at the same time in July 2016. Any retroactive eligibility of members was accounted for in this tabulation. The MCEs are submitting their results to the OMPP on a quarterly basis with a 30-day lag after the end of the reporting period. To the extent that eligibility changes occurred more than 30 days after the end of the reporting period, these would be captured by B&A but not by the MCEs.

A summary of the findings for each performance measure appear in Exhibits III.4 and III.5 beginning on page III-8. Both exhibits are laid out the same and show three columns of data. The first column is the result of the measure as tabulated by the MCE and reported to the OMPP. The second column is result of the measure as tabulated by B&A using the data provided to us from the OMPP's EDW. The third column is the difference.

Exhibit III.3
EQRO's Assessment of Validating Performance Measures, by MCE

Measure:	**W15**	**Percentage of members with 6 or more well-child visits in past 15 months, ages 0-15 months**
Anthem	HHW	Validated, with caveat
	HCC	Not applicable
MHS	HHW	Not validated
	HCC	Not applicable
MDwise	HHW	Not validated
	HCC	Not applicable

Measure:	**W34**	**Percentage of members with 1 or more well-child visits in past 12 months, ages 3-6 years**
Anthem	HHW	Validated, with caveat
	HCC	Validated, with caveat
MHS	HHW	Validated
	HCC	Not validated
MDwise	HHW	Validated, with caveat
	HCC	Validated

Measure:	**AWC**	**Percentage of members with 1 or more well-child visits in past 12 months, ages 12-21 years**
Anthem	HHW	Validated, with caveat
	HCC	Validated, with caveat
	HIP Plus	Not validated
MHS	HHW	Validated, with caveat
	HCC	Not validated
	HIP Plus	Not validated
MDwise	HHW	Validated, with caveat
	HCC	Validated, with caveat
	HIP Plus	Not validated

Measure:	**PPC**	**Percentage of deliveries that received a prenatal care visit as a member of the MCO in the first trimester OR within 42 days of enrollment**
Anthem	HHW	Validated
MHS	HHW	Validated
MDwise	HHW	Not validated

Measure:	**PPC**	**Percentage of deliveries that received a postpartum care visit on or between 21 and 56 days after delivery**
Anthem	HHW	Validated
MHS	HHW	Not validated
MDwise	HHW	Validated

Exhibit III.4
Validation Report on Well Care Visit Performance Measures

Reporting Period >>	Q1 2016
Experience Period Ends on Last Day of >>	Q4 2015

MCE	Program	Reported by the MCE	Computed by B&A	Difference
Measure:	**W15**	**Percentage of members with 6 or more well-child visits in past 15 months, ages 0-15 months**		
Anthem	HHW	59.2%	57.2%	-2.0%
	HCC	Not reported		
MHS	HHW	53.0%	62.3%	9.3%
	HCC	40.0%	Not computed	
MDwise	HHW	64.9%	60.5%	-4.4%
	HCC	Not reported		
Measure:	**W34**	**Percentage of members with 1 or more well-child visits in past 12 months, ages 3-6 years**		
Anthem	HHW	66.5%	67.5%	1.0%
	HCC	38.4%	39.4%	1.0%
MHS	HHW	69.8%	69.8%	0.0%
	HCC	70.3%	41.1%	-29.2%
MDwise	HHW	72.6%	69.6%	-3.0%
	HCC	37.1%	37.0%	-0.1%
Measure:	**AWC**	**Percentage of members with 1 or more well-child visits in past 12 months, ages 12-21 years**		
Anthem	HHW	48.7%	49.3%	0.6%
	HCC	24.7%	25.7%	1.0%
	HIP Plus	12.7%	20.7%	8.0%
MHS	HHW	53.8%	55.2%	1.4%
	HCC	42.4%	24.8%	-17.6%
	HIP Plus	28.8%	25.8%	-3.0%
MDwise	HHW	56.2%	53.1%	-3.1%
	HCC	24.0%	24.5%	0.5%
	HIP Plus	28.9%	18.4%	-10.5%

Exhibit III.5
Validation Report on Prenatal and Postpartum Performance Measures
Hoosier Healthwise Program Only

Reporting Period >>	Q1 2016
Experience Period Ends on Last Day of >>	Q4 2015

MCE	Measure	Reported by the MCE Result	Computed by B&A Result	Difference Result
Anthem	Prenatal	77.1%	76.5%	-0.6%
	Postpartum	59.8%	59.2%	-0.6%
MHS	Prenatal	75.3%	75.1%	-0.2%
	Postpartum	60.6%	57.0%	-3.6%
MDwise	Prenatal	74.8%	79.1%	4.3%
	Postpartum	58.6%	59.3%	0.7%

Measure:	PPC - Prenatal	Percentage of deliveries that received a prenatal care visit as a member of the MCO in the first trimester OR within 42 days of enrollment
Measure:	PPC - Postpartum	Percentage of deliveries that received a postpartum care visit on or between 21 and 56 days after delivery

Well Care Measures

B&A could validate to Anthem's results on five of the six well care measures reviewed; for MHS, two of the six; for MDwise, four of the six. The measure that could not be validated for any MCE was the AWC measure in HIP. However, this may be due to data limitations for B&A more than MCE calculations.

In the HIP, the OMPP requires the MCEs to report results for three different products under HIP: HIP Plus, HIP Basic and HIP State Plan. The measure that B&A was validating against was the result for the HIP Plus product, since each MCE indicated that the majority of their HIP population was enrolled in this product line. B&A did not have the ability to segregate the HIP enrollees by product line. Therefore, B&A's results are for all HIP eligible members in AWC whereas the MCEs' results are for the HIP Plus members in AWC.

A further degradation of the finding related to HIP AWC is the low sample size to start with. Even when considering all HIP product lines, B&A computed a total HIP eligible population of 6,081. This is across three MCEs and three product lines. To the extent that the total eligibles are distributed across nine subgroups, the numerator results may not be significant due to low sample.

Prenatal and Postpartum Measures

B&A could validate to Anthem's results on both measures; for MHS, on the prenatal measure only; for MDwise, on the postpartum measure only. The reason why all measures could not be fully validated by B&A may also be a limitation in the data.

For the prenatal measure, the type of visits considered for numerator compliance is dependent upon the time period the mother is enrolled with the MCE. In particular, one test is 280 days prior to birth and another is within 42 days of enrollment. The issue is with respect to the actual enrollment start date. B&A obtained member month information on each member for each program/MCE. Therefore, the enrollment was rounded to the nearest month, not day. If a woman did not start to actively engage with an MCE until the 6th day of the month, B&A would have counted the first five days toward a 280 day test or 42 day test since the assumption had to be that the member was "actively engaged" in every day of the month based on the member month record.

For the postpartum measure, the issue is not so much with the completeness of the enrollment data as to the count of days from delivery. Assuming the mother was continuously enrolled in the MCE, B&A used the delivery claim to obtain the date of delivery to then count for a postpartum service between 21 and 56 days after delivery. Through the analytical process, B&A discovered (and the MCEs confirmed) that there are sometimes conflicting delivery dates when comparing the hospital claim and the physician's claim for the mother. To the extent that the dates are mismatched, this could influence the postpartum care results since the service is date sensitive.

Recommendations to the OMPP Related to Validation of Performance Measures

Based on the validations completed for the five measures selected for this year's study, B&A makes the following recommendations to the OMPP.

1. The OMPP should provide clarity on the counting of members who cross programs. For the prenatal visit measure, the instructions indicate to count the months when the woman was a member of the MCE, but not the number of months in the MCE in the same program. To the extent that mothers may move between HIP and HHW within the same MCE, there may be confusion on how to count total members to include in this report.

2. To help investigate the root cause for changes over time as well as to assess if anomalous data is due to low sample size, the OMPP should update its report templates to add fields for the MCEs to report the numerator and denominator values, particularly on the "HEDIS-like" measures submitted each quarter.

SECTION IV: VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

Introduction

As part of the Calendar Year (CY) 2014 External Quality Review (EQR), the Office of Medicaid Policy and Planning (OMPP) asked Burns & Associates (B&A) to assist in revising the reporting mechanism for the managed care entities (MCEs) to submit to the OMPP the results of their Performance Improvement Projects (PIPs).

B&A convened quality team members from each MCE and the OMPP to work collaboratively on a new reporting tool that became known as the Quality Improvement Project (QIP) Report. The draft of the new tool is in Microsoft Excel and combined elements from the National Committee on Quality Assurance (NCQA) Quality Improvement Project Form and elements from the CMS External Quality Review (EQR) Protocol 3: *Validating Performance Improvement Projects*. More of the focus on this new reporting tool is the definition of interventions, how they will be measured, and an assessment of the interventions on quality outcomes.

The OMPP selected the QIP term to differentiate between it and the Performance Improvement Projects that it requires of MCEs resulting from Corrective Action Plans. Before the implementation of this tool, the State and the MCEs used the terms "QIPs" and "PIPs" synonymously. In this report, references to "QIPs" means the same thing as "PIPs" in CMS EQR Protocol 3. The OMPP's new QIP Report became effective January 1, 2015.

The MCEs are required to have QIPs for all three programs that it administers—Hoosier Healthwise (HHW), Hoosier Care Connect (HCC) and Healthy Indiana Plan (HIP) 2.0. The MCEs have the option to conduct the same QIP across programs. For this year's EQR, Burns & Associates (B&A) selected the following QIPs for validation from each MCE:

<u>Anthem</u>

- New Member Health Needs Screening (HHW, HCC and HIP programs)
- Appropriate Use of Emergency Department Services (HHW only)
- Follow-up Visit after Inpatient Psychiatric Hospitalization (HCC only)
- Adult Preventive Care (HIP only)

<u>Managed Health Services (MHS)</u>

- Follow-up Visit after Inpatient Psychiatric Hospitalization (HHW, HCC and HIP programs)
- Appropriate Use of Emergency Department Services (HHW and HIP)
- Alcohol and Other Drug Dependence Treatment (HCC and HIP)

<u>MDwise</u>

- Follow-up Visit after Inpatient Psychiatric Hospitalization (HHW, HCC and HIP programs)
- Adolescent Well Care (HCC and HIP)
- Post-partum Care (HHW only)

Additionally, the EQR Review Team conducted follow-up conversations on activities that the MCEs were performing to better understand the provision of Non-Emergency Medical Transportation (NEMT) in the HHW program. This was a recommendation made by B&A in the focus study conducted on NEMT in

the EQR completed in CY 2014. On this topic, all of the MCEs have, in our opinion, satisfactorily completed research to answer the follow-up questions posed by the MCEs related to the NEMT study.

EQR Team members Mark Podrazik and Kristy Lawrance reviewed the QIP Report submissions as part of a desk review first. Then, on August 24 and 25, the team members conducted onsite meetings with each MCE to discuss the QIPs under review. This included follow-up questions from our desk review as well as a discussion with the relevant staff who had primary responsibility for the interventions that were put in place for the QIPs that were selected.

Review of Performance Improvement Projects

B&A followed the steps in Activity 1 of the CMS EQR Protocol #3: *Validating Performance Improvement Projects* to complete this validation.

Activity 1: Assess the Study Methodology

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

Activity 2, Verify Study Findings, is an optional activity and was not completed as part of this year's EQR.

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

B&A completed the Centers for Medicare and Medicaid's (CMS's) *EQR Protocol 3, Attachment A, PIP Review Worksheet* for each QIP reviewed as part of the validation. B&A did customize some of the components in the PIP Review Worksheet to better assess the specific QIPs at the MCE. In particular, more focus was spent on the MCE interventions for each QIP to determine if distinct interventions were measurable and how the MCEs measure their interventions and outcomes.

Desk Review

The MCEs submitted the annual QIP reports to B&A for each QIP for the desk review. Elements of the report include study question, the methodology used, interventions chosen, and results from both the benchmark period and any remeasurement periods. The EQR team members reviewed these materials and developed customized questions for each MCE/QIP for the onsite interviews.

Onsite Meeting

The MCEs had representatives from their team who were the leads for each QIP and those that could speak to the specific QIP interventions available for the onsite interviews. The EQR team members jointly met with MCE representatives to go over the questions in the customized interview protocols for

each QIP. In some instances, the MCEs brought supplemental information to the meeting to explain more fully the analytics completed on QIP measure results.

Post-Onsite Evaluation

The EQR team members considered the items from the desk review, the responses in onsite interviews, and supplemental information provided by the MCEs as requested to complete the assessment on each MCE QIP.

Anthem QIP Findings

New Member Health Needs Screening (HNS)

The OMPP has made timely compliance of new member HNSs a component of its Pay for Outcomes (P4O) program with the MCEs. Anthem developed a QIP related to new member HNS for the HHW, HCC and HIP populations.

The measure is the rate of completed HNSs within 90 days of enrollment in the program (either HHW, HCC or HIP). The numerator is the number of HNS completed within 90 days of notification to the MCE of a new member. The denominator is all new members to the MCE needing an HNS less any members that terminated prior to 90 full days of enrollment. Results of this measure are required to be submitted to the OMPP on a quarterly basis for each program.

In CY 2015, the quarterly rates reported by Anthem for completed HNSs varied from 21 percent to 44 percent in HHW (baseline for CY 2014 was 42%), from 13 percent to 85 percent in HCC (no baseline, new program in CY 2015), and from 16 percent to 42 percent in HIP (baseline for CY 2014 was 25 percent, but this was prior to expansion of the program in early CY 2015). The goal given by the OMPP is 70 percent. Anthem later said that the high percentage of 85 percent in HCC in one quarter needed to be resubmitted to the OMPP.

Anthem provided two reasons for the large variation in the completion rates within each program across the quarters as well as the variation across the programs. The primary reason was the rapid and immediate increase in enrollment first in HIP 2.0 and then in HCC. For example, the HIP denominator (those who required an HNS) grew 132 percent from Q1 to Q2 2015. The HCC denominator grew 57 percent from Q2 to Q3. To keep up with the large increases in membership volume, strained resources were diverted from one program to another during the enrollment "surge". As a result, the completion rates for HNS in the "non-surge" programs suffered.

Interventions

Anthem defined six interventions for HHW, two interventions for HCC and four interventions for HIP. Some interventions were common across the three programs. Other interventions were initially contemplated but never implemented or quickly abandoned. As a result, there was not an opportunity to assess the effectiveness of many of these interventions.

Other interventions replaced the ones that were originally contemplated. These interventions are summarized below.

1. Process improvements. Anthem uses a subcontractor to assist in making outbound calls to welcome new members and to initiate the HNS. There were issues identified with the lists of

members for the contractor to contact, the lists of members who needed reminder calls prior to the 90-day deadline to complete an HNS, and reports generated on the populations within each program who had completed or not completed an HNS. There were also data validity issues that needed to be resolved with the OMPP contractor who delivers to each MCE the new enrollee information. Anthem worked extensively with this contractor who also maintains a repository of all Indiana Medicaid members who have completed an HNS.

In addition to resolving the data exchanges with its subcontractor, Anthem developed a detailed work plan of the HNS process and convened the team who is the owner of tasks in the work plan. A new set of reports were developed so that Anthem can track completion rates by demographic information (e.g., gender, age) as well as tie HNS completion against member claims utilization. It is hoped that the joining of HNS information with claims will enable Anthem to better target members for case management or for adherence to HEDIS measures.

2. Mode of completion of the HNS. One of the issues cited by Anthem as to why the HNS completion was not higher is because of the length of the HNS and the time to complete it. Whereas originally the only method for HNS to be completed was telephonically with the member, Anthem has now implemented a web-based HNS for members to complete and has also worked with a company to offer kiosks in every Walmart in Indiana to enable members to complete the HNS via touch screen at the kiosk. In the web-based method, questions that are posed to members are conditional based on prior responses. This means that members do not have to be asked every question online (whereas they have been in the telephonic survey). Anthem reports that this has cut HNS completion time by five to seven minutes.

   The Walmart kiosks were just implemented in the summer of 2016. Members are sent a Walmart gift card by mail and encouraged to complete the HNS at the kiosk in the store. The gift card only gets validated at the kiosk after the member has successfully completed the HNS at the kiosk. The gift card can then be used immediately thereafter in the store.

Because the revised interventions all began at some point in CY 2016, it is still too soon to assess their effectiveness. Early returns, however, on the redemption of the Walmart gift cards (meaning successful completion of new HNSs) is high. Anthem is already planning a new intervention as well. Anthem is developing a mobile application for members to welcome them to the program. Emails or texts will be sent via the mobile application to remind members to complete a timely HNS.

Emergency Department Utilization

Anthem previously had a QIP related to Emergency Department (ED) Utilization in CYs 2012 through 2014. That QIP was discontinued and a new one began in 2016 with a focus on the HHW population. Two measures were developed:

1. The ED utilization rate per 1,000 HHW member months
2. The rate of decrease for the cohort of HHW members in Marion County (Indianapolis) who are in the highest groups of a chronic illness indicator index

For the first measure, the result in the baseline period (CY 2014) was 67.3 ED visits/1,000 member months. In the latest QIP study period (CY 2015), the result was 54.4. What has not been researched by Anthem was whether this improvement is a result of the interventions put in place or due to the change in HHW enrollment in CY 2015 (most all adults moved from HHW to HIP).

For the second measure, results were not tabulated because the intervention related to this measure was discontinued.

Interventions

Anthem initiated two interventions for this QIP. The first is called the ED Action Campaign which is interactive voice response (IVR) calls placed to members who used the ED more than twice in 180 days for diagnoses that likely could have been treated outside of the ED. The result of this intervention shown in the QIP is the percent of members who complied with the IVR. The initial (baseline) year of CY 2013 showed a result of 27 percent compliance; in CY 2014, the result was 28 percent; in CY 2015, 25 percent. To date, therefore, this intervention does not appear to have yielded a change in the ED utilization rate. One limitation documented in CY 2015 was whether IVR calls could be made to members on the national "do not call" list. It was later clarified that so long as the person is an Anthem member, calls are allowed.

The second intervention is in-person home visits completed by Indianapolis Emergency Medical Response teams to at risk HHW members. The assessment of the intervention was not completed because only two HHW members had in-home visits in the 1st Quarter of CY 2016.

Anthem mentioned another intervention in the onsite meeting that was not recorded in the QIP report. Anthem analyzed the ED rate by facility (hospital) and then visited facilities that had a higher-than-average ED rate among Anthem HHW members. These facilities were unwilling to participate in an intervention pilot.

Anthem has just started to work with CVS clinics as a way to promote alternatives to the ED with its members.

<u>Follow-up Visit after Inpatient Psychiatric Hospitalization (FUH)</u>

Anthem had previously had a QIP for Follow-up Visit after Inpatient Psychiatric Hospitalization (FUH) for its HHW population but discontinued it because the MCE had results on this HEDIS measure above the 90th percentile among Medicaid health plans nationally. With the introduction of HCC and the knowledge that inpatient psychiatric hospitalizations may be prevalent in this program, Anthem decided to initiate a QIP for HCC on this topic.

Anthem defined two measures for this QIP which are consistent with the current HEDIS FUH definition:

1. 7-Day: The percentage of members age six and greater that have attended a FUH appointment within seven days of discharge from an acute psychiatric setting with a mental health diagnosis.
2. 30-day: The percentage of members age six and greater that have attended a FUH appointment within 30 days of discharge from an acute psychiatric setting with a mental health diagnosis.

Because HCC just started in April 2015, the results from CY 2015 serve as the baseline for this QIP. The HEDIS FUH result for 7-day was 45.9 percent (the goal is the HEDIS 90th percentile rate of 63.8 percent); for 30-day, Anthem's result was 67.8 percent (the goal is the HEDIS 90th percentile rate of 80.3 percent).

Interventions

Anthem identified four interventions for this QIP at the outset but has since discontinued all four. Three new interventions replaced the previous four. Three of the four interventions related to placing calls to members. Specifically, calls were intended for members to determine if they made a 7-day appointment

and also follow-up calls to members who did not keep the appointment. The change was made in the timing of these calls. The new interventions are:

1. Anthem will contact members while in the hospital to reinforce the need for the 7-day follow-up appointment.
2. Anthem will contact members in advance of their scheduled follow-up appointment.

The other intervention that had put in place but has since been suspended was to provide an incentive payment to community mental health centers (CMHCs) for providing the 7-day follow-up appointment to members. Although it was offered, there was no uptake by providers. Instead, Anthem has converted to a member incentive that began in June 2016 which is a $20 gift card for completion of the 7-day appointment.

Adult Preventive Care

In CY 2014, Anthem performed at the 90th percentile rate for this HEDIS measure in the HIP with a rate of 91.2 percent (hybrid method). In CY 2015, the rate was 83.2 percent. This latest rate is inclusive of the expansion population in HIP 2.0. This QIP was not introduced by Anthem until January 2016 and has been started at the request of the OMPP due to the large increase in the HIP 2.0 population.

The measure itself is the percent of HIP members who have had an adult preventive care visit. Anthem follows the HEDIS definition for the numerator and denominator for this measure.

Interventions

The interventions defined for the QIP are:

1. Live outreach calls to members who are not numerator compliant with the HEDIS measure (i.e., lacking a preventive visit). The effectiveness will be measured as the number of calls reached (numerator) among those lacking a preventive visit (denominator). The denominator of members without a visit will be updated monthly.

2. Anthem clinic days. The effectiveness of these targeted clinic days will be measured as the number of HIP members who attended a clinic day (numerator) as a percentage of those who were invited (denominator).

During the onsite interview, Anthem also described internal process improvements such as a new database that was created to track all members that meet the denominator in both interventions as well as enhanced reporting that will be used to track the measures and the intervention effectiveness across a number of domains.

MHS QIP Findings

Follow-up Visit after Inpatient Psychiatric Hospitalization (FUH)

MHS began its QIP for FUH in CY 2015. MHS uses the HEDIS definition as the measures for this QIP:

1. 7-Day: The percentage of members age six and greater that have attended a FUH appointment within seven days of discharge from an acute psychiatric setting with a mental health diagnosis. This measure used in the HHW, HCC and HIP QIPs.

2. 30-day: The percentage of members age six and greater that have attended a FUH appointment within 30 days of discharge from an acute psychiatric setting with a mental health diagnosis. This measure is only used in the HCC QIP. This is one of the measures in the OMPP's P4O program.

In HHW, MHS has seen steady improvement in the FUH 7-day rate in recent years. The baseline year (CY 2013) result was 63.1 percent (the 90th percentile nationally was 63.2%). This increased in CY 2014 to a rate of 64.9 percent and in CY 2015 to 69.5 percent. Because HCC just started in April 2015, the results from CY 2015 serve as the baseline for this QIP. The HEDIS FUH result for 7-day was 40.7 percent and for 30-day the result was 55.0 percent. In HIP, information was available for CY 2014 where the rate was 53.0 percent (HIP 1.0 population) for the 7-day measure. With the expansion population entering HIP 2.0 in CY 2015, the rate decreased to 43.3 percent.

Interventions

Two interventions were defined for this QIP and they are the same for all three programs:

1. Calls to members from Intensive Case Managers in the behavioral health unit
2. Follow-up appointment scheduling prior to discharge from the hospital ("bridge appointment")

For each measure, MHS developed two study groups. This was for each program. In the intervention for calls from case managers, one group was tracked where the calls were made to members. The control group was members where calls were not made. The effectiveness of this intervention was apparent in all three programs:

- 7-day compliance was 80 percent among HHW members where case manager calls contacted the member and 50 percent among those not called.
- 7-day compliance was 56 percent among HCC members where case manager calls contacted the member and 34 percent among those not called.
- 7-day compliance was 67 percent among HIP members where case manager calls contacted the member and 31 percent among those not called

The bridge appointment intervention also proved to be effective for members in all three programs:

- 7-day compliance was 70 percent among HHW members who had a bridge appointment and 65 percent among who did not.
- 7-day compliance was 44 percent among HCC members who had a bridge appointment and 32 percent among who did not.
- 7-day compliance was 47 percent among HIP members who had a bridge appointment and 38 percent among who did not.

In addition to these interventions, MHS reported during the onsite interview that two new interventions were introduced in the summer of 2016. MHS learned that their reimbursement rate to providers to conduct the bridge appointment was lower than their peers. This rate was increased in July 2016. A supplement to the reminder calls intervention was made in June 2016 in that email communications have also started with some members in lieu of calls.

MHS reported that they will continue to utilize the interventions mentioned above as part of standard business practice, but that they will discontinue this QIP in CY 2017 and replace it with a hospital readmissions QIP that focuses on behavioral health.

Emergency Department (ED) Utilization

MHS began its QIP for Emergency Department Utilization in CY 2014 (service dates in 2013). ED utilization is one of the current P4O measures that the OMPP has in its contract with the MCEs. The QIP is in place for the HHW and HIP populations.

For this QIP, MHS elected to include two measures to determine the efficacy of its QIP activities: (1) the HEDIS Emergency Department Utilization Rate (all ED utilization per 1,000 member months) and (2) the OMPP Report QR-GSU7 Type of Emergency Room Utilization rate. MHS uses the current HEDIS definition for the first measure and updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year. The OMPP-defined measure is the number of ED visits deemed emergent (using diagnosis criteria) as a percentage of all ED visits for the population.

For the first measure, a lower rate is more favorable. For the experience in CY 2014, the HHW result was 65 visits per 1,000 member months; in CY 2015, it was 53 visits per 1,000 member months. There was not improvement in the results for HIP, however. In CY 2014, the HIP result was 92 visits per 1,000 member months. When the expansion population appeared in CY 2015, the rate increased to 110 visits per 1,000 member months. MHS believes that part of this increase in HIP is due to the OMPP policy of presumptive eligibility in which many individuals present in the ED and become presumptively eligible for HIP.

Appropriate use of the ED is improving, however, in both programs. In the second measure, a higher rate is more favorable because this means that more ED visits were for emergent than non-emergent reasons. In HHW, the CY 2014 rate was 29 percent, but this increased to 42 percent in CY 2015. In HIP, the CY 2014 rate was 35 percent, but this increased to 46 percent in CY 2015.

Interventions

MHS has four interventions for this QIP:

1. Integrated Care Management model (involving medical case managers, behavioral health case managers and social workers)
2. ED diversion counseling facilitated by the Medical Case Management Team
3. Successful Right Choices Program (RCP) participation
4. First Year of Life Program enhancement

The first intervention was introduced in CY 2015 while the other three were carried forward from the prior year. The First Year of Life Program is specific to HHW due to the differences in the program populations.

The analysis of the effectiveness of the integrated care management model was completed by using a sample population in each program and measuring their ED use before and after the intervention. In the HHW population (n= 175), this intervention did not appear to be effective. ED use was .18 visits per member pre-intervention and .37 visits post-intervention. In HIP, however, the rates were 1.4 ED visits per member pre-intervention and 1.1 visits per member post-intervention, so the intervention appears to have been effective.

The ED diversion counseling did not seem to be particularly effective in either HHW or HIP. The percentage of members with three or more ED visits in a six month period that were successfully

contacted has eroded from a 40 percent contact rate in CY 2013 to a 20 percent contact rate in CY 2015. MHS is opting to try other modes of communication (e.g., email) in the future.

The goal of the RCP (often known as a lock-in or restricted card program) is to reduce overutilization by linking a member to a single primary medical provider, hospital and pharmacy. The intervention in this QIP measures how many "graduate" from the program by reducing their overutilization. The intervention appears to be at least somewhat effective, but a higher graduation rate is desired. The baseline period of CY 2013 showed a graduation rate of 24 percent (all MHS Indiana Medicaid lines of business); in CY 2015, it was 32 percent. It is not clear how much the RCP participation rate affects the overall ED Utilization Rate.

The enhancements to the First Year of Life educational program also appear to be effective. The ED utilization rate among children 0-12 months old dropped from 20.3 percent in the 1st Quarter of 2014 to 12.6 percent in CY 2015.

MHS indicated a new process intervention is targeted for later in 2016 in which MHS will receive a daily file that records ED visits from a consortium of hospitals from the previous day. This information will be passed on to case management nurses and field offices to "work" the list to contact high ED utilizers.

Alcohol and Other Drug Dependence (AOD) Treatment (HCC and HIP)

MHS introduced a new QIP in CY 2015 related to initiation and engagement of alcohol and other drug dependence treatment. MHS uses the HEDIS definition (IET) as the measures for this QIP:

1. The total members who initiated treatment within 14 days of an AOD diagnosis as a percentage of all adolescent and adult members with a new episode of AOD; and
2. The total members who initiated treatment and had two or more additional services within 30 days of the initiation visits as a percentage of all adolescent and adult members with a new episode of AOD.

This QIP is being used in both the HCC and HIP programs at MHS. Because the QIP was new in CY 2015, the HEDIS IET results for CY 2016 (measurement year in CY 2015) serve as the baseline for both measures in HCC. The baseline initiation rate in HCC is 38 percent; in HIP, the CY 2016 result is 36 percent (it was 38 percent in the previous year in HIP). The engagement rate in HCC is eight percent. In HIP, the engagement rate is 11 percent for the CY 2016 reporting year and 10 percent in the prior year.

Interventions

One intervention was utilized by MHS in this initial year of the QIP, namely, joint rounds between medical and behavioral case management staff for all members who have conditions related to substance abuse. The effectiveness of this intervention has yet to be fully determined by MHS. The MCE is contemplating a cohort analysis of members who are willing to engage in case management versus those who are not would be one way to measure the effectiveness of this intervention.

MHS reported in the onsite interview that other interventions are already underway in CY 2016 that can be leveraged in this QIP. For example, MHS is placing RNs in large practice sites to assist practices with chart reviews to identify gaps in care, to contact members with missed appointments, to conduct follow-up with members after ED visits, and to create triggers for clinical staff.

MDwise QIP Findings

Follow-up Visit after Inpatient Psychiatric Hospitalization (FUH)

MDwise began its QIP for FUH in HHW in CY 2009, in HIP in CY 2011 and in HCC in CY 2015 at the introduction of the program. MDwise cited that the reason why this QIP remains in place is because the rate for the measure has plateaued at the 50th percentile of Medicaid health plans nationally in HHW and at the 25th percentile in HIP. MDwise uses the HEDIS definition for its measure in this QIP:

- 7-Day: The percentage of members age six and greater that have attended a FUH appointment within seven days of discharge from an acute psychiatric setting with a mental health diagnosis. This measure used in the HHW, HCC and HIP QIPs. MDwise actually tracks two versions of this measure—one is a quarterly update based on administrative claims only; the second is the annual rate computed by the HEDIS auditor which may use the hybrid method (administrative claims and medical records).

In HHW, MDwise has seen steady improvement in the FUH 7-day rate in recent years. The baseline year (CY 2013) result was 52.0 percent (the 90th percentile nationally was 63.2%). This increased in CY 2014 to a rate of 60.5 percent and in CY 2015 to 67.8 percent. Because HCC just started in April 2015, the results from CY 2015 serve as the baseline for this QIP. The HEDIS FUH result in HCC for 7-day is 36.8 percent. In HIP, the baseline year (CY 2013) result was 41.3 percent; in CY 2014, 45.4 percent; and in CY 2015, the rate decreased to 38.9 percent.

Interventions

Two interventions were defined for this QIP and they are the same for all three programs:

1. Quarterly inpatient provider report cards- All in-network behavioral health inpatient providers receive a quarterly report card showing the 7-day follow-up rate for their inpatients (separate rates are provided for HHW, HCC and HIP). Member-specific detail accompanies this report along with the national rates at the 75th and 90th percentile for comparative purposes.

2. Assistance from the high risk care management team to assist with follow-up appointment scheduling- Care managers will begin their outreach to members regarding 7-day follow-up appointments as soon as they are notified of an inpatient psychiatric admission.

For each program, MDwise tallied the number of report cards distributed each quarter and the number of members contacted (as a percent of all potential members who were inpatients), but neither of these data points could be tied back to the effectiveness of the interventions themselves on improving the FUH rate. MDwise stated in the onsite interview that this was an area of focus in CY 2016.

MDwise also reported that they did examine the 7-day follow-up rates by gender and race/ethnicity and did not find significant differences in compliance across these demographics. Therefore, no interventions were targeted in this manner. Also, to help assist with scheduling the 7-day follow-up appointments, the MDwise team will work with CMHCs to find logical connections between members and CMHCs such as the member's prior engagement with a CMHC.

Adolescent Well Care

MDwise uses the HEDIS definition of Adolescent Well Care (AWC) as the measure for this QIP. This is the number of members age 12 to 21 with an annual well care visit as a percentage of all eligible members in this age group.

In the past, this was a QIP in HHW. It was retired in HHW, however, since MDwise exceeded the 90th percentile rate nationally (in fact, they achieved the 95th percentile). The decision was made to leverage the work done to improve the AWC rate in HHW and work on the HCC and HIP populations. For HIP, although the AWC measure is used, it only relates to members age 19 to 21.

Interventions

Two interventions were defined for this QIP and they are the same for both programs:

1. MDwise Member Rewards promotion- Members are able to redeem rewards such as gift cards for receiving an annual visit.
2. Network Improvement Team provider outreach- Targeted outreach is provided to high-volume provider practices to guide them in ways in which to improve their AWC rate.

MDwise had considered another intervention for HCC specifically pertaining to the wards and fosters population, but this never materialized when data transfer could not be completed with the Department of Child Services and contacts at each local office could not be developed.

The information provided in the QIP report showed that the Member Rewards program does not appear to incentivize adolescent well care visits. The redemption rate among members is less than one percent. There was no meaningful way that MDwise reported on how it measured the effectiveness of the Network Improvement Team provider outreach.

MDwise did indicate that it has undertaken additional interventions related to this QIP but results are not yet available. One intervention is that coders are working with provider offices to conduct a hybrid approach to simulate the annual HEDIS compilation, but instead of doing it on a sample of 411 members (the usual standard), MDwise is doing it on all adolescents that meet the denominator in HCC and HIP. The second intervention is that MDwise team members are working with provider offices to review their panel of MDwise members to identify missed opportunities to meet HEDIS numerator compliance on a number of measures, including AWC.

Postpartum Care

MDwise began its QIP for Postpartum Care in HHW beginning in HEDIS 2012 (measurement period in CY 2011). Postpartum Care is one of the current P4O measures that the OMPP has in its contract with the MCEs.

For this QIP, MDwise elected to include one measure to determine the efficacy of its QIP activities—the percentage of deliveries that received a postpartum care visit on or between 21 and 56 days after delivery. MDwise uses the current HEDIS definition for the measure and updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year.

The MDwise HHW postpartum care has improved from 71.5 percent compliance (HEDIS 2012 baseline year) to 76.6 in the most recent measurement period (HEDIS 2016). In the last two years, MDwise has

exceeded the 90th percentile rate of all Medicaid health plans nationally. When asked what they thought attributed to the increase in the rate, MDwise stated that they implemented P4O for all MDwise obstetricians, not just those enrolled as Primary Medical Providers (PMPs). This is the only incentive that MDwise gives to non-PMPs in its programs. The payment is attributed to the doctor who does the majority of the prenatal care rather than the one that delivers the baby.

Interventions

To try to improve scores on this HEDIS measure, MDwise uses the same interventions as discussed in the AWC QIP:

1. MDwise Member Rewards promotion
2. Network Improvement Team provider outreach

The redemption rate for rewards is also low in this QIP (1-2% of all members redeem). MDwise did compare the rate of postpartum visits for members redeeming Reward Points and those who did not. MDwise saw a positive difference in the rate of postpartum exams between the two cohorts (those that redeemed had a 12% higher postpartum visit rate than those that did not). They believe that the program has a positive impact in motivating members to get their postpartum exam.

There was no meaningful way that MDwise reported on how it measured the effectiveness of the Network Improvement Team provider outreach in this QIP. MDwise has additional passive activities that are not measurable, such as mailing a pregnancy booklet and postpartum postcards, providing educational calls that stress the importance of postpartum care to newly pregnant members, involving members in a Text4Baby messaging program with pregnant mothers, newsletter articles, and baby showers. They have also developed an OB billing chart and have made postpartum a P4O measure with their providers.

Recommendations to the MCEs and the OMPP Related to Validation of Quality Improvement Projects

Based on our review of the QIPs, B&A has developed specific recommendations to the MCEs and to the OMPP.

<u>Recommendations to the MCEs</u>

1. It was apparent to the EQR Review Team after the onsite meetings that each MCE had implemented and, in many cases, documented the effectiveness of their interventions more than what had been submitted on the QIP Reports. It should be noted that the results on MHS's QIP reports were more comprehensive than the other two MCEs. A recommendation to all MCEs is to improve the reporting on the effectiveness of interventions in the QIP report. Specifically,
    a. If data is not available to conduct the effectiveness of interventions, indicate the reason why (e.g., source data was not available, source data was incomplete, low sample size, the intervention was discontinued early in the process).
    b. In the final section of the QIP report, there is an option to describe qualitatively any challenges or barriers in computing the results from the interventions that were conducted. The information supplied in this portion of the QIP report could be strengthened.

2. Anthem and MDwise need to perform quality checks on the QIP report submissions (e.g., check for data missing in fields, incorrect or obsolete information, etc.).

Recommendations to the OMPP

1. The MCEs all indicated that after using the QIP Reporting tool for two years now, they found it useful. However, when B&A cited the lack of reporting on some elements in the tool back to the MCEs, the feedback was that the MCEs needed more clarity on the method to submit documentation and the level of detail expected. For example, the tool currently has "locked" fields that require completion, but no option to attach additional reports or detail on analytics that may have been completed on interventions or examples of resources used in the interventions themselves. Many of these examples were provided to B&A or described in the onsite meetings but were not evident in the desk review.

   Therefore, B&A recommends that the OMPP reconvene the team of representatives from all MCEs that originally participated in the development of the QIP Reporting tool (or the individuals at the MCEs that are filling it out today). This should be conducted prior to the due date when the MCEs are to submit their QIPs for CY 2017. The meeting should center on what elements of the tool are working, what could be improved, and how the tool should be modified so that it is useful to both the MCEs and to the OMPP.

2. In conjunction with the first recommendation, B&A suggests that the OMPP convene the MCEs in a QIP "pre-meeting" prior to the start of CY 2017 where each MCE gives a brief presentation of their QIPs for the year. This meeting serves not only as a learning collaborative but also as a way for the OMPP to gain a better understanding of why the QIPs will be put in place, why specific interventions are being proposed, and specific methods that will be used to assess the effectiveness of interventions. Some examples include assessing year-over-year improvement, establishing a baseline period and then assessing improvement from the baseline, or creating a control group that did not receive the intervention to compare to the group that did receive the intervention.

3. Recognizing that each of the MCEs serves the HHW, HCC and HIP populations and that some QIPs may be relevant to all three populations, the OMPP may want to consider options for the MCEs to present the results of their QIPs under one unified report that covers all three programs when this is appropriate.

SECTION V: FOCUS STUDY ON AUDIT OF PROVIDER DIRECTORIES

Introduction

With the introduction of Hoosier Care Connect (HCC) and Healthy Indiana Plan (HIP) 2.0 in Calendar Year (CY) 2015, Indiana's Office of Medicaid Policy and Planning (OMPP) saw significant growth in the managed care portion of its Medicaid delivery system. As noted in Section I, managed care enrollment grew by 44 percent from December 2014 to December 2015, from 730,246 to 1,052,953 members.

The three managed care entities (MCEs) contracted to deliver services to this new population—Anthem, Managed Health Services (MHS) and MDwise—needed to work quickly to expand their provider networks or to shore up capacity in their existing networks to satisfy this new demand. The greatest focus was in the first half of CY 2015 since HIP 2.0 began in February and HCC began in April.

The three MCEs each have contracts to deliver services in the Hoosier Healthwise (HHW), HCC and HIP. Providers have the option to contract with one, two or all three MCEs. Providers also have the option to contract with just the HHW, HCC or HIP program or any combination of programs.

In order for a provider to contract with any MCE or program, however, the provider must first be enrolled in Indiana's Health Coverage Program (IHCP). The application and enrollment process in the IHCP is administered for the OMPP by its fiscal agent, Hewlett Packard Enterprise (HPE). The MCEs receive file notifications of additions, deletions and changes to the IHCP from HPE.

The large influx of providers, the multitude of contracting options a provider can choose from, and the need to continually transfer current provider information between HPE and the MCEs suggests the possibility that provider information may vary across MCEs, across programs and between the MCEs and HPE. The expansion of eligibility in HIP to those previously uninsured coupled with the transition of many HCC members who had previously been enrolled only in the fee-for-service portion of the program means that hundreds of thousands of members are encountering the Medicaid managed health care delivery system for the first time. The OMPP strives to ensure that members can navigate this delivery system as easily as possible.

The purpose of the study, therefore, was to:

- Assess the reliability of the information provided by the MCE to its members enrolled in HHW, HCC and HIP about contracted providers;
- Assess the consistency of provider information within a program but across MCEs; and
- Assess the consistency of provider information between the MCEs and HPE.

Burns & Associates (B&A) used multiple approaches to conduct the study:

1. Tests were completed to simulate from the member's perspective how he/she would query the MCE's "find a doctor" online tool.
2. A sample of providers that contracted with one or more MCEs was tested using the MCE's online query tool to see how results were the same or different across the MCEs as well with HPE's online query for IHCP.
3. A full review of all providers contracted with multiple MCEs was reviewed to compare the consistency of the provider's street address and office phone number.
4. A sample of 720 outbound calls was made to provider offices to verify key information about the provider against what is stored in the MCE's provider directory.

Methodology for Conducting the Study

B&A conducted an initial phone call with each MCE to better understand how their provider information is tabulated and stored. The follow-up to this initial call was a data request to each MCE to obtain a database of their provider directory in electronic format.

Upon receipt of each MCE's database, B&A conducted validation tests to ensure that the database contained the relevant information needed for this study, including the provider's name, physical address, office phone number, specialty (as assigned by the MCE) and NPI. B&A also ensured that there was an indicator that showed if the provider was contracted under HHW, HCC and/or HIP.

As needed, B&A conducted follow-up calls with each MCE about their database to ensure that we understood the contents and to verify the completeness of what was delivered. As a result of these follow-up calls, in some instances an MCE delivered an updated database to B&A.

A listing of the variables received from each MCE appears in Exhibit V.1.

Exhibit V.1
Key Variables Provided by the MCEs in their Provider Directory for this Review

	Anthem	MHS	MDwise
Provider Type (facility or practitioner)	✓		✓
Indiana Program Enrollment (HHW, HCC, HIP)	✓	✓	✓
First Name	✓	✓	✓
Last Name	✓	✓	✓
Title (MD, etc.)	✓	✓	
Gender	✓	✓	✓
Group Name	✓	✓	✓
NPI	✓	✓	✓
Medicaid ID	✓		
Specialty	✓	✓	✓
Board Certification	✓	✓	✓
Street Address	✓	✓	✓
City, State, Zip	✓	✓	✓
County	✓	✓	✓
Phone Number	✓	✓	✓
Fax Number	✓	✓	
Accepting New Patients	✓	✓	✓
ADA Accessible	✓	✓	✓
Public Transportation Accessible	✓		✓
Hospital Affiliation(s)	✓	✓	✓
Language(s) Spoken	✓	✓	✓
Office Hours	✓	✓	✓

To ensure that the data being examined in the study came from its source format at the MCE, B&A allowed each MCE to submit data in a non-standardized format. B&A "normalized" the data across MCEs to ensure consistency in developing a sample for the study. The process to normalize the data included the following steps:

1. If a unique NPI served more than one program (HHW, HCC, HIP), B&A ensured that the provider was tagged separately for each program.
2. B&A mapped the home county where the provider is located to one of the eight defined MCE regions used by the OMPP.
3. B&A mapped the MCE-defined specialty for each provider into one of five higher-level groups:
    a. Primary Medical Provider (PMP), excluding OB/GYNs and Pediatricians
    b. OB/GYNs (includes those contracted as PMPs and those who are not)
    c. Pediatricians
    d. Behavioral Health providers
    e. All other specialties
4. The format of some fields such as phone numbers was aligned so that the format was the same across all MCEs. For other fields such as street address, however, the original data was preserved. This meant, for example, that a provider's address could appear as 123 Main Street in one MCE file, 123 Main St. in a second file, and 123 Main Street, Suite 101 in a third file.

Sampling

In total, there are 33,858 unique NPIs across all three MCE databases combined which encompass all three of OMPP's programs. These 33,858 NPIs can be duplicated within and across databases in multiple ways. For example:

- The same NPI can appear in an MCE database under different specialty assignments.
- The same NPI can appear in an MCE database under different regions.
- The same NPI can appear in an MCE database to indicate they are contracted under HHW, HCC and/or HIP.
- The same NPI can appear in more than one MCE database. In fact, there are:
    - 14,844 NPIs that appear in only one MCE database
    - 11,925 NPIs that appear in two of the MCEs' databases
    - 7,089 that appear in all three of the MCEs' databases

Most of the time that duplication was seen across MCE databases was in the B&A group Other Specialists, accounting for 73 percent of all duplication of providers.

A sample was constructed that was used to outreach to providers telephonically to verify information. The sample consisted of 720 unique providers. Because of the duplicity of the NPIs within and across MCEs, the sample is not representative of the total volume of records within each MCE's source file. However, consideration was given to ensure that each sample had representation across these variables:

- Equal representation across the HHW, HCC and HIP programs (239-241 from each)
- Equal representation across the eight MCE regions (89-91 from each, out of state were excluded)
- Equal representation across each of the five B&A provider specialty groups (143-145 from each)
- Equal representation across the MCEs (240 from each)
- Proportional representation based on the occurrences of unique NPIs in MCEs (44% of the sample is among NPIs in only one MCE, 35% of the sample is among NPIs in two MCEs, 21% of the sample is among NPIs in all three MCEs)

Exhibit V.2 on the next page compares the sample for the telephonic audit of directory information against all providers in the MCE's provider directory databases.

Exhibit V.2
B&A's Provider Audit Sample vs. Total Providers in Indiana's Medicaid Managed Care Programs

	Totals From MCE Provider Directory Electronic Files		Total from Sample Generated by B&A for Phone Audit	
	Number	Pct of Total	Number	Pct of Total
By Program				
Hoosier Healthwise	30,067	33.6%	240	33.3%
Hoosier Care Connect	28,961	32.4%	239	33.2%
HIP 2.0	30,416	34.0%	241	33.5%
Unduplicated Total	**33,858**		**720**	**100.0%**
Duplicated Total	89,444	100.0%		
By MCE				
Anthem	30,412	50.7%	240	33.3%
MHS	10,919	18.2%	240	33.3%
MDwise	18,629	31.1%	240	33.3%
Total	**33,858**		**720**	**100.0%**
Duplicated Total	59,960	100.0%		
By Provider Specialty Rollup Group (as defined by B&A)				
Primary Care exc. Pediatrics and OB-GYN	2,954	7.6%	143	19.9%
Primary Care, Pediatrics	1,719	4.4%	143	19.9%
OB-GYNs	872	2.3%	145	20.1%
Behavioral Health Specialties	3,184	8.2%	145	20.1%
Other Specialties	29,990	77.5%	144	20.0%
Total	**33,858**		**720**	**100.0%**
Duplicated Total	**38,719**	**100.0%**		
By Region				
Northwest	4,312	8.7%	89	12.4%
North Central	3,666	7.4%	90	12.5%
Northeast	4,587	9.2%	91	12.6%
West Central	3,990	8.0%	90	12.5%
Central	13,473	27.1%	90	12.5%
East Central	4,871	9.8%	90	12.5%
Southwest	5,471	11.0%	90	12.5%
Southeast	6,012	12.1%	90	12.5%
Out of State	3,394	6.8%		
Total	**33,858**		**720**	**100.0%**
Duplicated Total	**49,776**	**100.0%**		
By Unique NPI to MCEs				
NPI found with just 1 MCE	14,844	43.8%	315	43.8%
NPI found with 2 MCEs	11,925	35.2%	251	34.9%
NPI found with 3 MCEs	7,089	20.9%	154	21.4%
Total	**33,858**	**100.0%**	**720**	**100.0%**

After the databases were normalized and the draft sample was drawn, B&A met with each MCE individually on August 3-4 to confirm the tabulations of their data used in the provider directory database. An explanation was also provided about the method that would be used to conduct the phone-based audit.

Desk Review of Database Information

The NPIs that were found in more than one MCE were then placed in a separate Microsoft Excel file for comparison (n= 19,014). Street addresses and phone numbers that appeared in each MCE's directory were aligned side-by-side to compare them across MCEs for each NPI. No sampling was done here. The full list of 19,014 was reviewed. There were multiple levels of verification of this file:

- First, for the street addresses and phone numbers, a function was used in Excel to identify exact matches.
    - For the phone numbers, an exact match was tagged "yes" and a non-match was tagged "no". No further review was conducted.
    - For the addresses, an exact match was tagged "yes" and a non-match was tagged "no". All "no" records were passed on to a second level review.
- The second level review was the visual inspection of the addresses across the MCEs (n= 11,208). Examples where there was a close match were converted from "no" to "yes". Using the previous example cited on page V-3, the following addresses would have been tagged "no" match in the first pass:
    - 123 Main Street
    - 123 Main St.
    - 123 Main Street, Suite 101
- The following rules applied to reassign close matches to "yes":
    - If the street address was the same, but the suite number was missing or different across MCEs, the address was converted to "yes".
    - If the street name was the same but the number was different across MCEs, the address remained tagged as "no".
    - If the street generic (e.g., street, avenue, parkway) was abbreviated in some databases but spelled out in others, but the generic was the same throughout, the address was converted to "yes".
    - If the street generic differed across MCE databases (e.g., 123 Main Street and 123 Main Avenue), the address remained tagged as "no".

Online Audit of Database Information

The desk review revealed that one of the reasons why provider information could have been different for the same NPI across the MCE's directories is in the situation where providers actually serve patients in multiple locations. Recognizing that this could be a legitimate reason for the NPIs that did not match, B&A selected a sample of 100 records where the addresses did not match across the MCEs. Then, B&A searched in each MCE's online query tool and recorded the number and variety of addresses and phone numbers that appeared online for each MCE's website (the search was limited to the HHW program). B&A also looked up the same providers on the IHCP provider query website and compared the results between HPE's database and the MCEs' databases.

Telephonic Audit of Database Information

During the month of August, three members of the External Quality Review (EQR) team placed calls to the sample of 720 providers. Calls were made during standard business hours on weekdays. The team members identified themselves to provider offices when the phone was answered and indicated the reason for the call. The information that was being validated was stored in a Microsoft Access database. An online data entry screen where the team member could read the information to the provider office staff member and then check online in the screen if the information matched or not. The specific information that was validated against the provider directories included:

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

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

The team member gave each call a completion status. The options included "complete", "incomplete" and "provider office refused to participate". When the status was designated incomplete, a reason was given for the incomplete status.

Findings

The results of the provider directory phone audit were disappointing. After the 720 calls were initially conducted, B&A achieved a status of 45 percent complete (n= 324), 51 percent incomplete (n= 369) and four percent refused (n= 27). Among the reasons cited for incomplete calls, 196 out of 369 were "office closed" or "had to leave a voice mail".

In September, B&A completed a second round of calls by attempting to reach the 196 offices which were closed or for which a voice mail was left. After the second round of calls, 96 of the 196 moved from "incomplete" to "complete".

Exhibit V.3 which appears on the next page and all subsequent exhibits reflect the results from the final tally of completed calls (n= 420). Even with this second round of calls included, the status was 58 percent complete, 38 percent incomplete and four percent refused. Among the reasons for the 273 incomplete calls,

- 38 calls had a disconnected phone number (14%)
- 62 calls had no answer (no option for voice mail (23%)
- 33 calls the team member was on hold more than three minutes with no option for leaving a voice mail (12%)
- 85 calls had to leave a voice mail (31%)
- 15 calls the office was closed (5%)
- 40 calls had a variety of other reasons for incomplete status (15%)

Exhibit V.3
Completion Status of Provider Directory Audit Calls Made

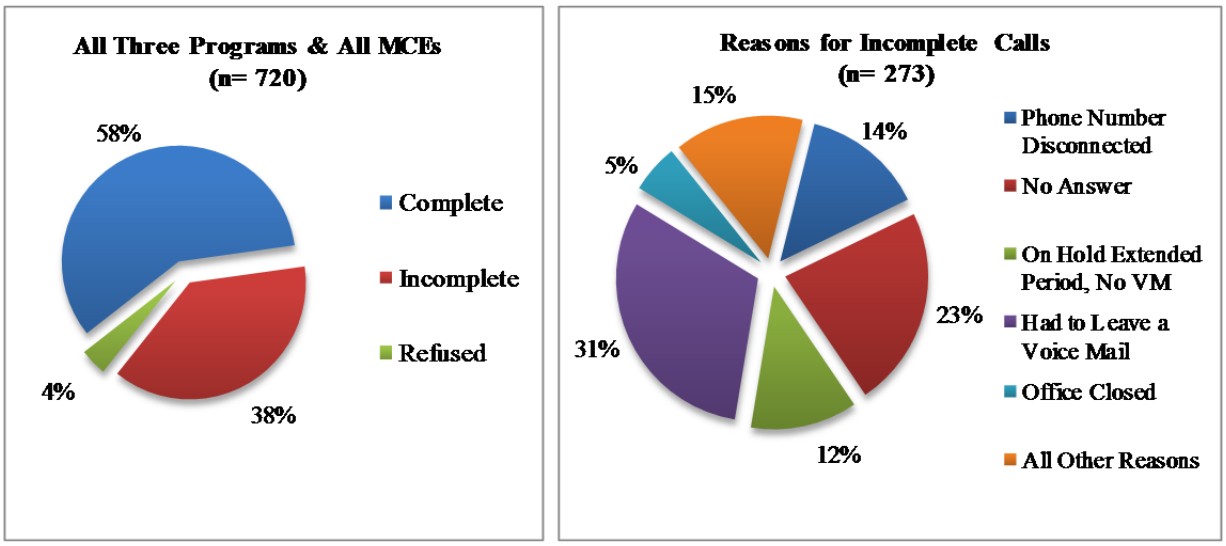


Exhibit V.4 on the next page shows the results for the 420 completed calls on the verification of whether the provider was located at the office address, the practice group name, the provider's specialty, the office address and the office phone number.

The exhibit is displayed as four boxes. The upper left box presents data on providers from all three MCEs (n= 420). The upper right box displays the information for providers contracted with Anthem (n= 310). The lower left box displays information for providers contracted with MHS only (n= 226), and the lower right box displays information for providers contracted with MDwise (n= 223). The sum of the three MCEs' samples will not equal the total because many providers are counted in multiple boxes if they contract with more than one MCE.

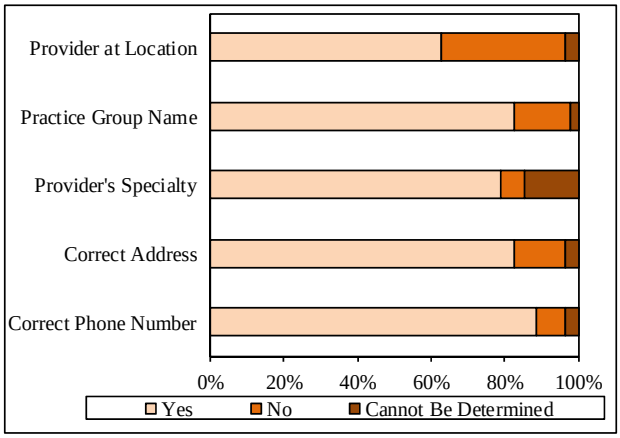
The possible values for each verification item are "Yes" (verified accurate), "No" (verified not accurate) or "Cannot be Determined". When Cannot be Determined was assigned, it meant that the person from the provider's office did not know the answer. This even included when the EQR team member was transferred within the office if the first person answering could not answer the questions.

Each box in the exhibit is displayed the same way. To illustrate, in the upper right box, for verifying if the provider was at the location called, the EQR team could verify this information 63 percent of the time (beige color of the bar), could not verify 34 percent of the time (orange color of the bar), and the validation could not be determined 10 percent of the time (brown color of the bar).

When reviewing each validation item, the phone number could be verified 89 percent of the time, the address and practice group name verified 83 percent of the time, provider specialty 79 percent of the time, and provider at location 63 percent of the time. These are the percentage across all MCEs. The verification rate for practice group name, address and phone number were very similar to the statewide averages across MCEs. Although not significant, the greatest difference was in the verification of the provider's specialty. Anthem and MDwise had rates above the all MCE percentage and MHS had a rate below this percentage.

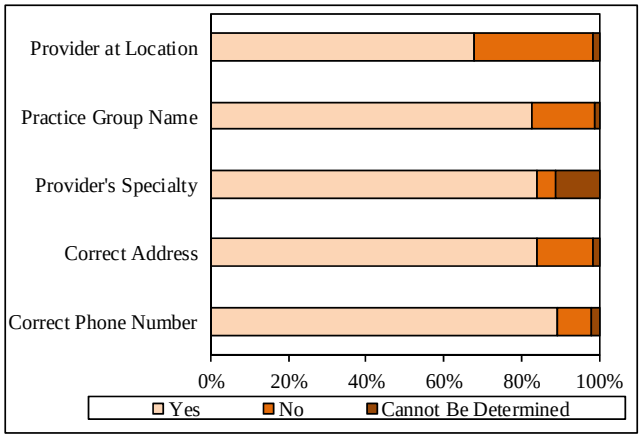
Exhibit V.4
Verification of Provider Information in Phone Audit

All 3 MCEs Combined (n= 420)



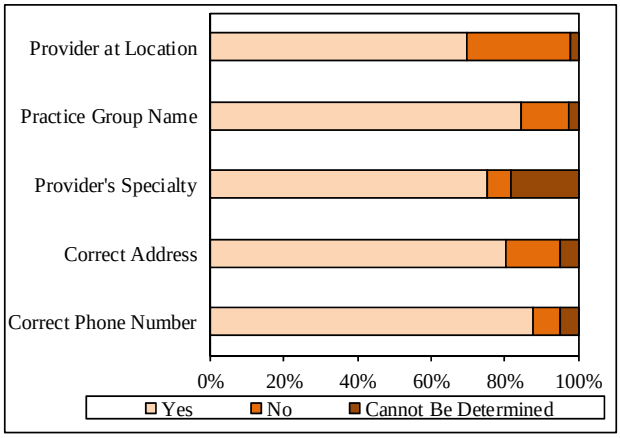
	Could the Following Information be Verified		
	Yes	No	Cannot Be Determined
Provider at Location	264	142	14
Practice Group Name	347	65	8
Provider's Specialty	331	28	61
Correct Address	347	59	14
Correct Phone Number	373	32	15

Anthem Only (n= 310)



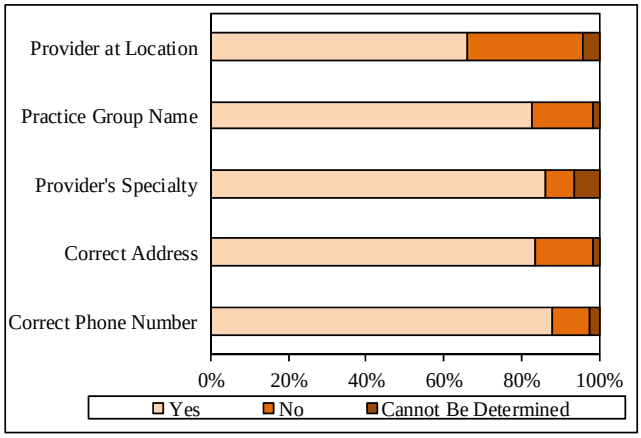
	Could the Following Information be Verified		
	Yes	No	Cannot Be Determined
Provider at Location	210	95	5
Practice Group Name	256	50	4
Provider's Specialty	261	15	34
Correct Address	260	45	5
Correct Phone Number	277	27	6

MHS Only (n= 226)



	Could the Following Information be Verified		
	Yes	No	Cannot Be Determined
Provider at Location	158	63	5
Practice Group Name	191	29	6
Provider's Specialty	170	15	41
Correct Address	182	33	11
Correct Phone Number	198	17	11

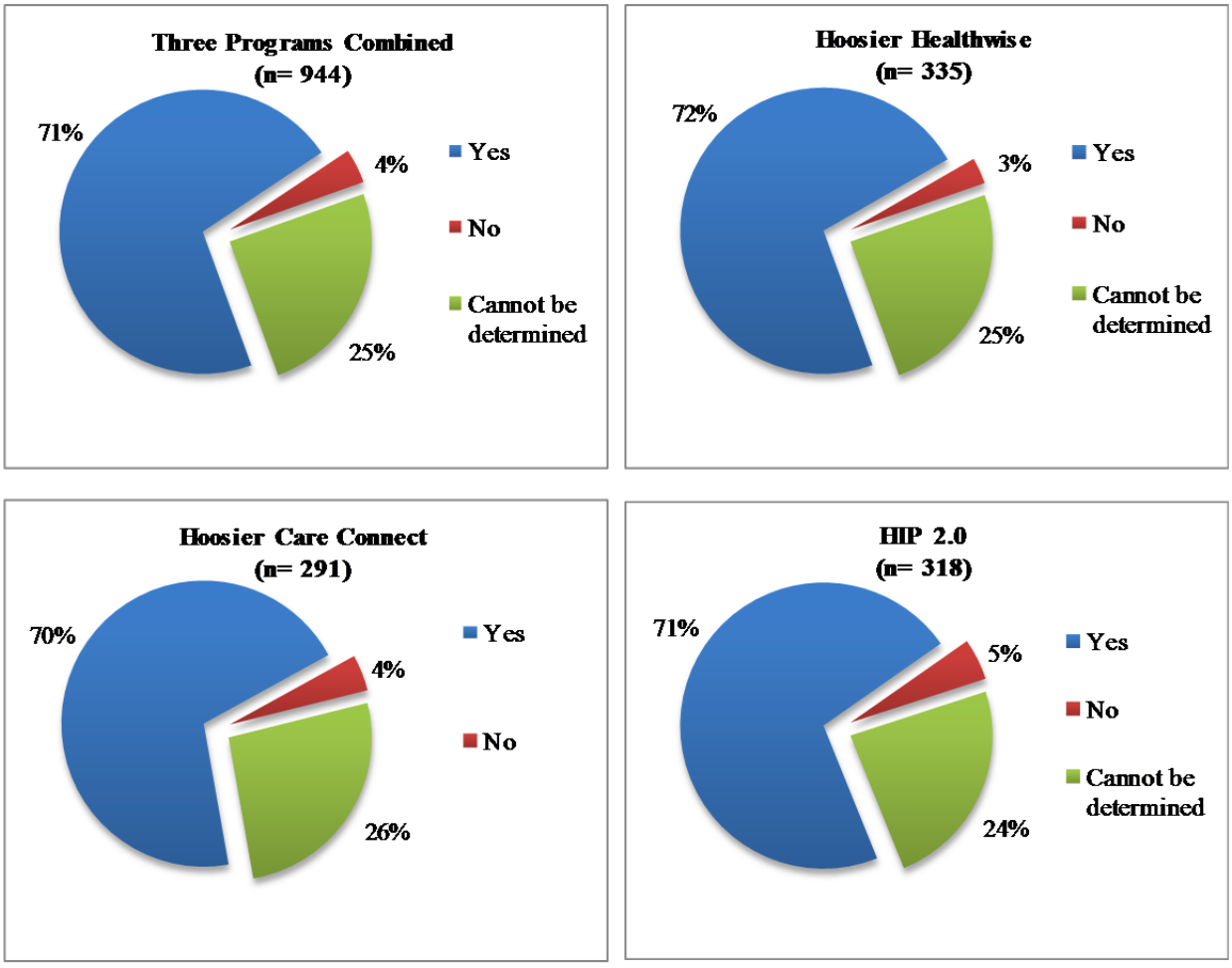
MDwise Only (n= 223)



	Could the Following Information be Verified		
	Yes	No	Cannot Be Determined
Provider at Location	147	67	9
Practice Group Name	184	36	3
Provider's Specialty	192	17	14
Correct Address	186	34	3
Correct Phone Number	196	22	5

Exhibit V.5 shows the results of the verification when providers were asked which Indiana Medicaid program(s) that they contract with (HHW, HCC and/or HIP). The results were consistent across programs, with approximately 71 percent of providers confirming that they contract with each of the programs. One quarter of provider offices could not confirm their contract relationship. Three to five percent of the provider offices stated that they do not contract with the program even though the MCEs' provider directories indicated that the provider did in fact contract with the program.

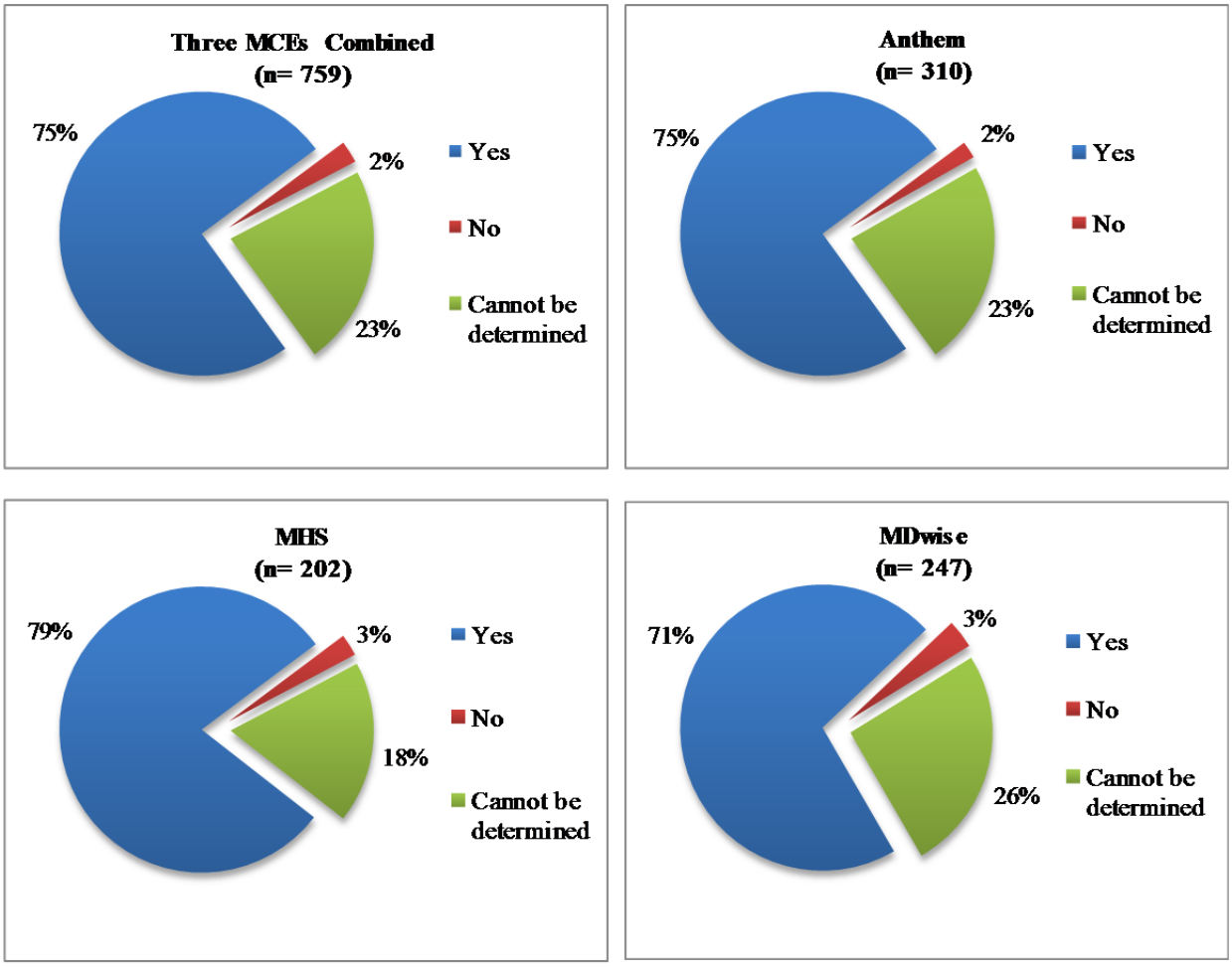
Exhibit V.5
Verification that Provider Contracts with Indiana's Health Coverage Program



Some providers contract with more than one program. When this occurred, B&A verified each contract relationship Therefore, in the total sample of 700 for Combined Programs, some providers are counted more than once.

Exhibit V.6 shows results to a similar question as Exhibit V.5, but this time the question was focused on the provider's contractual relationship with the MCE. The rates confirming their contract status were slightly better than what was found in Exhibit V.5, with 75 percent of Anthem providers confirming their contract with Anthem, while 79 percent and 71 percent of MHS and MDwise providers, respectively, confirming their contract status with each MCE. There were two to three percent respondents among each of the MCE's providers who indicated that they did not contract with the MCE when the MCE said that the provider did.

Exhibit V.6
Verification that Provider Contracts with Indiana's Managed Care Entities

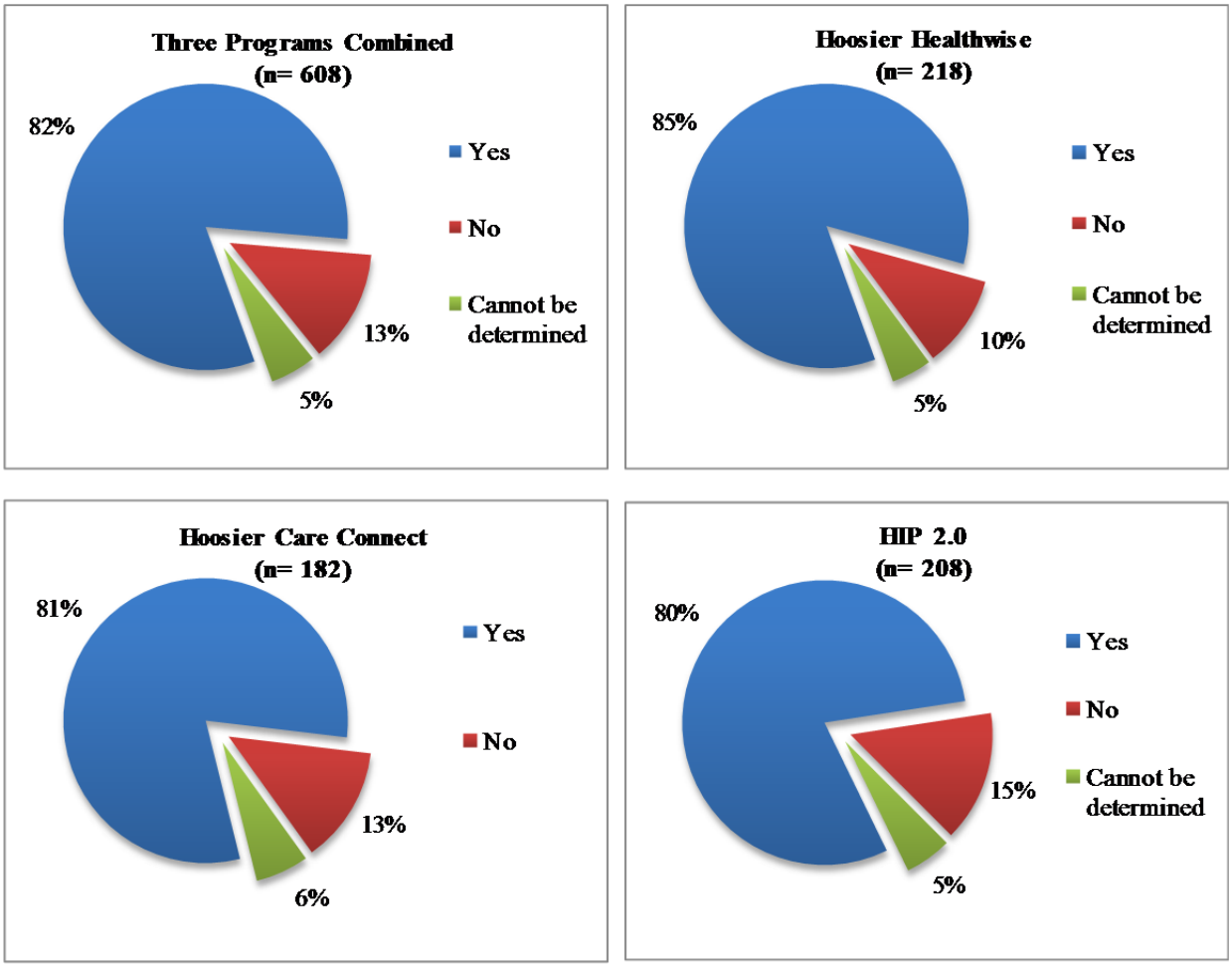


Some providers contract with more than one MCE. When this occurred, B&A verified each MCE provider contracts Therefore, in the total sample of 533 for Combined MCEs, some providers are counted more than once.

Exhibits V.7 and V.8 are subsets of Exhibits V.5 and V.6. If the provider affirmed that they contracted with a program (Exhibit V.5) or an MCE (Exhibit V.6), the database that B&A used for reference indicated whether or not the provider was accepting new patients. The results shown in Exhibits V.7 and V.8, therefore, are only among providers who affirmed that they were under contract and for which the MCE database indicated that the provider was accepting new patients. The results shown in the exhibits, therefore, are to show which providers confirmed that they were accepting new patients.

Exhibit V.7 below shows that more than four out of five providers confirmed that they were accepting new patients. Anywhere from 10 to 15 percent of the providers across the programs, however, indicated that they were not accepting new patients when the MCEs' databases (and their online directories) indicate that the provider is accepting new patients.

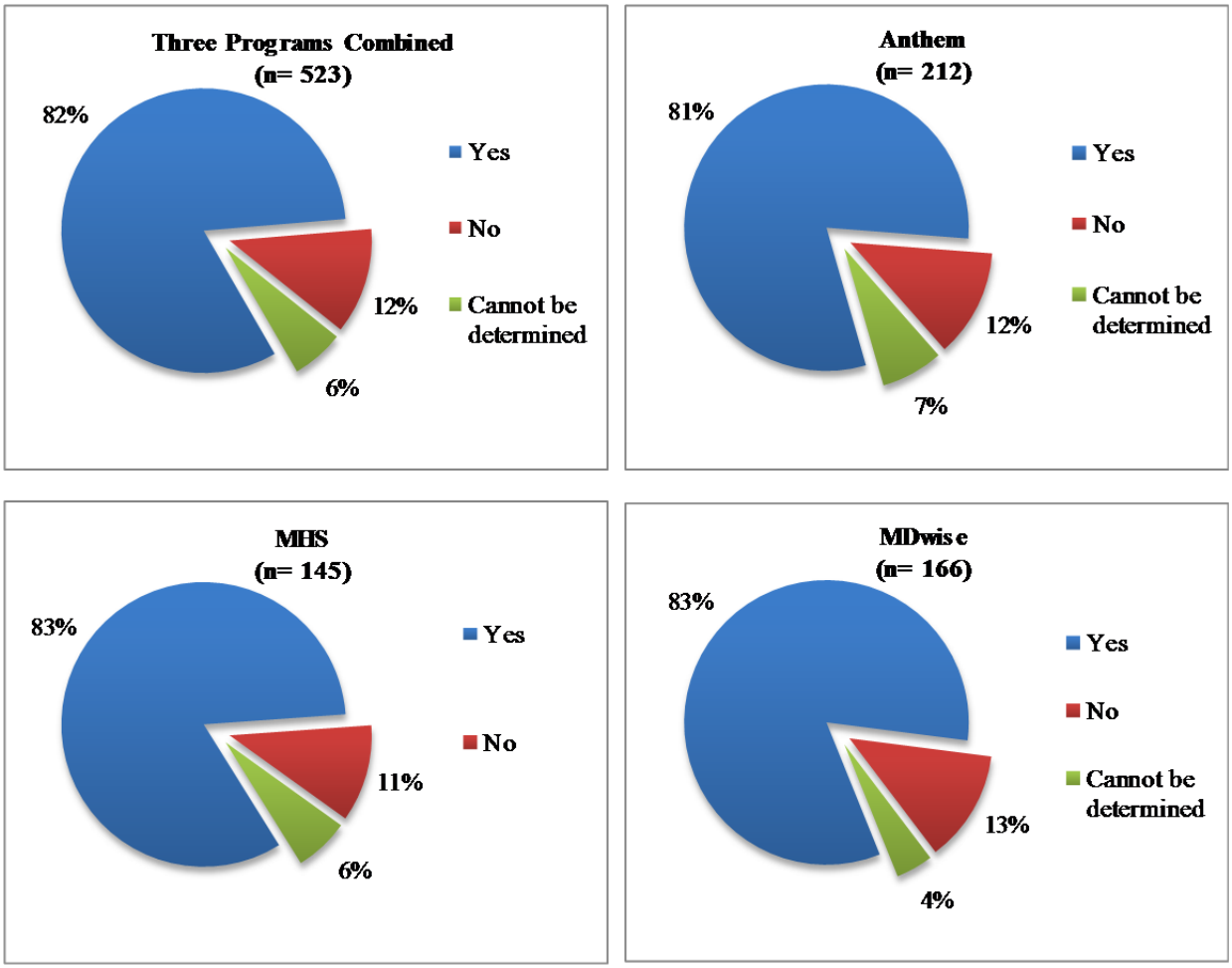
Exhibit V.7
Verification that Provider is Accepting New Patients, by Indiana Health Coverage Program



The results shown here are limited to: (a) providers who confirmed that they contract with the program; and (b) of these, the number reported by the MCEs that indicated that they are accepting new patients.
Some providers contract with more than one program. Therefore, in the total sample of 393 for Combined Programs, some providers are counted more than once. It was assumed that when provider indicated "Yes", he/she was accepting patients for any program he/she is contracted with.

Exhibit V.8 below shows the results related to accepting new patients for providers by MCE. The results mirror what was found in Exhibit V.7 and are also similar across the MCEs.

Exhibit V.8
Verification that Provider is Accepting New Patients, by MCE

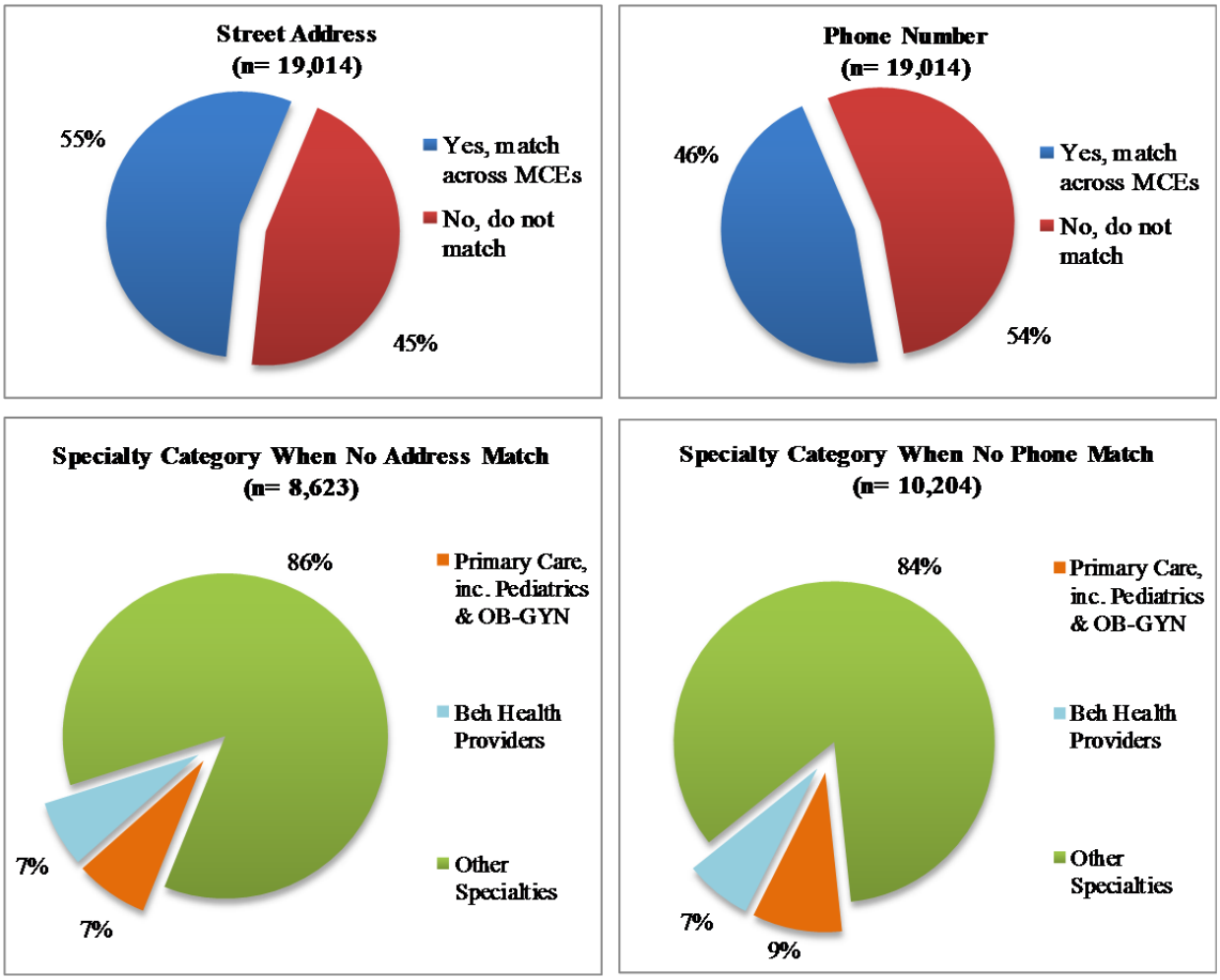


The results shown here are limited to: (a) providers who confirmed that they contract with the MCE; and (b) of these, the number reported by the MCEs that indicated that they are accepting new patients. Some providers contract with more than one MCE. Therefore, in the total sample of 304 for Combined MCEs, some providers are counted more than once.

Exhibit V.9 shows the results of the desk review of the MCEs' provider directories for the provider NPIs that appeared in two or more MCE databases. B&A conducted the exact match rate in Excel and then the visual match rate by hand where we allowed for close matches to convert from a "no match" to a "yes" match.

Despite this, the exhibit shows that the match rate for addresses was 55 percent and phone numbers was 46 percent. Approximately 85 percent of non-match providers were specialists other than behavioral health providers. Seven percent of addresses and nine percent of phone numbers were non-matches among primary care, pediatric and OB/GYN providers. The remaining seven percent of non-matches were from behavioral health providers.

Exhibit V.9
Check if Street Address and Phone Number of Providers Listed in More than One MCE's Directory Match



The results of this exhibit should be treated as an indicator, but not an absolute truth, of a problem. This is because most all of the NPIs that appeared in more than one MCE database also had more than one entry in each database. This means that the provider, particularly specialists, could serve multiple locations and have multiple addresses and phone numbers. To test the consistency of addresses and phone numbers, B&A conducted a sample of 100 of these non-match providers in each MCE's online provider directory query. The items that a member can query on each database appear in Exhibit V.10.

Each MCE gives members the option to conduct an initial search based on provider specialty, distance and whether or not the provider is accepting new members. After viewing the results of the query, all of the MCEs give the members the option to refine the query with more specific filters. Additional information about a provider often appears in a pop-up window when the user clicks on the provider's name.

Anthem and MDwise give members the options to email results to themselves or to print PDF versions of reports (these functionalities were tested and they work). MHS gives members the option to print reports (also works).

Exhibit V.10
Features of Each MCE's Online Provider Directory Search Functionality for Members

Starting search criteria:	Anthem	MHS	MDwise
Specialty Type - General	✓	✓	✓
Specialty Type - Specific*	✓	✓	✓
By Name	✓	✓	✓
Delivery System^			✓
Distance criteria	✓	✓	✓
Accepting New Patients filter	✓	✓	✓
Able to serve as PCP filter	✓		

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

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

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

*Anthem has 50 specialties listed. MHS has 139 specialties listed. MDwise has 60 specialties lists.
^Due to MDwise's delivery system structure where providers contract with a specific delivery system, this is unique to MDwise.

The sample of 100 providers for which addresses and phone numbers did not match in the desk review were tested in the online MCE provider query function to see what results came up under each MCE. A random sample was selected among primary care doctors, pediatricians, OB/GYNs, behavioral health specialists and acute care specialists. For all MCEs, B&A only selected the HHW option under "find a provider". As a result, six providers did not appear as they must not contract with the HHW program. A final sample of 94, therefore, was tested. These providers were also queried in the OMPP's IHCP online database as well. A summary of the results of this online search appear below.

B&A counted the number of the 94 providers that appeared in each MCE's database. For those that appeared, the number of times the provider appeared was recorded. Then, the number of unique addresses and the number of unique phone numbers was determined.

Exhibit V.11 shows that Anthem has a unique address appear for every time one of the 47 providers in our sample appears in Anthem's online query for the provider. In only 74 percent of the time was there also a unique phone number. In other words, if one of the 47 providers who appeared had four entries in Anthem's online search, there were also four unique addresses but only three unique phone numbers. The "1-to-1" match rates were lower for the other MCEs as well as for the IHCP database. It is possible that there may be fewer phone numbers than locations if a specialty practice has multiple offices but perhaps one central scheduling office that directs calls. What is more curious is when there are more phone numbers than unique entries as was seen in the case of 12 of MHS's providers.

Exhibit V.11
Testing the Matching of Provider Entries to Addresses and Phone Numbers
in the MCE's Online Provider Queries

	Anthem	MHS	MDwise	IHCP (OMPP)
Number of Providers Appearing (out of 94 possible)	47	54	63	57
Number of Unique Addresses Matches Number of Entries for Provider	47	38	56	49
Number of Unique Addresses Was Fewer Than Entries for Provider	0	0	7	4
Number of Unique Addresses Was More Than Entries for Provider	0	16	0	4
Address 1-to-1 "Match Rate"	100%	70%	89%	86%
Number of Unique Phone Numbers Matches Number of Entries for Provider	35	41	39	39
Number of Phone Numbers Was Fewer Than Entries for Provider	12	1	24	18
Number of Phone Numbers Was More Than Entries for Provider	0	12	0	0
Phone Number 1-to-1 "Match Rate"	74%	76%	62%	68%

It should also be noted that, among the 94 providers reviewed on the MCEs' online directories, when a provider appeared on an MCE directory, there were 38 instances when the provider did not appear in the IHCP directory.

Recommendations

There are a number of opportunities for improving the provider directories among the MCEs and the alignment of data between the MCEs and IHCP (managed by HPE for the OMPP). Based on this review, B&A offers the following recommendations to improve the information that members use when they are seeking access to care.

Recommendation to the OMPP

1. B&A understands that there have been some meetings facilitated by the OMPP which convene HPE and the MCEs on the transfer of provider enrollment information. We encourage this dialogue to continue and to be strengthened. In particular:
    a. B&A understands that the MCEs currently receive many data files from HPE containing updates with provider information. Many of the files cannot easily be linked, yet each file contains relevant provider-specific information. The OMPP should task HPE with creating a unified file that contains all provider updates within IHCP to transmit to the MCEs.
    b. B&A recommends that a procedure be developed that enables the MCEs to transmit updated information about IHCP providers back to HPE in a timely manner so that it could be shared with the other MCEs. B&A recognizes that provider-specific information should come from the provider directly, but developing a feedback loop from the MCEs to OMPP about known provider information changes would provide HPE with a trigger to proactively contact providers about changes as they become known to verify this change with the provider.
    c. B&A recommends that in meetings between OMPP, HPE and the MCEs that standard business rules be developed to streamline information such as the assignment of providers to provider specialties or the syntax in text fields (e.g., abbreviations or not, suffixes on names or not).

Recommendations to the MCEs

1. The information from HPE about providers is helpful to the MCEs, but it remains the responsibility of the MCEs to maintain current provider information. If not already in place, it is recommended that each MCE create three procedures:
    a. Align the information obtained on provider contracts to the provider directories;
    b. Align the information obtained on recredentialing forms to the provider directories; and
    c. Align the information obtained by provider relations staff while in the field to the provider directories.

2. The MCEs should conduct a "scrubbing" process of their directories to ensure that duplicates do not appear in online provider queries. It is expected that a provider's name will appear multiple times when they work across multiple locations. It is not expected that a provider's name will appear multiple times when working at the same location.

3. The MCEs are encouraged to validate phone numbers as it is shown that the same phone number appears for a provider across multiple locations in a provider query. This is possible (if there is a centralized scheduling office for the provider), but it should be validated.

4. The MCEs need to educate the providers about their contractual obligation to accept new patients when they have agreed to so that they are not informing members with contrary information.

SECTION VI: FOCUS STUDY ON BENEFICIARY ACCESS TO PROVIDERS

Introduction

The managed care entities (MCEs) contracted with the Office of Medicaid Policy and Planning (OMPP) in the Hoosier Healthwise (HHW), Hoosier Care Connect (HCC) and Healthy Indiana Plan (HIP) 2.0 programs are required to ensure sufficient access to services across a number of provider specialties. One mechanism that the OMPP uses to monitor access to providers is through the review of geoaccess reports that the MCEs submit to the OMPP for each program. Geoaccess reports plot the location of individual providers for a particular specialty on a map to visualize where providers are located within the state for the population served. Additionally, analytics in the geoaccess reports compute the shortest distance for each member in the population to a provider, the shortest distance to the second-closest provider, etc.

The OMPP has developed contractual requirements for the MCEs to meet that set maximum distance requirements for members to access over two dozen specialties. For example, the threshold for primary medical providers (PMPs) is a minimum of one provider within 30 miles of every member. The MCEs are required to submit geoaccess reports for each of the three OMPP programs (HHW, HCC and HIP) and to report on access for each provider specialty separately. Specific elements that are required to be included in each report are:

- Member count by region, county and zip code;
- Provider specialty count by region, county and zip code; and
- Member-to-specialist ratio by region, county and zip code.

Reporting is mandated specifically for PMPs, behavioral health providers and other specialists. The OMPP has given the MCEs discretion in how the category of behavioral health providers is defined. There is also discretion as to which specialties are included in reporting for the "other specialists" category.

The MCEs usually submit the maps to plot providers for each specialty as well as concentric circles of member access to the provider specialty for each of the eight regions of the state defined by the OMPP (refer to Appendix A for the map showing the counties within each region). In addition to the maps, the MCEs submit information in tabular format to show, at the county level, the number of providers in the county, the number of members in the county, and the shortest distance from a member's home to a provider's office.

In Section V of this report, there were opportunities discovered to strengthen the integrity and accuracy of the MCEs' provider directories. With the large influx of members in Calendar Year (CY) 2015 resulting from the introduction of HCC and the large expansion of HIP, access to providers is a high priority for the OMPP. The geoaccess reports are helpful in one aspect to assess distance to providers, but the reports do not take into account which providers are the ones that members actually access. For example, the provider with the shortest distance to a member may not be accepting new patients. The purpose of this study, therefore, was to evaluate member access to providers within HHW, HCC and HIP by validating the geoaccess reports submitted by the MCEs for each program.

Methodology for Conducting the Study

Burns & Associates (B&A) compiled the geoaccess reports submitted to the OMPP by the MCEs for the period ending 4th Quarter of CY 2015. (For HHW, the OMPP requires annual geoaccess report submissions. For HCC and HIP, the OMPP required quarterly submissions in CY 2015.) B&A inventoried the reports submitted and identified the provider specialties that were submitted which were most common across the MCEs. Exhibit VI.1 shows the provider specialties that were included in the study, the access standard defined by the OMPP, and an indicator if the MCE submitted geoaccess reports specific to this specialty category.

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

Provider Specialty	Standard Set by OMPP
Primary Care	1 provider within 30 miles
Behavioral Health	1 provider within 45 miles
OB/GYN	2 providers within 60 miles
Cardiologist	2 providers within 60 miles
Cardiothoracic Surgeon	1 provider within 90 miles
Dermatologist	1 provider within 90 miles
Gastroenterologist	2 providers within 60 miles
General Surgeon	2 providers within 60 miles
Nephrologist	2 providers within 60 miles
Neurologist	2 providers within 60 miles
Neurosurgeon	1 provider within 90 miles
Occupational Therapist	2 providers within 60 miles

Provider Specialty	Standard Set by OMPP
Oncologist	2 providers within 60 miles
Ophthalmologist	2 providers within 60 miles
Optometrist	2 providers within 60 miles
Orthopedist	2 providers within 60 miles
Otolaryngologist	2 providers within 60 miles
Physical Therapist	2 providers within 60 miles
Psychiatrist	2 providers within 60 miles
Pulmonologist	2 providers within 60 miles
Radiologist	2 providers within 60 miles
Speech Therapist	2 providers within 60 miles
Urologist	2 providers within 60 miles

The information used to conduct the validation came from three sources:

- The geoaccess reports submitted by the MCEs;
- Electronic versions of provider directories submitted by the MCEs to B&A; and
- Claims data with dates of service in CY 2015

Tabulating Information from the Geoaccess Reports

B&A built nine table shells (3 MCEs x 3 programs) that recorded information from the MCEs' geoaccess reports for each of the 23 specialties in the study. Data was recorded for each specialty at the county level. The data in the table includes:

- The number of members in the county for the MCE/program;
- The number of providers located in the county;
- The member-to-provider ratio;
- The percentage of members in the county meeting the OMPP access standard for the specialty;
- The percentage of members in the county not meeting the OMPP access standard;
- The average distance for members in the county to reach the closest provider.

Information for the 92 counties was then rolled up to the region level (8 regions). Summary statistics were tabulated at the county level, the region level and the statewide level for each specialty and across each of the nine table shells.

Tabulating Information from the Provider Directories

The source data used for this tabulation is the same provider directories that were used in the verification of provider directory data discussed in Section V of this report. In the MCE provider directory files, each MCE has a field for provider specialty. In all of the directories, this is a free-form text field, not an alpha or numeric coding system for specialties. As a result, B&A had to organize the specialties into categories using the following process:

1. B&A sorted each MCE's provider directory file to identify the unique specialty descriptors found in each program (HHW, HCC and HIP).
2. Since it was found in the provider directory review that the same National Provider Identifier (NPI) could appear multiple times in an MCE's directory, B&A limited the dataset so that each NPI appeared only once.
3. B&A counted the unique NPIs by specialty descriptor.
4. The listing of specialty descriptors was matched by visual inspection to the list of 23 specialties that were in the study.
5. B&A provided the list of our mapping of the MCE's specialty descriptors to the 23 specialties listed in the study along with the count of providers in each specialty to the MCEs. The MCEs were given the opportunity to provide feedback to update this mapping.
6. B&A accepted all suggestions made by the MCEs to update the mapping. Once this was completed, all specialty descriptors remaining that were outside of the 23 specialties in the study were excluded.
7. For the providers that remained in the study, each provider was identified if they were enrolled in the HHW, HCC and/or the HIP.
8. A county assignment was given to each provider based on their office location (the county assignment was provided by the MCE in the database).
9. The count of providers by MCE/program/specialty/county was completed. Each provider was assigned to only one county.

Tabulating Information from Claims

Encounters submitted by the MCEs to the OMPP's Enterprise Data Warehouse (EDW) for services rendered to their members in HHW, HCC and HIP during CY 2015 were used in this study. This is the same dataset that was provided to B&A by the OMPP for other aspects of this External Quality Review (EQR). The encounters were segmented by MCE and program for analytical purposes. When a provider enrolls in Medicaid's Indiana Health Coverage Program (IHCP), the provider is identified by provider type and specialty. The provider is assigned a specialty code based on their enrollment information. This specialty code is associated with the provider on all claims and encounters representing services delivered by the provider.

B&A used the EDW provider specialty code to identify the specialist services that would be considered in this study. Exhibit VI.2 on the next page identifies the mapping of EDW specialty codes to the specialties used in this study. With the exception of primary care and behavioral health, this is a 1-to-1 mapping.

The encounter claims within each MCE/program were further limited to the provider specialty codes shown in Exhibit VI.2. The rendering provider ID was used on each claim (as opposed to the billing ID).

Encounters were matched against the membership in each MCE/program. The services were then further divided into groups for each of the 92 counties based on the member's residence.

Frequencies were completed on the number of providers that rendered services within each specialty. This was computed for each MCE/program separately. Counts were tabulated for:

- The number of unique rendering providers within the specialty statewide;
- The number of unique rendering providers within the specialty for each of the eight regions; and
- The number of unique rendering providers within the specialty for each of the 92 counties.

The information tabulated from each data source was then compared side-by-side as a means to understand differences in the metrics used to assess provider access. The specific metrics analyzed included:

- Member-to-provider ratio
- Average distance (in miles) from member to provider
- Comparison of actual providers identified in the database against the number of providers reported in the geoaccess reports
- Comparison of the actual number of providers used by members during CY 2015 against the number of providers on the MCE's provider roster for each specialty

Exhibit VI.2

Provider Specialties in the Study and Crosswalk to Provider Specialty Code in OMPP's EDW Provider File

Provider Specialty	EDW Provider Specialty Code(s)
Primary Care	316, 318, 335, 344, 345
Behavioral Health	110, 111, 112, 113, 114, 117
OB/GYN	328
Cardiologist	312
Cardiothoracic Surgeon	313
Dermatologist	314
Gastroenterologist	317
General Surgeon	319
Nephrologist	324
Neurologist	326
Neurosurgeon	325
Occupational Therapist	171
Oncologist	329
Ophthalmologist	330
Optometrist	180
Orthopedist	331
Otolaryngologist	332
Physical Therapist	170
Psychiatrist	339
Pulmonologist	340
Radiologist	341
Speech Therapist	173
Urologist	343

Findings

Exhibits VI.3 and VI.4, which appear on pages VI-6 and IV-7, show the results of B&A's tabulation of information from the geoaccess reports submitted by the MCEs to the OMPP.

Exhibit VI.3 shows member-to-provider ratios for each of the 23 provider specialties examined and separately for the HHW, HCC and HIP enrollment within each MCE. B&A also developed a standard of members-to-providers for comparative purposes. The standards used in the study are:

- For primary care providers, 100 members to 1 provider
- For behavioral health providers and OB/GYNs, 500 members to 1 provider
- For all other specialties, 1,000 members to 1 provider

The columns beside the member-to-provider ratios show the number of regions (out of 8) that exceeded the standard set above for each provider specialty. Anthem met the standards in almost every specialty category for all three programs. The exceptions to this are one region for primary care in HHW (Southwest) and multiple regions for dermatology, neurosurgeon and speech therapist in HHW and HIP.

Although MHS had a statewide average of 69 members to one primary care provider, it had five regions in the state where this threshold was above 100 (East Central, West Central, Northeast, Southeast and Southwest). The Central Region is what brought down the statewide average. The West Central Region also had a higher ratio in HCC and HIP. In total, MHS had 17 specialties in HHW where at least one region exceeded the threshold, 19 specialties in HCC and 21 specialties in HIP. The specialties with the highest member-to-provider ratios are cardiothoracic surgeon, dermatologist, neurosurgeon and speech therapist.

MDwise had member-to-provider ratios below the threshold for primary care and OB/GYN in all regions except for the Southeast Region in HIP. In total, MDwise had 15 specialties in HHW where at least one region exceeded the threshold, 14 specialties in HCC and 22 specialties in HIP. The specialties with the highest member-to-provider ratios are cardiothoracic surgeon, dermatologist, neurosurgeon and speech therapist.

Exhibit VI.4 shows the tally reported by the MCEs of the number of counties where each reported meeting the OMPP access standard for the specific specialty. For example, all three MCEs reported meeting the access standard of one primary care provider within 30 miles in all 92 counties in all three programs. There were a few instances where an MCE reported less than 90 of the 92 counties meeting the standard in a particular county. Anthem had no instances like this. MHS reported 84 to 86 counties meeting the standard for speech therapists in HHW, HCC and HIP. MDwise reported 80 counties meeting the threshold for otolaryngologist and 88 counties meeting the threshold for pulmonologist.

In the exhibit, the red cells highlight the instances where the average distance to travel to the closest provider within the specialty is higher than the threshold set by the OMPP. Out of 207 possibilities (23 specialties x 3 MCEs x 3 programs), red appears in 11 of these cells. In every cell that is highlighted in red, the standard set by the OMPP is two providers within 60 miles. Seven of the 11 cells have a value between 60 and 65 miles, three cells have values in the 70-80 mile range, and the highest value cell is 89.4 miles (MDwise/ HCC/ otolaryngologist).

Exhibit VI.3

Member-to-Provider Ratios by MCE / Program / Specialty Category

Member and Provider Numbers reported by the MCEs on Geoaccess reports submitted to OMPP. Tabulation of regions above threshold calculated by Burns & Associates.

	Member-to-Provider Ratio			# Regions Exceeding Standard (out of 8)			Member-to-Provider Ratio			# Regions Exceeding Standard (out of 8)			Member-to-Provider Ratio			# Regions Exceeding Standard (out of 8)		
	Anthem			Anthem			MHS			MHS			MDwise			MDwise		
Provider Specialty	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP
Primary Care	77	14	23	1	0	0	69	22	65	5	1	1	29	11	21	0	0	1
OB/GYN	56	10	67	0	0	0	208	75	224	1	1	1	156	81	125	0	0	1
Behavioral Health	47	9	22	0	0	0	96	9	94	0	0	1	246	59	229	2	0	1
Cardiologist	30	5	35	0	0	0	170	61	177	0	1	1	107	104	86	0	0	0
Cardiothoracic Surgeon	213	39	NR	0	0	NR	3,213	1,083	2,896	7	3	6	498	330	378	4	2	4
Dermatologist	514	94	495	3	0	2	1,954	1,024	1,944	6	2	4	1,297	623	987	5	3	5
Gastroenterologist	96	18	154	0	0	0	500	212	540	4	1	1	307	226	249	0	2	1
General Surgeon	96	17	87	0	0	0	282	116	290	0	1	1	279	132	222	0	0	1
Nephrologist	95	17	112	0	0	0	794	285	811	5	1	3	379	302	332	3	2	2
Neurologist	119	22	88	0	0	0	605	224	609	2	1	1	278	123	197	2	0	2
Neurosurgeon	485	89	617	2	0	5	2,259	611	2,252	6	3	6	765	1,206	669	5	3	5
Occupational Therapist	194	35	112	0	0	0	1,302	457	1,326	4	2	3	505	262	483	3	1	3
Oncologist	116	21	144	0	0	0	541	258	579	5	2	2	220	167	483	1	1	3
Ophthalmologist	177	32	194	0	0	0	983	368	1,014	5	1	1	442	386	380	2	2	1
Optometrist	134	25	164	0	0	0	NR	NR	NR	NR	NR	NR	381	271	367	0	1	1
Orthopedist	79	14	96	0	0	0	334	133	350	0	1	1	222	148	178	1	1	1
Otolaryngologist	199	36	146	0	0	0	738	281	731	4	1	1	432	84	371	0	0	1
Physical Therapist	47	9	19	0	0	0	452	169	452	2	0	2	243	260	219	2	1	1
Psychiatrist	87	16	96	0	0	0	NR	NR	NR	NR	NR	NR	749	106	689	5	0	3
Pulmonologist	85	16	184	0	0	0	567	209	589	4	1	1	340	238	287	0	1	1
Radiologist	NR	4	NR	NR	0	NR	1,129	375	1,126	5	1	4	280	61	148	2	0	2
Speech Therapist	642	117	1,182	2	0	4	2,409	861	2,628	6	3	5	1,352	579	1,264	5	2	3
Urologist	166	30	164	0	0	0	637	269	625	3	1	1	385	426	328	1	1	1

Thresholds set by Burns & Associates to calculate number of regions exceeding threshold.	
Primary Care	Greater than 100 members to 1 provider.
Behavioral Health	Greater than 500 members to 1 provider.
OB/GYN	Greater than 500 members to 1 provider.
20 other specialties	Greater than 1,000 members to 1 provider.

NR means that the MCE did not report information about this provider specialty on the Geoaccess report.

MHS did report Psychiatrist information on a report to OMPP. However, they are blended in the generic Behavioral Health category.

Exhibit VI.4

Average Distance to Contracted Provider by MCE / Program / Provider Specialty

Number of counties meeting target reported by the MCEs on Geoaccess reports submitted to OMPP. Average distance reported by the MCEs but tabulated by B&A.

	Number of Counties Meet OMPP Target (out of 92)			Value of County with Highest Avg. Dist. (in miles)			Number of Counties Meet OMPP Target (out of 92)			Value of County with Highest Avg. Dist. (in miles)			Number of Counties Meet OMPP Target (out of 92)			Value of County with Highest Avg. Dist. (in miles)		
	Anthem			Anthem			MHS			MHS			MDwise			MDwise		
Provider Specialty	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP
Primary Care	92	92	92	17.4	18.4	17.9	92	92	92	17.2	16.4	17.1	92	92	92	13.8	15.3	14.0
OB/GYN	92	92	92	26.5	26.5	25.6	92	92	92	35.2	34.4	33.7	92	90	92	24.9	26.2	25.2
Behavioral Health	92	92	92	24.9	27.5	16.4	92	92	92	26.3	26.5	27.8	92	92	92	19.8	29.7	19.9
Cardiologist	92	92	92	28.0	28.0	27.6	92	92	92	34.3	40.1	34.8	92	91	92	27.8	33.4	28.2
Cardiothoracic Surgeon	92	92	NR	35.8	37.3	NR	92	92	92	60.0	78.7	61.3	92	91	92	50.7	63.1	50.8
Dermatologist	92	92	92	40.7	40.9	39.4	92	92	92	75.5	75.5	75.5	92	90	92	68.4	71.2	68.2
Gastroenterologist	92	92	92	33.8	35.2	32.6	92	92	92	52.9	53.0	52.6	92	90	92	29.9	54.0	NR
General Surgeon	92	92	92	30.1	30.8	30.1	92	92	92	37.3	32.1	34.1	92	90	92	NR	33.3	28.5
Nephrologist	92	92	92	35.3	35.9	23.8	92	92	92	42.7	46.5	42.8	92	90	92	28.4	45.4	27.4
Neurologist	92	92	92	23.8	24.1	35.7	92	92	92	54.3	55.1	54.5	92	90	92	35.5	36.3	35.3
Neurosurgeon	92	92	92	37.0	38.1	54.1	92	92	92	76.0	78.8	76.7	92	90	92	52.8	77.7	53.1
Occupational Therapist	92	92	92	37.2	39.7	40.4	92	92	92	45.7	43.5	45.0	92	90	92	42.0	54.9	42.0
Oncologist	92	92	92	34.9	34.9	27.5	92	92	92	45.3	45.0	45.5	92	90	92	35.1	36.3	42.0
Ophthalmologist	92	92	92	31.8	33.4	29.7	92	92	92	45.7	45.1	46.6	92	90	92	33.2	42.3	28.8
Optometrist	92	92	92	24.5	25.9	22.4	NR	NR	NR	NR	NR	NR	92	90	92	30.9	53.2	32.0
Orthopedist	92	92	92	29.3	30.1	30.9	92	92	92	33.8	38.2	30.5	92	90	92	28.0	29.6	27.6
Otolaryngologist	92	92	92	29.7	29.8	30.5	92	91	92	54.1	**61.8**	54.0	92	80	92	30.9	**89.4**	35.0
Physical Therapist	92	92	92	31.2	31.5	30.7	92	92	92	41.3	41.4	41.2	92	91	92	37.1	40.7	36.8
Psychiatrist	92	92	92	28.7	28.2	31.5	NR	NR	NR	NR	NR	NR	92	92	92	36.7	NR	37.1
Pulmonologist	92	92	92	22.1	21.9	27.3	92	92	92	48.3	46.2	47.4	92	88	92	42.7	**64.3**	38.1
Radiologist	NR	92	NR	NR	26.2	NR	92	90	92	55.3	**62.6**	55.3	92	90	92	38.4	36.3	35.2
Speech Therapist	92	92	91	42.5	42.8	**61.9**	84	84	86	**75.7**	**79.2**	**76.1**	92	90	92	42.2	58.1	47.2
Urologist	92	92	92	20.0	20.5	33.4	91	91	91	**60.6**	**63.7**	**61.7**	92	90	92	30.9	49.0	26.9

Cells in red represent situations where the county with the highest average distance exceeds the OMPP contractual standard.

Exhibit VI.5 shows the comparison between information reported on the MCEs' geoaccess reports and the information that each MCE provided to B&A in their electronic provider directories. For each MCE, there are two sets of 3-column figures. The first set of three columns represents the number of unique providers that B&A tabulated from each MCE's database, by specialty, within each program. Because providers can choose to contract with just one Medicaid program or multiple programs, each column represents the number of providers contracted in the HHW, HCC and HIP programs specifically.

The second set of 3-column figures divides the number of providers in the previous columns by the number of *duplicated* counts of providers in the MCE's geoaccess report. Here is an example of how the ratio was tabulated:

> In Anthem's HHW count of primary care providers, the total count of providers statewide was found to be 2,461. This includes providers that could be duplicated across individual counties. The total count of unique primary care providers in Anthem's provider directory database was found to be 2,456. Therefore, the ratio computed was 1.0 [2,456 divided by 2,461].

The duplicated providers on the geoaccess report can occur as follows:

> Among the 2,461 providers counted in the statewide total, 848 were counted in the Central Region. There are 11 counties that map to the Central Region. The geoaccess report counts the number of providers that are available within 30 miles of members in each county. Marion County alone has 445 providers. Hamilton County (which is adjacent to Marion) has 117 providers. The radius of 30 miles for some members in Marion County crosses into Hamilton County. Therefore, some primary care providers are counted in the totals for both Marion and Hamilton Counties.

B&A was aware of this duplication from the start. Therefore, the duplicated number of providers in the geoaccess report is only being used as a benchmark against the unduplicated count of providers in the directory. The number of providers is not expected to match between the two data sources. B&A was interested in studying the difference between the number of duplicated providers (from the geoaccess report) to the unduplicated providers (the MCE directory). In Exhibit VI.5, values shown in red display ratios of 1.2 or lower. This means that the number of duplicated providers is close to the number of unduplicated providers, implying that there may be reporting problems since the duplicated value should be higher than the unduplicated value. Conversely, values shown in green display ratios of 10.0 or higher. This means that there are far fewer unique providers in the MCE directory than are counted in the geoaccess reports.

When Exhibit VI.5 is reviewed in detail by MCE, Anthem's ratios appear to be most in line with what is expected; that is, there are few instances of red values shown (meaning that duplicated counts of providers on the geoaccess reports are always higher than the unduplicated counts of providers in the MCE's directory). Anthem has no values in green for any specialty reviewed.

Both MHS and MDwise have a considerable number of cells shown in red. For MHS, this is true in 20 of the 23 specialties reviewed (optometrists and psychiatrists could not be measured because these specialties were not reported by MHS in their geoaccess reports). MDwise also had red values in 22 of 23 specialties in the HHW and HCC program but far fewer in the HIP analysis. MHS also had anomalies reported on the other extreme where green values are shown for gastroenterologist, neurologist, pulmonologist, and radiologist. MDwise did not have any specialties with green values.

Exhibit VI.5

Comparison of Unique Providers Contracted with MCEs and their Geoaccess Reports by MCE / Program / Provider Specialty

Number of unduplicated providers summed from provider directories submitted to B&A for this project.

	Number of Providers in MCE Directory (Unduplicated Count)			Ratio of Unduplicated Providers to Geoaccess Report Coverage			Number of Providers in MCE Directory (Unduplicated Count)			Ratio of Unduplicated Providers to Geoaccess Report Coverage			Number of Providers in MCE Directory (Unduplicated Count)			Ratio of Unduplicated Providers to Geoaccess Report Coverage		
	Anthem			Anthem			MHS			MHS			MDwise			MDwise		
Provider Specialty	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP
Primary Care	2,461	2,461	3,766	**1.0**	**1.0**	1.6	2,734	2,464	2,618	**0.8**	**0.7**	**0.8**	9,012	7,156	9,911	**0.9**	**0.7**	**1.0**
OB/GYN	1,142	1,142	1,181	3.0	3.0	1.8	781	698	749	**0.9**	**0.7**	**0.8**	1,081	779	1,142	1.3	**0.9**	1.5
Behavioral Health	2,307	2,509	1,110	1.7	1.6	5.7	653	689	687	2.3	6.2	2.2	489	1,038	118	1.8	**0.9**	**7.7**
Cardiologist	1,581	1,581	2,047	4.0	4.0	2.0	942	863	943	**0.9**	**0.7**	**0.9**	1,771	893	1,866	**1.2**	0.6	1.3
Cardiothoracic Surgeon	334	327	762	2.7	2.7	NR	113	98	110	**0.4**	**0.4**	**0.4**	272	175	293	1.6	**1.0**	**1.9**
Dermatologist	149	149	195	2.5	2.5	1.5	65	58	66	**1.1**	**0.6**	**1.1**	143	114	141	**1.2**	**0.8**	1.5
Gastroenterologist	436	436	570	4.5	4.5	1.6	26	222	260	**11.1**	**0.8**	**1.0**	594	260	615	**1.2**	**1.0**	1.4
General Surgeon	866	866	804	2.3	2.3	2.0	494	426	484	**1.0**	**0.8**	**1.0**	695	510	714	**1.1**	**0.8**	1.3
Nephrologist	449	449	758	4.4	4.4	1.7	243	232	241	**0.7**	**0.6**	**0.7**	455	207	488	1.3	**0.9**	1.3
Neurologist	545	545	841	2.9	2.9	1.9	2	2	1	**119.5**	**84.5**	**233.0**	758	466	782	**1.1**	**1.0**	1.3
Neurosurgeon	165	165	182	2.4	2.4	1.3	91	73	87	**0.7**	**0.8**	**0.7**	162	77	161	1.8	**0.6**	1.9
Occupational Therapist	723	723	819	1.4	1.4	1.6	165	164	179	**0.7**	**0.5**	**0.6**	371	268	371	**1.2**	**0.8**	1.2
Oncologist	900	585	1,372	1.8	2.8	**0.7**	104	80	104	2.6	1.8	2.4	859	388	371	**1.2**	**0.9**	1.2
Ophthalmologist	582	582	622	1.8	1.8	**1.2**	197	181	200	**0.7**	**0.6**	**0.7**	398	162	401	1.3	**0.9**	1.4
Optometrist	1,084	1,084	665	1.3	1.3	1.3	259	259	249	NR	NR	NR	441	253	429	1.3	**0.8**	1.3
Orthopedist	908	908	969	2.7	2.7	1.5	544	456	541	**0.8**	**0.6**	**0.7**	934	483	970	**1.1**	**0.8**	1.2
Otolaryngologist	417	417	604	2.3	2.3	1.6	310	252	305	**0.6**	**0.5**	**0.6**	435	362	445	**1.2**	1.9	1.3
Physical Therapist	3,553	3,553	0	**1.1**	**1.1**	**0.0**	328	298	328	**1.0**	**0.8**	**1.0**	978	286	968	**0.9**	**0.8**	**1.0**
Psychiatrist	698	698	845	3.1	3.1	1.8	637	605	633	NR	NR	NR	119	132	122	2.5	4.0	2.5
Pulmonologist	440	440	509	5.1	5.1	1.5	21	33	20	**12.1**	5.5	**12.1**	593	277	616	**1.1**	**0.9**	**1.2**
Radiologist	198	2,313	189	NR	3.7	NR	5	5	5	**25.6**	**20.2**	**25.2**	1,039	1,122	1,324	**0.8**	**0.8**	**1.1**
Speech Therapist	136	136	156	2.2	2.2	**0.8**	74	81	74	**0.8**	**0.5**	**0.7**	147	122	148	**1.1**	**0.8**	**1.1**
Urologist	468	469	23	2.4	2.4	1.3	237	131	232	**1.0**	**1.1**	**1.0**	407	170	420	1.4	**0.8**	1.5

NR means that the MCE did not report this information on their Geoaccess report.
Therefore, the ratio of providers in the MCE directory to Geoaccess availability could not be calculated.
Cells in red highlight ratios at or below 1.2. This indicates that there are more unique providers in the MCE directory than the Geoaccess reports state.
Cells in green highlight ratios at or above 10.0. This indicates that there are far fewer unique providers in the MCE directory than the Geoaccess reports state.

Exhibit VI.6 on the next page also utilizes the unique count of providers counted in each MCE's provider directory by specialty within MCE. In this exhibit, this value is the denominator in a new ratio computed. The numerator of the ratio is the unique count of the providers in the specialty category that members in the MCE/program used during CY 2015. This is a unique count statewide. As was described in the example used in Exhibit VI.6, a primary care provider in Anthem HHW that has an office in Marion County may serve HHW patients who live in Marion and Hamilton Counties. Therefore, although the provider could be counted as serving members in more than one county, this provider is only counted once in the columns in Exhibit VI.6 representing "number of providers used by members".

In the methodology section, it was mentioned that B&A used the specialty code as recorded in the OMPP's EDW for each provider when counting the number of providers used by members. The unique count of providers by specialty category in each MCE's provider directory is assigned with labels using free-form text. For example, "nuclear medicine", "nuclear radiology", "pediatric radiology" and "radiology" labels were all mapped to the Radiology category on this report from one MCE's directory. In another MCE's directory, "nuclear medicine", "nuclear medicine- nuclear cardiology", and "radiology- vascular and interventional radiology" were all mapped to the Radiology category. In the third MCE's directory, "nuclear medicine practitioner" and "radiologist" were mapped to this category.

The ratios shown in Exhibit VI.6, therefore, are intended to reveal two findings:

- To identify differences between how the MCEs label provider specialties (which, in turn, presumably is how the providers are reported in categories on the geoaccess reports), and
- To identify if there are large differences between the number of providers on an MCE's roster and the number of providers that actually deliver services to the MCE's members.

Exhibit VI.6 shows that there are large differences between the counts of providers on the roster and the counts of providers delivering services. This could be due to one or both of the items mentioned above (differences in the mapping to the specialty category or number of providers simply not seeing members). Values highlighted in red on the exhibit display ratios of 1.2 or lower. These are instances where there are far fewer unique providers in the MCEs' provider directory than actually see members (which is indicative of a mapping issue). Values highlighted in green display ratios of 10.0 or higher. These are instances where there are far more unique providers in the MCE's provider directory than actually see members. These values could be indicative of either (a) significant available capacity of providers, (b) a potential "false positive" of provider availability, and/or (c) a mapping problem.

When examined at the MCE level, Anthem has green values across almost all specialty categories except for four (primary care, dermatologist, ophthalmologist and optometrist). Anthem has only two instances of red values and both are in HIP only. MHS has red values in five specialty categories (gastroenterologist, neurologist, optometrist, pulmonologist and radiologist). Green values appear in five categories as well, but all but one appear in the columns for HHW and HCC only and not HIP. MDwise has red values in five specialty categories as well (behavioral health, ophthalmologist, optometrist, psychiatrist and speech therapist). Green values appear in nine categories, of which seven appear in the HHW column, two appear in the HCC column, and four appear in the HIP column.

Exhibit VI.6

Comparison of Unique Providers Contracted with MCEs and the Number of Providers Used by the MCE's Members

Number of unduplicated providers summed from provider directories submitted to B&A by the MCEs. Number of unduplicated providers used compiled by B&A from claims.

	Number of Providers Used by Members (Unduplicated Count)			Ratio of Unduplicated Providers to Geoaccess Report Coverage			Number of Providers in MCE Directory (Unduplicated Count)			Ratio of Unduplicated Providers to Geoaccess Report Coverage			Number of Providers in MCE Directory (Unduplicated Count)			Ratio of Unduplicated Providers to Geoaccess Report Coverage		
	Anthem			Anthem			MHS			MHS			MDwise			MDwise		
Provider Specialty	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP
Primary Care	497	555	591	5.0	4.4	6.4	559	476	1,381	4.9	5.2	1.9	471	560	458	9.0	7.0	11.4
OB/GYN	135	97	115	8.5	**11.8**	**10.3**	166	98	352	4.7	7.1	2.1	148	110	110	3.3	4.4	5.9
Behavioral Health	257	229	265	9.0	**11.0**	4.2	260	194	280	2.5	3.6	2.5	263	239	233	**0.9**	2.3	**0.3**
Cardiologist	52	68	93	**30.4**	**23.3**	**22.0**	59	70	197	**16.0**	**12.3**	4.8	64	84	100	**12.8**	4.8	5.8
Cardiothoracic Surgeon	14	23	19	**23.9**	**14.2**	**40.1**	18	17	22	6.3	5.8	5.0	16	28	18	9.4	3.6	6.8
Dermatologist	28	25	42	5.3	6.0	4.6	32	25	40	2.0	2.3	1.7	30	31	27	1.7	1.8	1.6
Gastroenterologist	26	29	34	**16.8**	**15.0**	**16.8**	28	35	98	**0.9**	6.3	2.7	33	41	33	**11.0**	3.6	7.8
General Surgeon	68	83	73	**12.7**	**10.4**	**11.0**	80	68	176	6.2	6.3	2.8	83	93	63	4.8	3.1	4.9
Nephrologist	14	30	32	**32.1**	**15.0**	**23.7**	19	26	32	**12.8**	8.9	7.5	12	35	33	**16.3**	3.2	8.4
Neurologist	40	57	44	**13.6**	9.6	**19.1**	48	49	109	**0.0**	**0.0**	**0.0**	53	61	45	7.2	3.5	7.0
Neurosurgeon	13	18	11	**12.7**	9.2	**16.5**	17	15	27	5.4	4.9	3.2	14	19	10	5.1	1.8	**10.7**
Occupational Therapist	6	5	4	**120.5**	**144.6**	**204.8**	5	3	18	**33.0**	**54.7**	9.9	7	8	2	**30.9**	**19.1**	**123.7**
Oncologist	23	37	28	**39.1**	**15.8**	**49.0**	31	46	62	3.4	1.7	1.7	26	44	29	**23.2**	4.5	5.7
Ophthalmologist	97	101	102	6.0	5.8	6.1	99	90	125	2.0	2.0	1.6	93	106	90	2.2	**0.8**	2.1
Optometrist	324	273	333	3.3	4.0	2.0	315	242	391	**0.8**	**1.1**	**0.6**	324	269	299	**0.7**	**0.6**	**0.8**
Orthopedist	68	67	48	**13.4**	**13.6**	**20.2**	76	67	177	7.2	6.8	3.1	78	73	46	5.2	3.0	**10.7**
Otolaryngologist	45	43	35	9.3	9.7	**17.3**	52	45	78	6.0	5.6	3.9	55	44	35	3.3	3.9	5.6
Physical Therapist	44	42	60	**80.8**	**84.6**	**0.0**	38	31	72	8.6	9.6	4.6	35	34	30	**19.6**	5.8	**15.9**
Psychiatrist	46	58	66	**15.2**	**12.0**	**12.8**	57	60	167	**11.2**	**10.1**	3.8	50	60	48	**1.0**	**1.1**	1.3
Pulmonologist	34	47	34	**12.9**	9.4	**15.0**	41	47	71	**0.5**	**0.7**	**0.3**	38	48	34	9.9	2.8	9.5
Radiologist	67	78	81	3.0	**29.7**	2.3	71	61	517	**0.1**	**0.1**	**0.0**	69	80	82	4.2	4.9	4.5
Speech Therapist	6	4	3	**22.7**	**34.0**	**52.0**	3	4	1	**24.7**	**20.3**	**74.0**	5	1	0	**29.4**	**122.0**	**0.0**
Urologist	25	31	26	**18.7**	**15.1**	**0.9**	30	30	59	7.9	4.4	3.9	32	38	26	6.9	2.4	7.9

Cells in red highlight ratios at or below 1.2. This indicates that there are far fewer unique providers in the MCE directory than members are actually using.
Cells in green highlight ratios at or above 10.0. This indicates that there are far more unique providers in the MCE directory than members are using.

Recommendations

The most significant finding of this study is that the reporting on the geoaccess reports that are submitted to the OMPP by the MCEs is inconsistent. Without further research, it is premature to assess if each MCE's geoaccess reports are not valid. What has been determined is that the OMPP cannot compare MCE network adequacy the same across the MCEs and potentially even across programs within the same MCE. With this in mind, B&A offers recommendations to the OMPP on the methodology and design of the geoaccess reports that are submitted by the MCEs. Some MCE-specific recommendations are also provided based on the evaluation of MCE-specific findings.

Recommendations to the OMPP

1. B&A recommends that the OMPP provide direction to the MCEs in the instructions for geoaccess reporting related to the assignment of providers to specialty categories. One option is to use the specialty category codes already assigned to the provider at IHCP enrollment. There are some specific items within certain specialties that should also be considered:

    a. Within the primary care category, clarity should be provided on whether the MCEs should count any provider with a primary care specialty (e.g., family practitioner, general practitioner) or only those providers that are willing to accept members and serve as the member's primary medical provider (i.e., their medical home). Clear distinction on the treatment of emergency medical providers should also be provided.
    b. Within the OB/GYN category, the OMPP should clarify if these providers should only be counted in this category or whether they could also be counted in other categories (e.g., primary care).
    c. Within the behavioral health category, there is an array of licensed and credentialed providers all merged in this category. Among the 23 specialties reviewed, this category has the greatest chance of being non-aligned across the MCEs depending on whether the category should include all level practitioners or only certain level practitioners. The OMPP should provide clear guidance as to which practitioners should be included in the report (or break this category into multiple categories).

2. Recognizing that a new contractual arrangement with the MCEs begins in CY 2017 where each of these MCEs will serve all three populations (HHW, HCC and HIP) and a fourth MCE will serve two populations (HHW and HIP), the OMPP may want to consider having the MCEs submit geoaccess reports by specialty but unifying all members enrolled with the MCE under all three programs.

3. One concern for both the OMPP and for members is the number of providers that are accepting new patients, in particular primary care providers. The OMPP may want to consider having the MCEs submit two versions of the primary care geoaccess reports—one for all contracted primary care providers, the other limited to those providers that are accepting new patients.

4. The OMPP should consider providing more detail to the MCEs on the format of the geoaccess reports to allow for easier monitoring by the OMPP. This may include some information delivered in a format other than PDF. For example, it would be helpful for the OMPP to analyze average distance results in an Excel table in order to sort the results as opposed to the PDF format that the data is currently delivered in.

Recommendations to the MCEs

1. The MCEs should provide consistency in the reporting of information by specialty category across the programs. Anthem reported information for the specialty categories except for cardiothoracic surgeon (not reported for HIP) and radiologist (not reported for HHW and HIP). MHS was consistent but did not report information on optometrists (psychiatrists were not reported separate from the behavioral health category like the other MCEs did, but OMPP gave discretion in this area).

2. Although there were few instances cited where this occurred, the MCEs should strive to meet the availability of specific provider specialties in conformance with the OMPP standards. Only 10 instances out of 239 were found where the MCEs did not meet the availability standard—one for Anthem, seven for MHS and two for MDwise.

3. The MCEs are encouraged to review their MCE-specific free-form specialty categories against the OMPP provider specialty codes in the event that this mapping is required by the OMPP. B&A consulted with each MCE about their MCE-specific mapping of specialties to the 23 specialty categories shown in the study and made changes to the mapping based on the MCEs' feedback. Even after this was completed, there is significant variance between the count of providers by specialty in the MCE's database and the geoaccess reports and claims history (using the EDW's specialty categorization).

SECTION VII: FOCUS STUDY ON THE UTILIZATION AND ACCESS TO DENTAL SERVICES

Introduction

Currently, the management of dental services is the responsibility of the managed care entities (MCEs) for the Hoosier Care Connect (HCC) and Healthy Indiana Plan (HIP) 2.0 programs. In a new contract period beginning in January 2017, the MCEs will also be responsible for managing dental services in the Hoosier Healthwise (HHW) program. The purpose of this study is to assess the adequacy of coverage for the provision of dental services throughout the state for HCC and HIP members and to set a baseline of the utilization of this service for future monitoring.

Methodology for Defining the Study Sample

Burns & Associates (B&A) used encounter claims with dates of service in Calendar Year (CY) 2015 to identify the dentists who delivered services to HCC and HIP members as well as utilization of dental services within each program. Because both the HCC and HIP 2.0 began in CY 2015, B&A limited the study to encounters from April through December 2015 for the HCC program and February through December for HIP 2.0.

Dental services are stored in the Office of Medicaid Policy and Planning's (OMPP's) Enterprise Data Warehouse (EDW) as a separate claim type (type 'D') on which providers bill the D-series HCPCS codes. B&A examined the frequency of the encounters submitted under claim type D within HCC and HIP at the statewide level and by MCE.

Total dental encounters included in the dataset are shown in Exhibit VII.1 to the right.

Exhibit VII.1
Dental Encounters Used in the Study

	Hoosier Care Connect	Healthy Indiana Plan
All MCEs	48,101	239,675
Anthem	18,666	101,690
MHS	7,521	60,537
MDwise	21,914	77,448

Specific attributes were reviewed for consistency between HCC and HIP as well as across MCEs. In general, the encounters were consistent along these dimensions:

- When examined by provider type, 85 percent of the encounters were delivered by dentists (office-based) and nine percent were delivered by dentists at clinics. The remaining had a missing provider type value. This ratio was consistent between the HCC and HIP populations and across the MCEs.
- Within the provider type of dentist, 90 percent of encounters were delivered by the specialty "general dentistry practitioner" while 10 percent were delivered by pediatric dentists or oral surgeons.

Using the encounters in the dataset described above, analytics were completed to assess utilization per 1,000 member months within each program at the county level. When measuring utilization per 1,000 member months, all encounters in the dataset were used. In HCC, member months for children under age two were excluded from the calculation. In HIP, no member exclusion was required since all members are age 19 or older.

Additionally, geocoding software (either the Google Distance Matrix web service or BING Maps web service) was used to map the driving distance from the member's home to the dentist's office[10]. For this portion of the study, each unique pairing of member-to-dentist location was identified. Therefore, if a member had repeat visits to the same dentist, only the first visit was counted in the analysis. The following process was used to compute driving distances:

1. The member's home location information was taken from the latitude and longitude data contained within the encounters file provided to B&A from the OMPP EDW.
2. The member's county assignment for display on the maps was accessed using the Federal Communication Commission web service. This was matched to the county assignment on the claims for verification purposes of latitude and longitude coordinates. In a small percentage of claims, the county assignment on the claim and the latitude/longitude county assignment did not match. When there was a mismatch, B&A defaulted to the county assignment associated with the latitude and longitude.
3. Provider location information was taken from the latitude and longitude data in the provider file supplied to B&A from the OMPP EDW.

Some additional exclusions were made prior to computing the average driving distance for members in each county as follows:

- There were 4.4 percent of the records that contained a blank provider ID field and thus were excluded because the provider's location was unknown.
- An additional 5.1 percent were excluded because the distance returned from the web service indicated a distance of either less than 0.2 miles (0.4 percent) or greater than 100 miles (4.7 percent). B&A attributed these results to incorrect latitude/longitude data on the member's encounter or the provider file rather than actual member experience.

After this process, 106,358 unique member-to-provider pairings were included in the study.

Once the driving distances were tabulated, an average driving distance was computed at the county level. Both the utilization per 1,000 member months and the average driving distance were computed across subgroups within the population as follows:

- At the county level for HCC displaying statewide values as well as at the MCE-specific level.
- At the county level for HIP displaying statewide values as well as at the MCE-specific level.

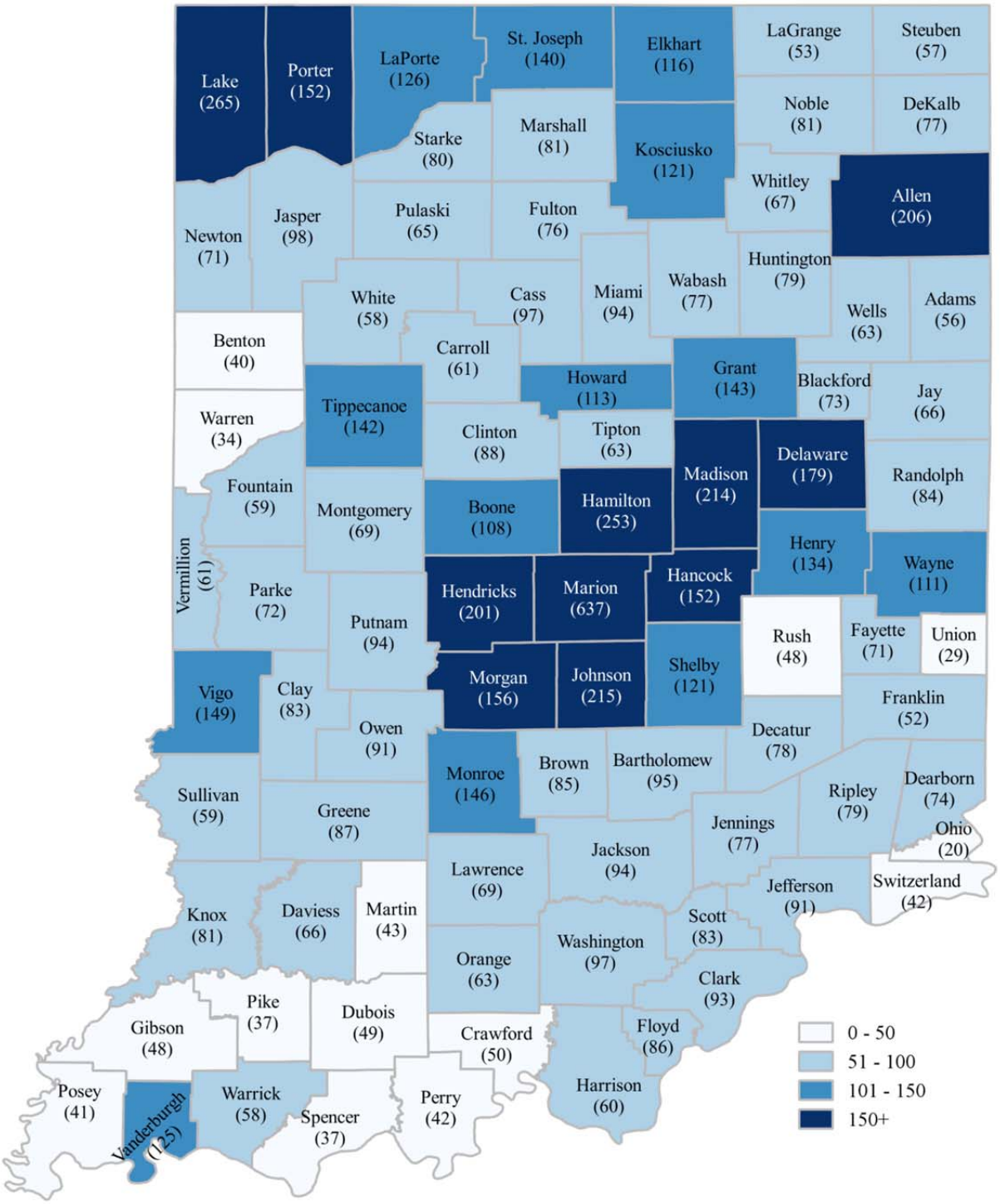
Findings

Exhibit VII.2 is a map that shows the count of unique providers that delivered dental services to the HCC and HIP populations combined in CY 2015. The counts shown in each county represent the number of unique dental providers seen by the members who live in the county. In total, there were 1,643 unduplicated dentists across the two programs providing dental care to Indiana Medicaid members. Of these, there were 1,091 and 1,405 unique dental care providers utilized by HCC and HIP members, respectively.

The exhibit shows that there are 14 counties that had 50 or fewer providers that delivered dental services to the members in their county. Among these, eight are in the Southwest Region. Two counties had fewer than 30 dentists serving members—Ohio (20 providers) and Union (29 providers).

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

Exhibit VII.2
Count of Providers Serving Hoosier Care Connect and Healthy Indiana Plan Members, by County



Exhibits VII.3, VII.4 and VII.5 show dental utilization per 1,000 member month results at the county level. Exhibit VII.3 compares the utilization per 1,000 member months between HCC and HIP. Exhibit VII.4 shows the utilization per 1,000 member months within HCC only but compares the rates between Anthem, MHS and MDwise. Exhibit VII.5 mirrors the display of Exhibit VII.4 but focuses on HIP dental utilization.

The maps are presented in the same format for ease of comparison. The darker the shade of blue, then the greater the utilization per 1,000 member months was in the county. The values shown in parentheses display the actual utilization per 1,000 member months.

A summary of findings across the three exhibits is discussed below:

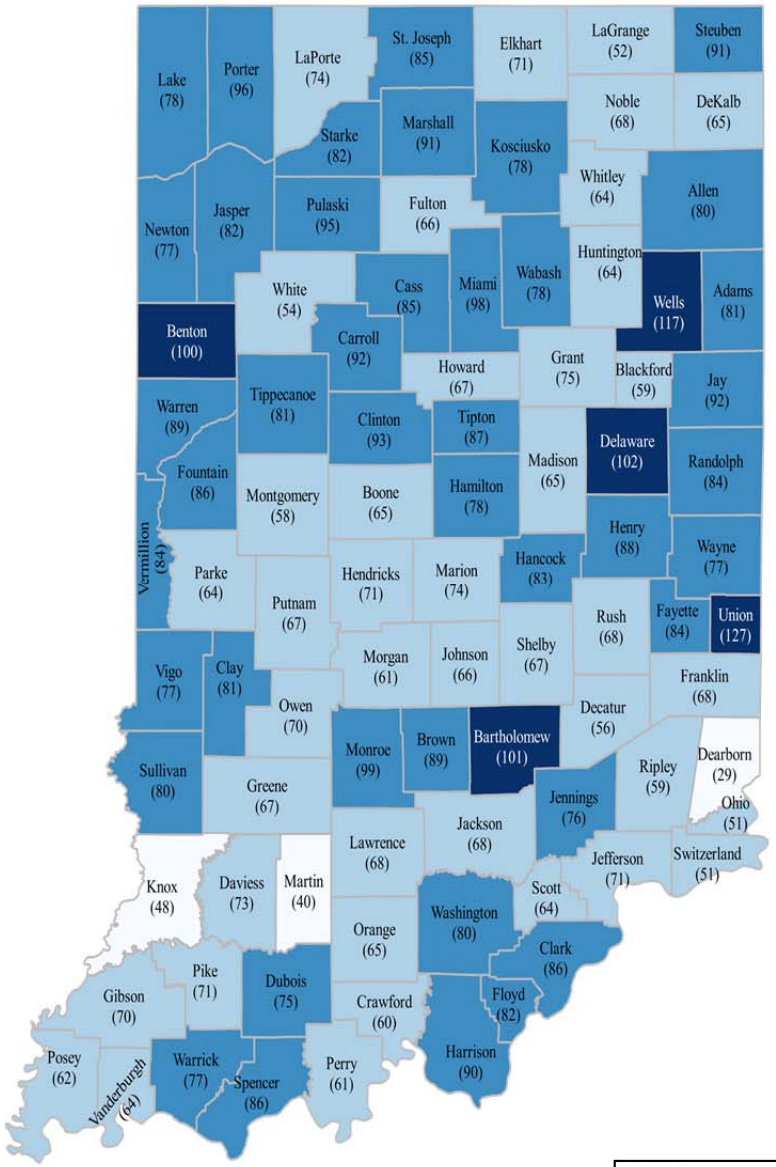
- When comparing utilization across the HCC and HIP programs (Exhibit VII.3), the average utilization per 1,000 member months statewide was identical for HCC and HIP at 76 visits per 1,000 member months. There are six counties with a utilization per 1,000 member months statistic that is less than 50—three among the HCC population (Dearborn, Knox and Martin) and four among the HIP population (Dearborn, Ohio, Posey and Vanderburgh).

- Among the HCC population exclusively (Exhibit VII.4), the average utilization per 1,000 member months varied across MCEs at 81 per 1,000 for Anthem, 60 per 1,000 for MHS and 80 per 1,000 for MDwise. The number of counties with a utilization per 1,000 member months statistic that is less than 50 was eight for Anthem, 34 for MHS and seven for MDwise. There were seven counties that were in this group for more than one MCE: Blackford, Dearborn, Knox, Martin, Ohio, Switzerland and White.

- Among the HIP population exclusively (Exhibit VII.5), the average utilization per 1,000 member months varied across MCEs at 76 per 1,000 for Anthem, 81 per 1,000 for MHS and 73 per 1,000 for MDwise. The number of counties with a utilization per 1,000 member months statistic that is less than 50 was four for Anthem, five for MHS and four for MDwise. There were two counties that were in this group for more than one MCE: Dearborn and Vanderburgh.

Exhibit VII.3
Utilization Per 1,000 Member Months, Hoosier Care Connect and Healthy Indiana Plan Members

HCC



HIP

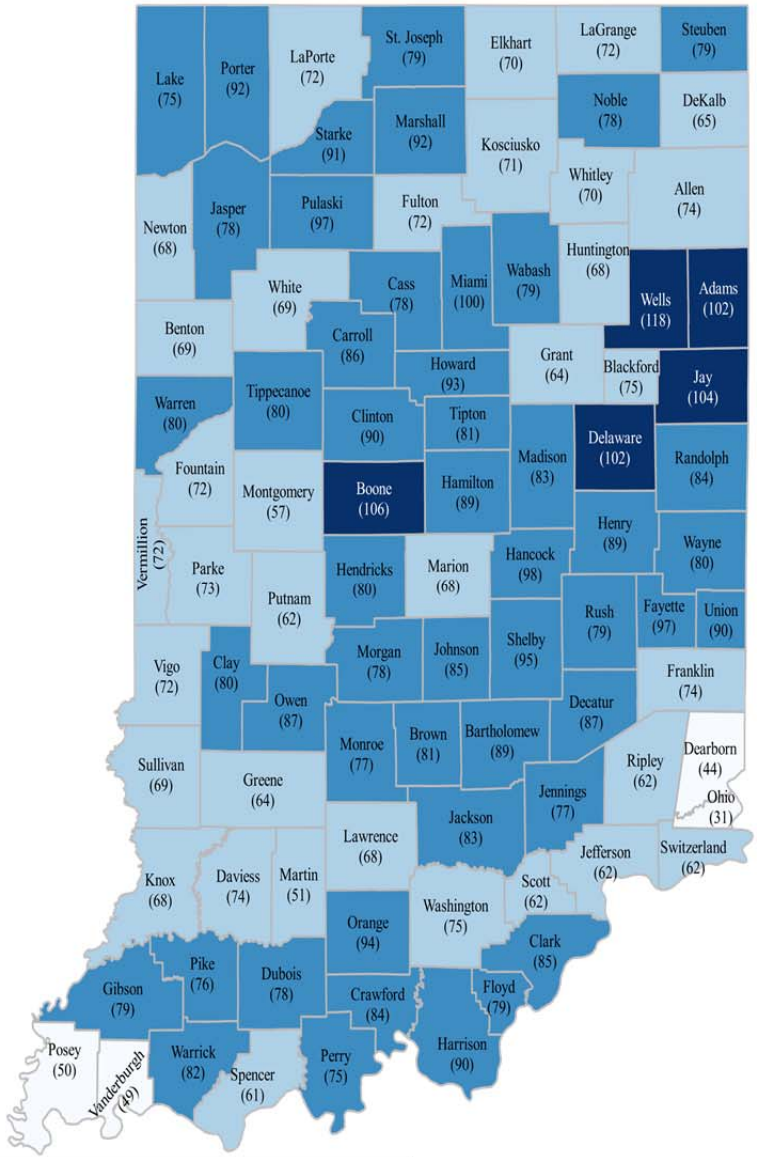


Exhibit VII.4
Utilization Per 1,000 Member Months in Hoosier Care Connect, by MCE

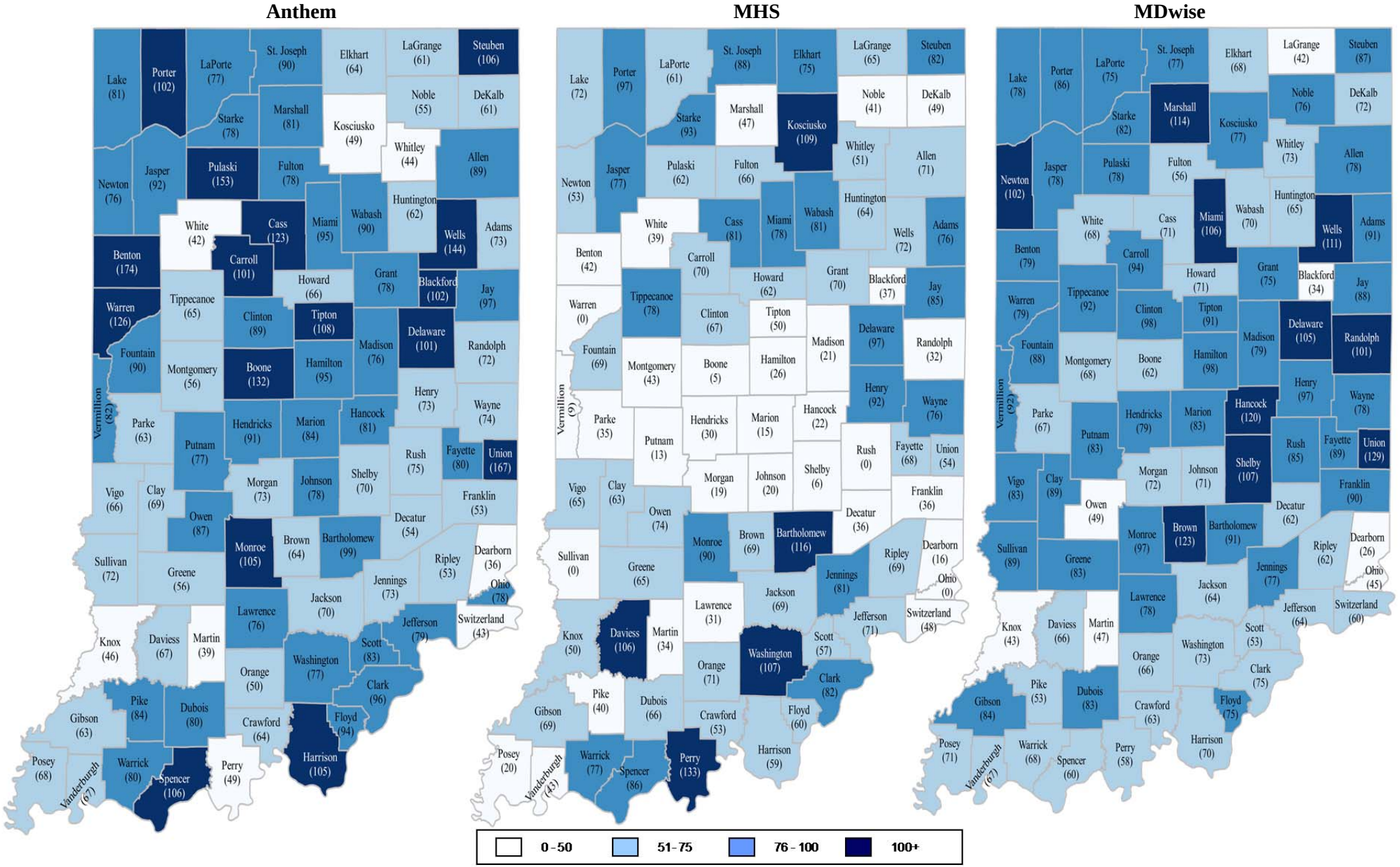
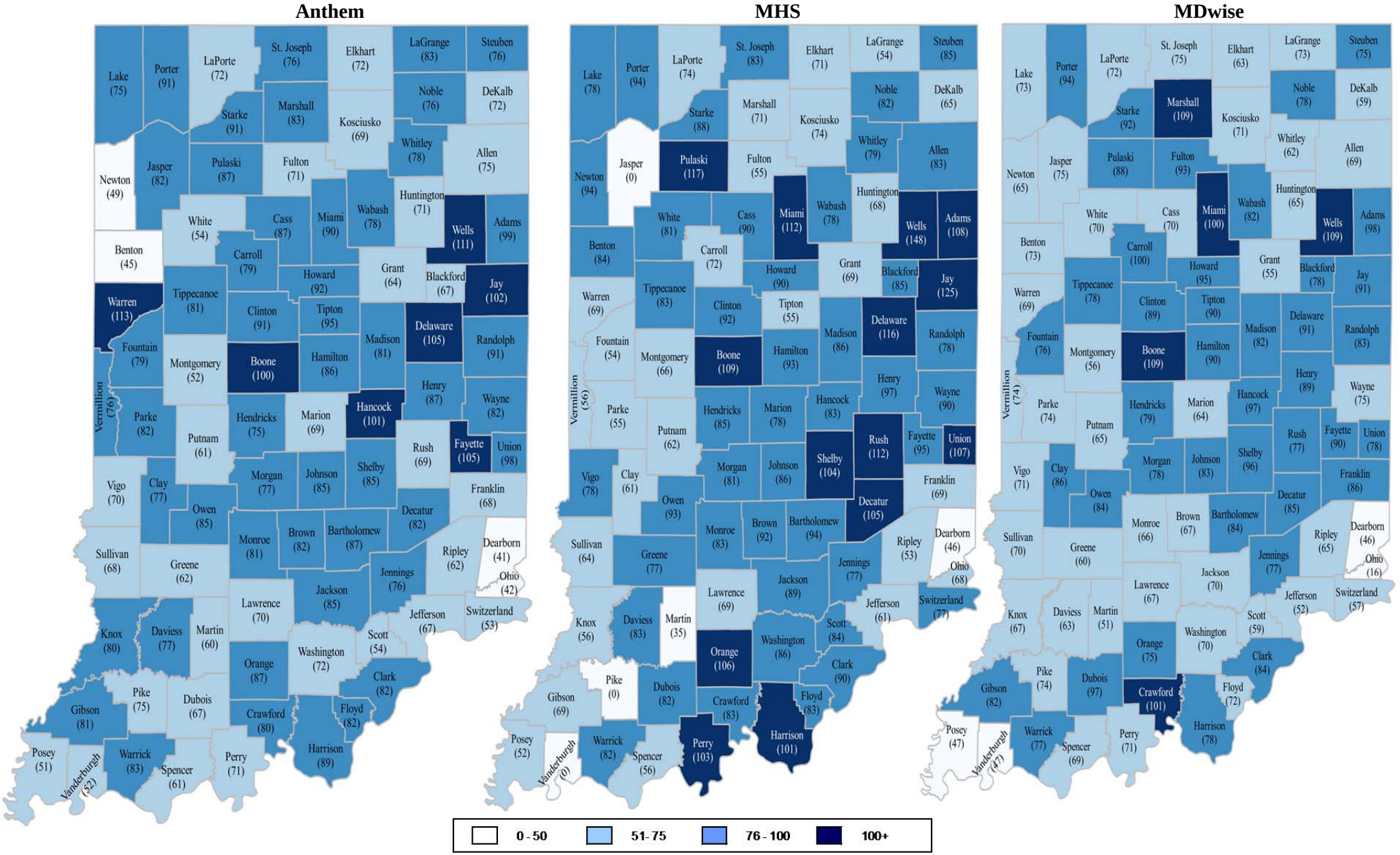


Exhibit VII.5
Utilization Per 1,000 Member Months in Healthy Indiana Plan, by MCE



Exhibits VII.6, VII.7 and VII.8 show the average distance travelled by members in each county to receive dental services. Exhibit VII.6 compares the average distance travelled between HCC and HIP. Exhibit VII.7 shows the average distance travelled for HCC members only but compares the rates between Anthem, MHS and MDwise. Exhibit VII.8 mirrors the display of Exhibit VII.7 but focuses on the average distance travelled for HIP members.

Similar to the maps shown for utilization per 1,000 member months, the maps shown here are presented in the same format for ease of comparison. The darker the shade of blue, then the greater the average distance travelled for members in the county. The values shown in parentheses display the actual average distance for each county. One difference from the utilization per 1,000 member month maps is that in some instances the county is shown in gray with no values. This means that there was less than 10 instances of member-to-dentist trips in the study, so B&A believed that the average distance was should not be reported. Also, counties with an average distance of greater than 50 miles have a red border highlight.

A summary of findings across the three exhibits is discussed below:

- When comparing the average distance travelled by members in the HCC and HIP programs (Exhibit VII.6), there are eight counties where the average distance was less than 10 miles and 20 where the average distance was greater than 30 miles for HCC members. The counts for HIP members were seven and 13 counties, respectively. There are eight counties where the average distance travelled was greater than 30 miles for both HCC and HIP members—Benton, Dearborn, Jackson, Newton, Parke, Pulaski, Ripley and Starke.

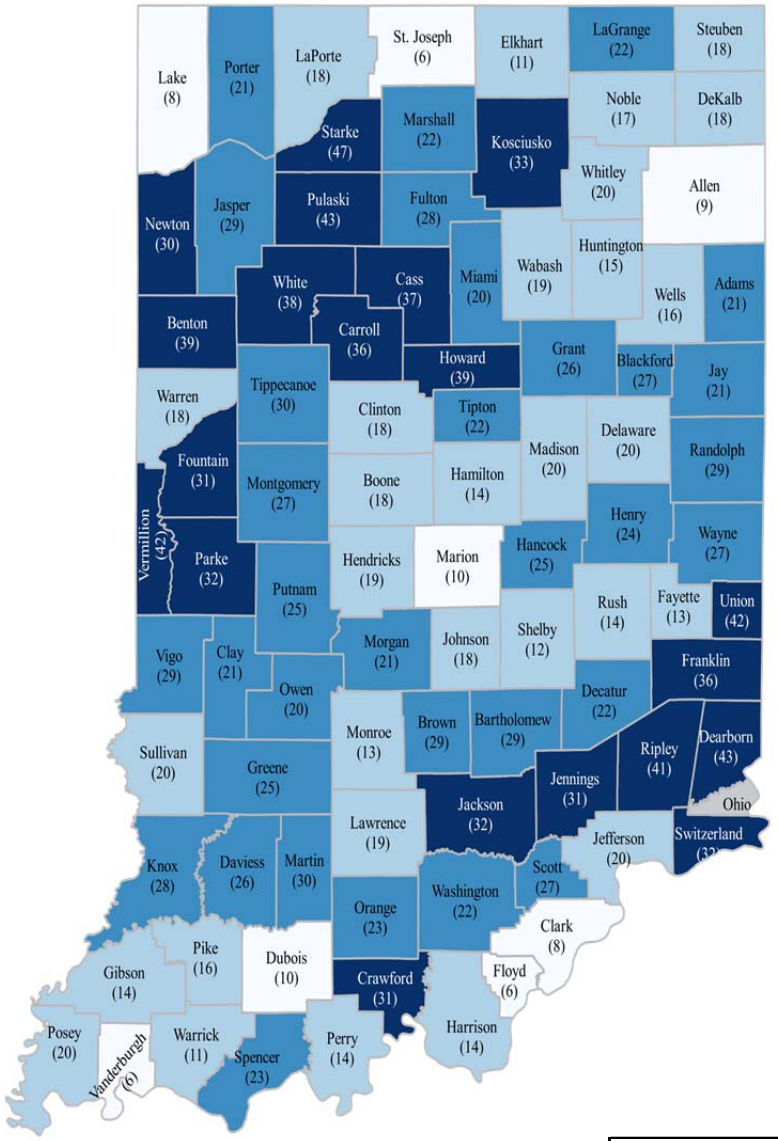
- Among the HCC population exclusively (Exhibit VII.7), for the counties where the sample size was sufficient for reporting purposes, the maximum average distance county for Anthem was Starke County (44.9 miles); for MHS, White County (52.1 miles); and for MDwise, Pulaski County (48.3 miles). The number of counties with average distances greater than 30 miles was 21 for Anthem, seven for MHS and 25 for MDwise. There were 16 of the 92 counties that had an average distance of greater than 30 miles in at least two of the MCEs—Bartholomew, Benton, Carroll, Cass, Crawford, Dearborn, Franklin, Howard, Jackson, Kosciusko, Newton, Ripley, Starke, Switzerland, Tippecanoe and Vermillion.

- Among the HIP population exclusively (Exhibit VII.8), for the counties where the sample size was sufficient for reporting purposes, the maximum average distance county for Anthem was Starke County (50.6 miles); for MHS, Starke County (50.3 miles); and for MDwise, Jackson County (47.4 miles). The number of counties with average distances greater than 30 miles was 17 for Anthem, 16 for MHS and 10 for MDwise. There were 15 of the 92 counties that had an average distance of greater than 30 miles in at least two of the MCEs—Benton, Brown, Cass, Dearborn, Grant, Howard, Montgomery, Newton, Ohio, Parke, Pulaski, Ripley, Scott, Starke and Vermillion.

- When the highest average distance counties were cross-tabulated between HCC and HIP, there were eight counties that appeared on both the HCC and HIP list as having an average distance of greater than 30 miles in two or more MCEs: Benton, Cass, Dearborn, Howard, Newton, Ripley, Starke and Vermillion.

Exhibit VII.6
Average Driving Distance to Dentists for Hoosier Care Connect and Healthy Indiana Plan Members
(Average distances shown in miles for members using single one-way trips from member home to provider location.)

HCC



HIP

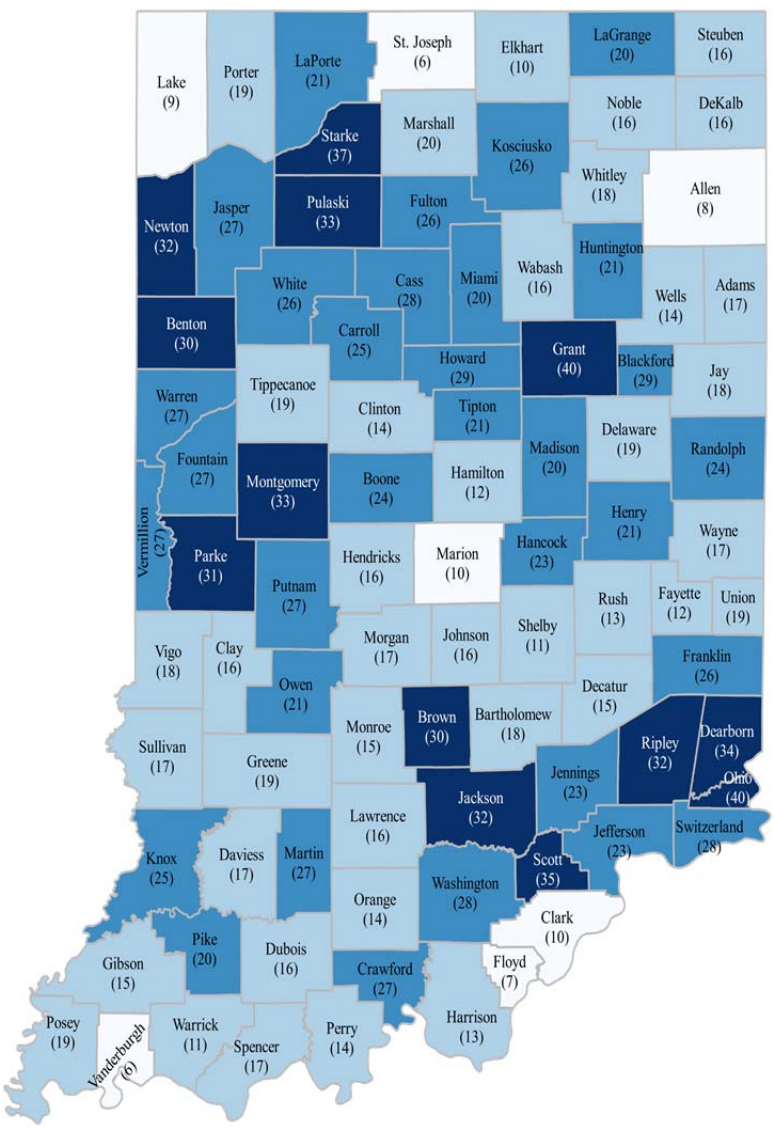


Exhibit VII.7
Average Driving Distance to Dentists for Hoosier Care Connect Members, by MCE
(Average distances shown in miles for members using single one-way trips from member home to provider location.)

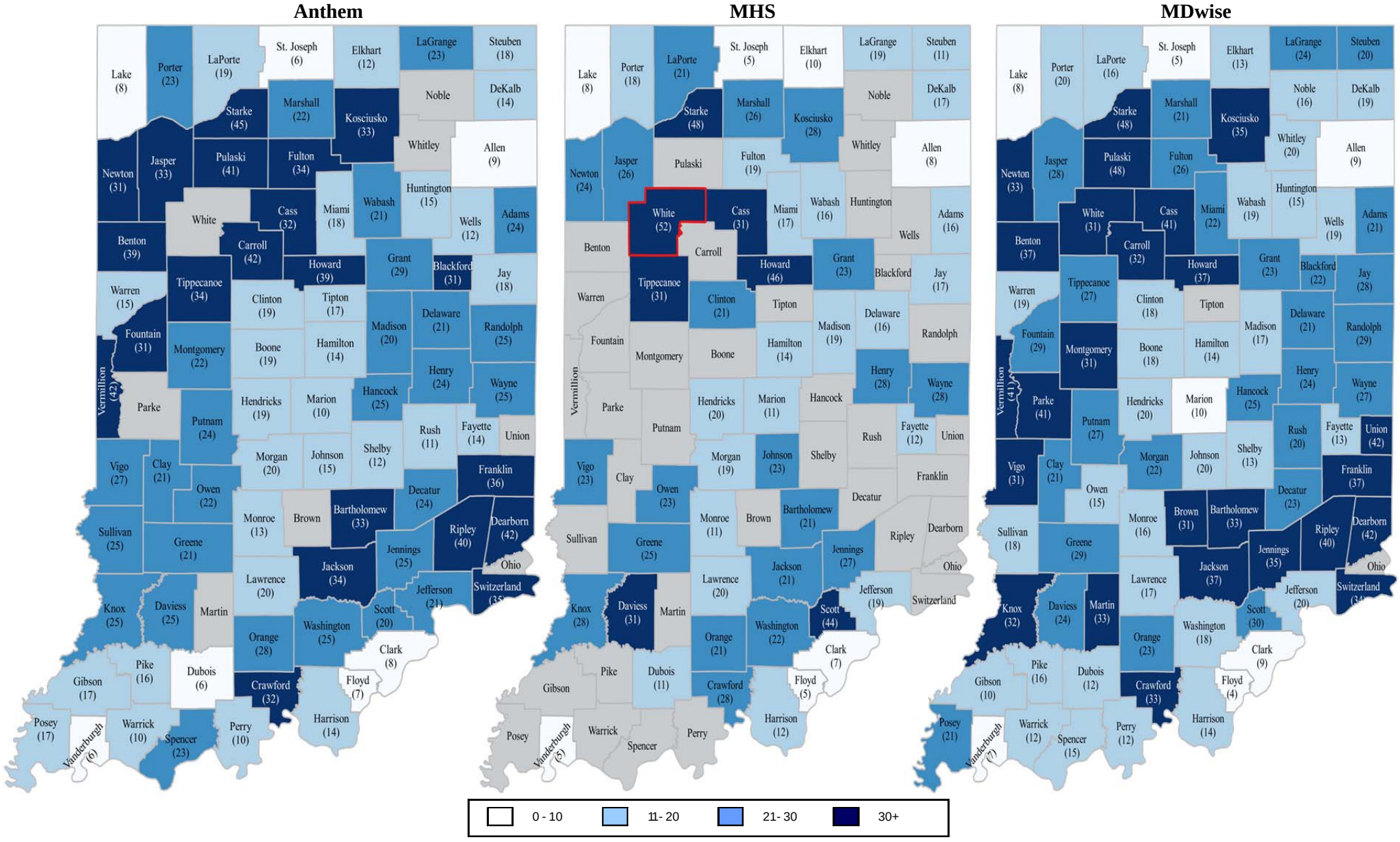
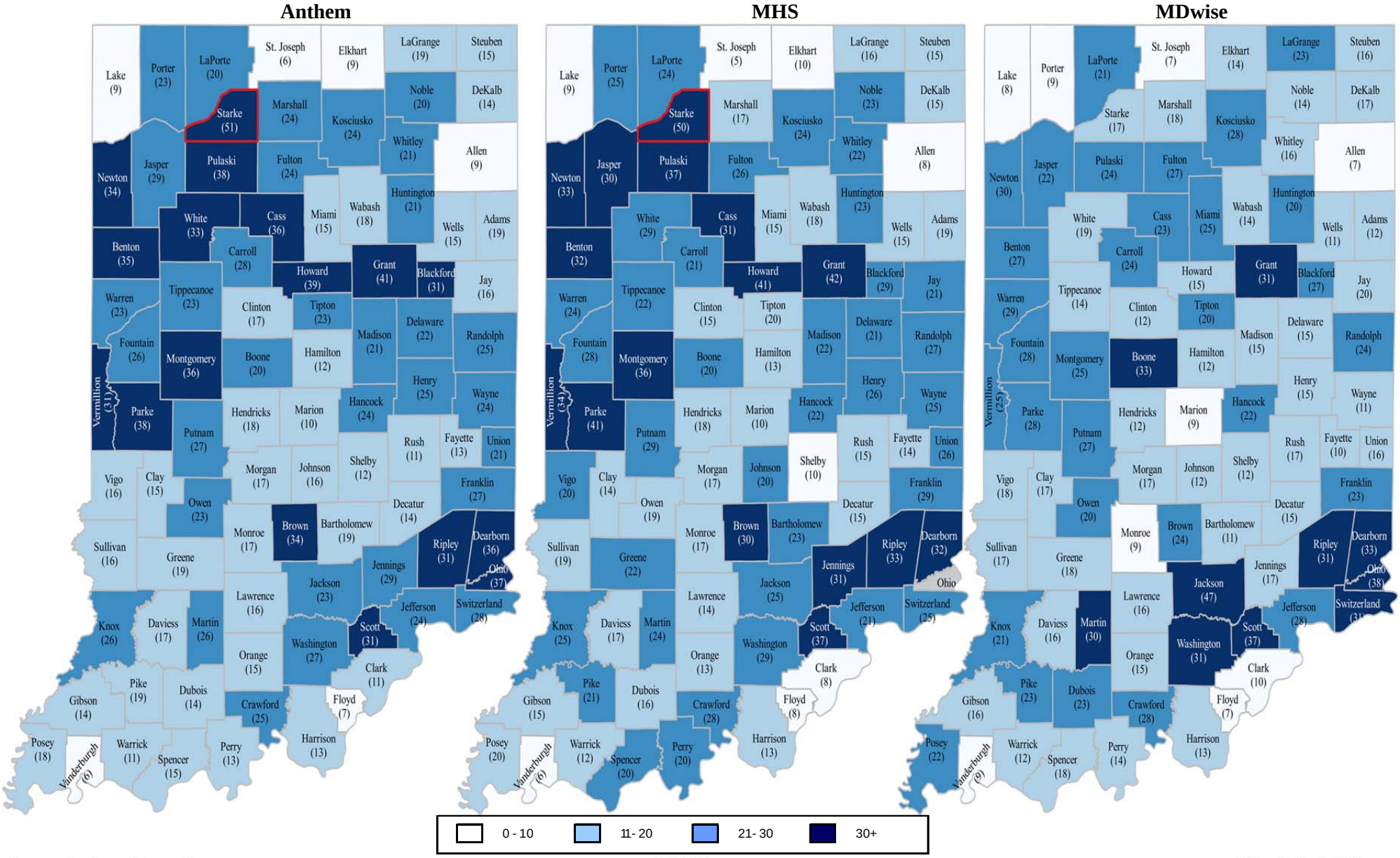


Exhibit VII.8
Average Driving Distance to Dentists for Healthy Indiana Plan Members, by MCE
(Average distances shown in miles for members using single one-way trips from member home to provider location.)



Profile of Members with a Dental Visit

Exhibits VII.9 and VII.10 on the following pages examine the members who use dental services in the HCC program (Exhibit VII.9) and the HIP program (Exhibit VII.10) by different subgroups within each population. The exhibits are intended to show if dental utilization is disproportionately used or not used by select subpopulations in either HCC or HIP.

The exhibits are formatted in a similar manner. In both exhibits, the populations from all three MCEs are combined. The red bars represent the percent of the total population that the subgroup represents as of December 31, 2015. The blue bar represents the percent of that subgroup that had a dental visit. The black line going straight across in each box shows the percentage of the entire population in the exhibit that had dental visits. This is used to compare the subgroup of interest against the total population.

Four boxes are shown in both exhibits. The upper left box examines dental use by gender. The upper right box examines dental use by region. The lower boxes examine dental use by race/ethnicity and by age group.

In the lower left box in Exhibit VII.9, for example, Caucasians represent 64 percent of the total HCC population as of December 2015 (the red bar). The percent of Caucasian members who had a dental visit during CY 2015 was also 64 percent (the blue bar). The average percent of all HCC members with a dental visit in HCC was 23.8 percent (the black line). For comparison, the average percent of HIP members with a dental visit in CY 2015 was 25.0 percent.

In Exhibit VII.9, for the HCC population, it was found that the percent of members who received a dental service closely aligned with the population overall when examined by gender, race/ethnicity and region. The only variance seen was by age group. It is not surprising that although the below age five, age six to 12 and age 13 to 18 age groups represent only 27 percent of the HCC population, each age group had a higher percentage of its members receive a dental visit than the overall average. The use of dental services was highest in the age 6 to 12 group and lowest in the age 19 to 29 group.

In Exhibit VII.10, for the HIP population, it was found that females were more likely to have had a dental visit (27.2% of its members) than males (20.7% of its members). There is consistent dental utilization among members by region despite what was found in the average distance maps. There is also relatively consistent dental use by race/ethnicity. Only 20 percent of the younger members in HIP age 19 to 29 had a dental visit, whereas 28 percent of members age 30 and over had a dental visit in CY 2015.

Exhibit VII.9
Percent of Total Population and Dental Care Users by Key Demographic Features
Hoosier Care Connect Population
Enrollment in HCC as of Dec. 31, 2015 = 97,622

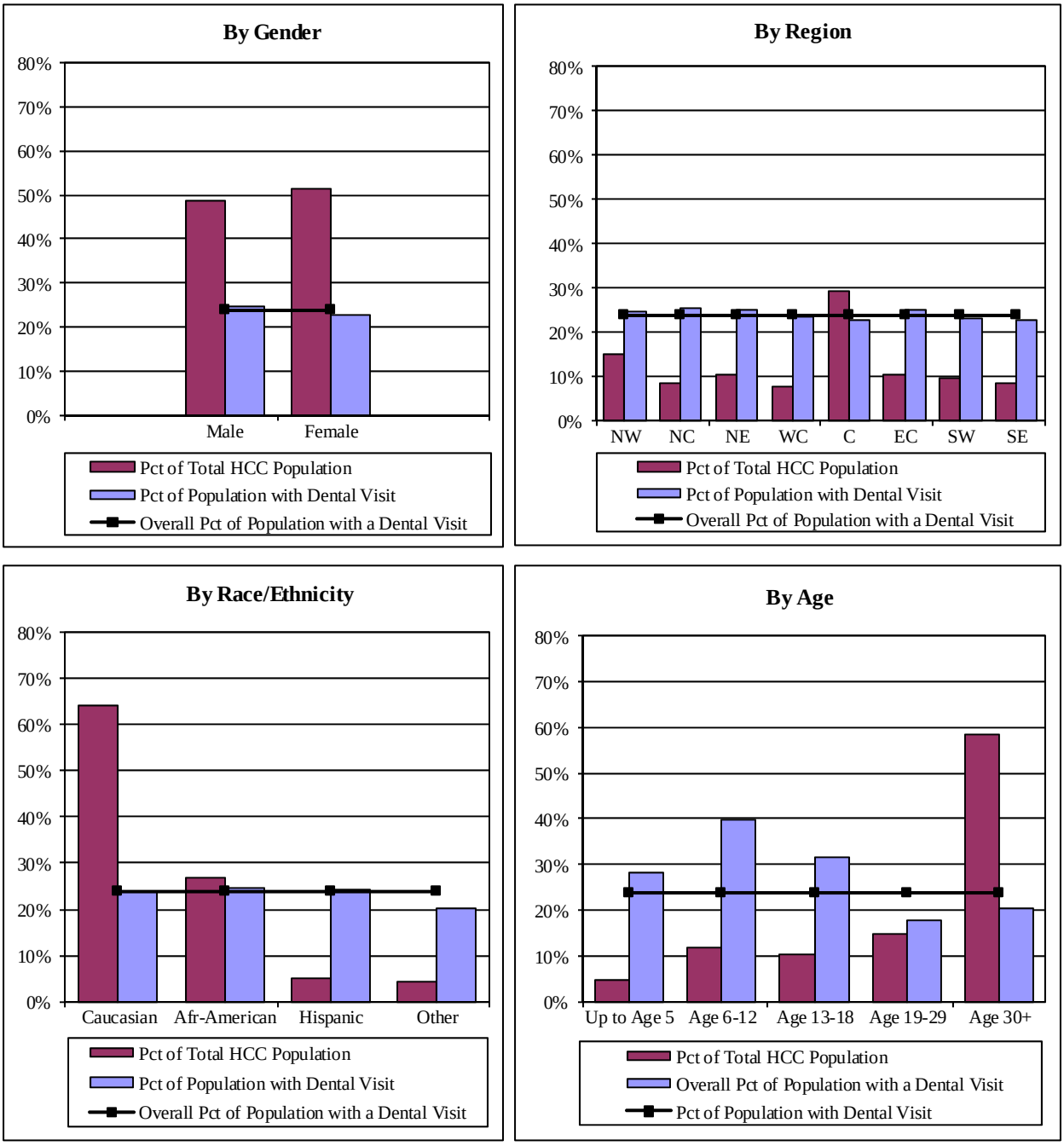
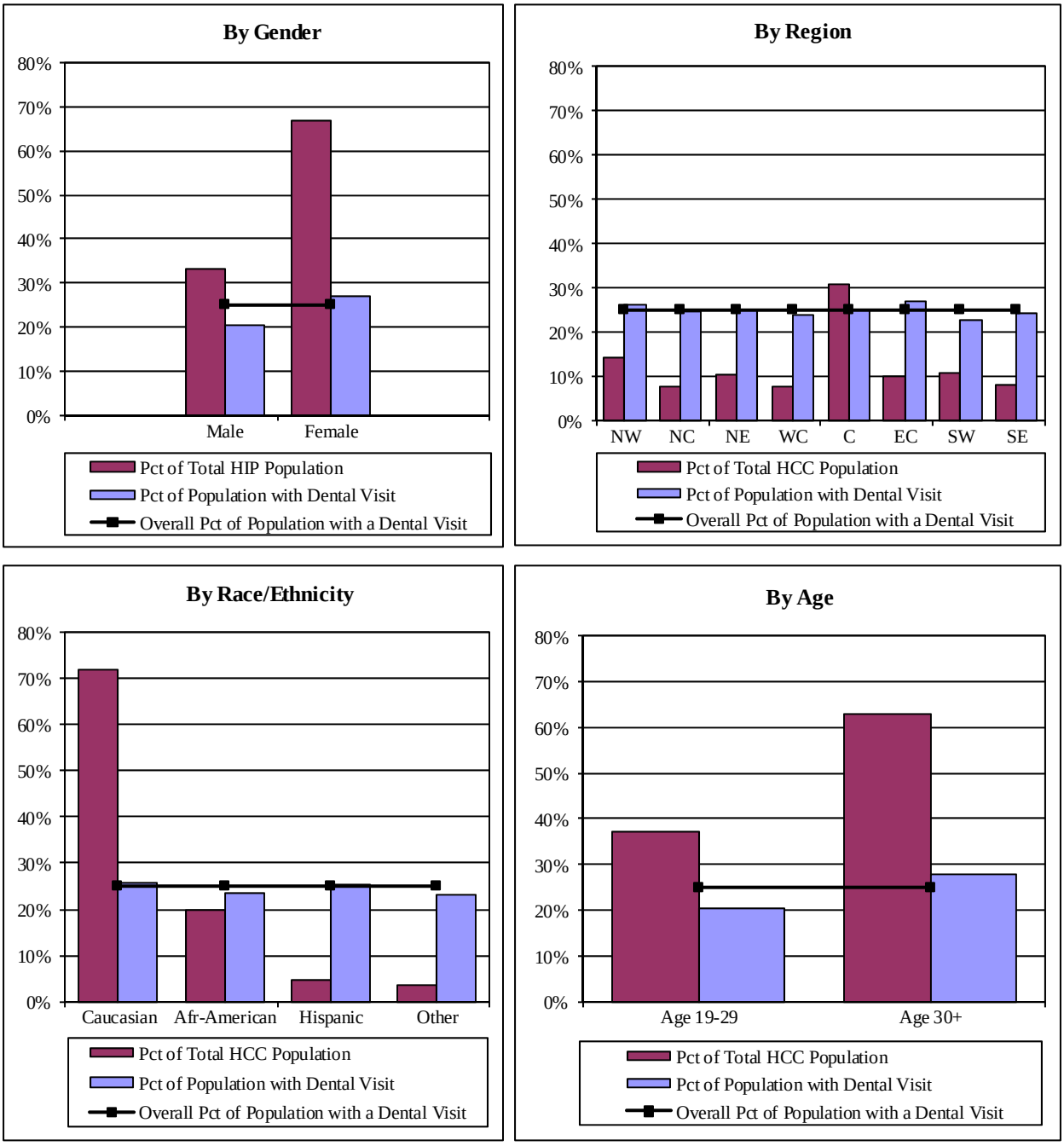


Exhibit VII.10
Percent of Total Population and Dental Care Users by Key Demographic Features
HIP 2.0 Population
Enrollment in HIP as of Dec. 31, 2015 = 354,879



Recommendations

The utilization per 1,000 member months was the same between the HCC and HIP populations. The utilization trends were also similar across the MCEs, with the exception of MHS in HCC which had a lower utilization rate than the other MCEs.

The MCEs also often had similar counties where members had lower utilization than the statewide average or higher average distance travelled than the statewide average. As such, the recommendations from this study are directed to all of the MCEs rather than to each MCE specifically.

1. The MCEs are encouraged to direct resources to increasing the dental provider network in the following counties in particular:

   - Counties with less than 30 providers serving members: Ohio, Union.
   - Counties with a utilization rate per 1,000 member months less than 50 (statewide) in either HCC or HIP: Dearborn, Knox, Martin, Ohio, Posey and Vanderburgh.
   - Counties with average distance travelled greater than 30 miles in two or more MCEs: Benton, Cass, Dearborn, Howard, Newton, Ripley, Starke and Vermillion.

   Of greatest importance are the counties that met more than one of these criteria: Dearborn and Ohio.

2. The MCEs should develop geoaccess reports for dentists similar to other specialties and the OMPP should make the submission of dental geoaccess reports part of the MCE's geoaccess portfolio submission beginning in CY 2017.

3. The MCEs are encouraged to tie complaints or grievances related to the access to dentists to dental geoaccess maps to determine if there is a trend among the grievances given to them.

4. The MCEs, in conjunction with the OMPP, may want to consider a targeted outreach about the dental benefit to members given the overall low use of this service in both HCC and HIP (24 percent and 25 percent, respectively). The group that could benefit from outreach the most is members age 19 to 29.

SECTION VIII: FOCUS STUDY ON THE INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

Introduction

Indiana is not immune to the prevalence of epidemic of drug abuse and, in particular, opioid addition that has been in the headlines throughout the past year. Of the 43,982 drug overdose deaths in 2013, 37 percent were associated with prescription opioid analgesics (e.g., oxycodone, hydrocodone and methadone).[11] Further, Medicaid beneficiaries are disproportionately affected by the epidemic since they are prescribed painkillers at twice the rate of non-Medicaid patients and are at three to six time the risk of overdosing on prescription painkillers.[12][13]

Most state Medicaid agencies offer addiction treatment benefits to members, but the array of services across the continuum varies quite a bit. Of the 49 Medicaid programs (including DC) that offer addiction treatment benefits,

- 29 offer non-hospital based detoxification;
- 48 offer outpatient services (such as individual, group or family counseling; life skills training; medication training; and peer supports);
- 37 offer partial hospitalization (e.g., services 4-8 hours per day) or intensive outpatient services (e.g., services offered 9-20 hours per week);
- 22 offer residential support services;
- 33 offer methadone maintenance; and
- All states cover at least one medication-assisted treatment (MAT).[14]

Indiana's Medicaid program offers two of these offerings to its members: outpatient services (more routine as well as intensive) through its services in its Medicaid Rehabilitation Option, or MRO. Indiana does not offer methadone maintenance as MAT but does offer Suboxone and buprenorphine tabs on its preferred drug list as medications for opioid dependence.

The responsibility for addiction treatment management is split in Indiana. The managed care entities (MCEs) are responsible for intensive detoxification (i.e., inpatient coverage) but the Office of Medicaid Policy and Planning (OMPP) is responsible for services through the MRO. The MCEs are required, however, to serve as case managers and facilitators of services provided to its members through MRO even though the MCE is not responsible for the payment of MRO services. In this regard, the MCEs are linked with both inpatient psychiatric hospital units and community-based providers delivering MRO services. This is true for all three Indiana Medicaid managed care programs—Hoosier Healthwise (HHW), Hoosier Care Connect (HCC) and Healthy Indiana Plan (HIP) 2.0.

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[11] Hedegaard H, Chen LH, Warner M. Drug-poisoning deaths involving heroin: United States, 2000–2013. NCHS data brief, no. 190. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics. 2015. Available at http://www.cdc.gov/nchs/data/databriefs/db190.htm

[12] Sharp MJ, Melnik TA. Poisoning deaths involving opioid analgesics-New York State, 2003-2012. *Morb Mortal Wkly Rep* 2015; 64:377-380.

[13] Coolen P, Lima A, Savel J, et al. Overdose deaths involving prescription opioids among Medicaid enrollees—Washington, 2004-2007. *Morb Mortal Wkly Rep.* 2009; 58:1171-1175.

[14] "What Addiction Treatment Services Are Covered By State Medicaid Programs?", an Open Minds Market Intelligence Report, May 2016. www.openminds.com

There are five objectives to this focus study:

1. To collect baseline data on the prevalence of the initiation and engagement of alcohol and other drug dependence treatment;
2. To identify the base of providers delivering services to these beneficiaries;
3. To gain an understanding of how services are being delivered today through face-to-face interviews with providers;
4. To learn about the MCEs' efforts to facilitate and manage members receiving these services; and
5. To provide recommendations to the OMPP and the MCEs about opportunities to leverage resources and improve outcomes for members.

Background

Burns & Associates (B&A) used the Healthcare Effectiveness Data and Information Set (HEDIS) 2016 specification for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) as the basis for the analytics in this study. The HEDIS measure identifies the percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following:

- *Initiation of AOD Treatment* **-** The percent of members who initiate treatment for AOD through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

- *Engagement of AOD Treatment* – The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

B&A added an additional measure to the study which we call Continuation of AOD Treatment.

- *Continuation of AOD Treatment* – The percent of members with initiation that become engaged

The HEDIS IET measure is relatively new and, therefore, is not as widely reported as other HEDIS measures. The latest national results on the measure showed a national average rate of 38.3 percent for initiation and 11.3 percent for engagement. [15]

Methodology for Defining the Study Sample

The HEDIS IET measures specifies the intake period as January 1 – November 15 of the measurement year to find new episodes of AOD. For this study, B&A used encounter information from Calendar Year (CY) 2015 and limited the dataset to this intake period. Data was collected for members in HHW, HCC and HIP.

The first step is to identify an *index episode*. The index episode is the earliest inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or emergency department (ED) visit during the study period with a diagnosis of AOD. The HEDIS specification uses multiple value sets to define an index episode. This includes the presence of diagnosis codes, inpatient procedure codes, CPT/HCPCS codes and revenue codes (to identify ED visits).

[15] The State of Health Care Quality 2015: HEDIS Measures of Care. Results represent 2014 data.

Once an index episode is found, the *Index Episode Start Date* (IESD) is identified. This is the earliest instance where the member has a claim with a diagnosis of AOD. It is important to identify the IESD because the study sample only includes members with new index episodes. To determine if an index episode is new, a test is run for "negative claims history". This means that for every index episode that is identified, B&A looked back 60 days to determine if the member had any other encounters with a diagnosis of AOD. When these diagnoses were found in the member's history, the index episode was excluded from the study.

In addition to the negative claims history test, in order for a member to be included in the sample, he/she had to be continuously enrolled with the MCE from 60 days prior to the IESD (to test for negative claims history) through 44 days after the IESD (which is the time span across both the initiation and engagement portions of the measure). Therefore, the member had to have continuous enrollment for a minimum of 105 days.

There is a limitation in the study related to continuous enrollment due to the fact that B&A received information on members enrolled with each MCE in monthly segments. Because we could not count back exactly 60 days from the IESD (the exact date of this is on the claim) or 45 days forward from the IESD, B&A rounded the continuous enrollment to the nearest month. To be conservative, this means that most members in the study had more than the 105 minimum days of enrollment. There may be some members that could actually have been eligible in the study but were dropped due to rounding to the nearest month.

B&A followed the HEDIS specification which requires that initiation and engagement rates be computed separately for two age groups within the population: one for members age 13 to 17, the second for members age 18 and over.

Once the index episodes are determined (the denominator), B&A then used the HEDIS value sets to identify encounters that met the test for initiation (one numerator) or engagement (the other numerator). The test for both initiation and engagement is either an inpatient stay or a set of CPT/HCPCS codes on claims that also have an AOD diagnosis. In order to meet the test for engagement, the member must first have met the test for initiation and then two or more encounters were found within 30 days of the initiation visit.

The computation of the rates in the IET measure were computed for HHW, HCC and HIP separately as well as a value for the Indiana Medicaid program overall (the combination of all three programs). Rates were also computed for each MCE separately. In some cases, a member may have switched during the measurement period across programs (e.g., from HHW to HIP). When this occurred, as long as the member met the enrollment minimum requirement, the member was retained in the study and all of the member's data was counted in the program where they were enrolled last. For the two age groups studied, the member's age was determined as of December 31, 2015 for placement in an age group.

It should be noted that since the HCC and HIP programs began in CY 2015 during the year (February 1 for HIP and April 1 for HCC), the number of members identified for treatment (in other words, the number of index episodes) is most likely understated because the full measurement period of January 1 – November 15 was not used for these programs.

Findings

Exhibit VIII.1 shows the statewide rates for initiation, engagement and continuing as well as the rates among subgroups of the population based on demographic attributes. Among the total study sample of

19,391 individuals, the statewide initiation rate for Indiana's Medicaid programs is 40 percent (the national Medicaid average was 38 percent). The engagement rate for Indiana Medicaid is 11 percent (equal to the national Medicaid average). The continuation rate computed by B&A (the percent of members that initiated who actually later engaged) is 27 percent (no national benchmark value available).

Some cells are highlighted in green or red to indicate differences from the statewide averages. A green cell indicates the cohort population had a rate that was five percent or greater than the statewide average. A red cell indicates the cohort population had a rate that was five percent or lower than the statewide average. When reviewing these trends,

- Adolescents are more likely than adults to initiate, engage, and continue treatment.
- African American members and members age 60 and over are less likely to continue treatment.
- Members in the East Central region had higher initiation and continuing rates than the statewide average.

Exhibit VIII.1
Rates of Initiation and Engagement for Alcohol and Drug Treatment in CY 2015
Hoosier Healthwise, Hoosier Care Connect and Healthy Indiana Plan Members Combined

green = 5% or more above the statewide average; **red** = 5% or more below the statewide average

Total in Study Sample Identified for Treatment = 19,391	Percent that Initiated Treatment	Percent that Engaged in Treatment	Percent that Continued Treatment
	40%	**11%**	**27%**
Age			
13 - 17 (Adolescent)	**46%**	**16%**	**35%**
18 + (Adult)	40%	11%	26%
Gender			
Male	38%	11%	29%
Female	42%	11%	26%
Race/Ethnicity			
Caucasian	41%	11%	28%
African American	39%	9%	**22%**
Hispanic	39%	11%	29%
Other	44%	13%	29%
Age Range			
13 - 17	**46%**	**16%**	**35%**
18 - 20	40%	11%	28%
21 - 29	**45%**	12%	26%
30 - 39	40%	12%	31%
40 - 49	38%	10%	26%
50 - 59	35%	7%	21%
60 and Older	38%	**5%**	**13%**
Region			
Central	40%	10%	26%
East Central	**45%**	15%	**33%**
North Central	43%	13%	30%
Northeast	39%	11%	29%
Northwest	39%	10%	24%
Southeast	41%	8%	20%
Southwest	39%	12%	30%
West Central	37%	11%	30%

Exhibits VIII.2 and VIII.3 examine the results at the program level and the MCE level, respectively. The exhibits are shown on pages VIII-6 and VIII-7. Once again, the green and red shading is used to identify subgroups within the population that are different than the overall population. In these exhibits, however, the differences shown are comparing the subgroup within the program or MCE against the same subgroup in the statewide totals (shown on Exhibit VIII.1). For example, in Exhibit VIII.2, HHW females are highlighted in green for their percent of initiated treatment result of 52 percent. When reviewing the statewide (all programs) result in Exhibit VIII.1 for females, the rate was 42 percent. Since the HHW females had a rate 10 percentage points above the statewide females average, it is highlighted in green. Similarly, in Exhibit VIII.3, adolescents enrolled with Anthem had a continuing treatment rate of 26 percent. The statewide average for adolescents reported in Exhibit VIII.1 was 35 percent. Since

Anthem's adolescent rate was more than five percentage points below the statewide average rate, it is highlighted in red.

When examining the results by program (Exhibit VIII.2), it was found that:

- Approximately 13 percent of the study population was enrolled in HHW, eight percent was enrolled in HCC and 79 percent was enrolled in HIP. As a result, the findings shown for HIP generally follow the statewide averages.

- Notable differences among the subpopulations include:
  - HHW members had a higher rate of initiation than the statewide average (47% vs. 40%)
  - HHW males had a higher rate of continuing treatment than males statewide, but HHW females had a lower rate of continuing treatment than females statewide.
  - The continuing rate was higher in HHW than the statewide average for all race/ethnicities except Caucasians.
  - The continuing rate for adults in HHW was lower than the statewide average, but the adult HHW sample is very small (n= 524 out of 2,478 HHW total members).
  - There are notable variances in the initiation rate and continuing rate in HHW across regions.
  - Most members in the HCC population have a lower continuing rate than the statewide average (7 out of 8 regions have a continuing rate more than 5% below the statewide average for the region). However, this may be due more to sample size since the entire HCC sample in the study is 1,517 members and no HCC region other than the Central region has a sample greater than 220 members.
  - Since the HIP population comprises most of the statewide population, the HIP trends resemble the statewide trends. The one exception is that Hispanic HIP members have a lower continuation rate than their peers statewide.

The results compared by MCE (Exhibit VIII.3) are more similar. Some notable differences that were found include:

- Anthem had lower continuation rates for adolescents, members age 18 to 20, and Hispanic and "other" race/ethnicity members.
- MHS had lower initiation rates for Hispanic and "other" race/ethnicity members and members in the Northwest region.
- MDwise had a higher rate of continuation for Hispanic members and members in the Southeast region than the comparable cohort of members statewide.

green = 5% or more above statewide average

red = 5% or more below statewide average

Exhibit VIII.2
Rates of Initiation and Engagement for Alcohol and Drug Treatment in CY 2015
By Program

	Hoosier Healthwise			Hoosier Care Connect			Healthy Indiana Plan		
	Total Identified for Treatment = 2,478			Total Identified for Treatment = 1,517			Total Identified for Treatment = 15,089		
	Percent that Initiated Treatment	Percent that Engaged in Treatment	Percent that Continued Treatment	Percent that Initiated Treatment	Percent that Engaged in Treatment	Percent that Continued Treatment	Percent that Initiated Treatment	Percent that Engaged in Treatment	Percent that Continued Treatment
Total	**47%**	**13%**	**28%**	**40%**	**8%**	**20%**	**39%**	**11%**	**28%**
Age									
13 - 17	45%	15%	34%	44%	18%	**40%**	-	-	-
18 and Over	**49%**	10%	**21%**	40%	8%	**19%**	39%	11%	28%
Gender									
Male	41%	**16%**	**39%**	41%	9%	**21%**	37%	10%	27%
Female	**52%**	10%	**20%**	40%	7%	**18%**	40%	11%	28%
Race/Ethnicity									
Caucasian	**48%**	13%	26%	40%	8%	**20%**	39%	11%	29%
African American	**46%**	13%	**28%**	40%	7%	18%	37%	8%	21%
Hispanic	42%	**17%**	**39%**	35%	10%	29%	37%	8%	**22%**
Other	40%	14%	**35%**	**54%**	15%	29%	42%	12%	28%
Age Range									
13 - 17	45%	15%	34%	44%	18%	**40%**	-	-	-
18 - 20	41%	12%	30%	**30%**	8%	25%	40%	10%	25%
21 - 29	**60%**	9%	**14%**	46%	12%	26%	43%	12%	28%
30 - 39	**60%**	8%	**14%**	40%	11%	28%	39%	12%	31%
40 - 49	50%	6%	**11%**	**43%**	10%	23%	38%	10%	26%
50 - 59	33%	-	-	38%	5%	**13%**	34%	8%	23%
60 and Older	-	-	-	41%	4%	9%	35%	5%	15%
Region									
Central	**46%**	11%	23%	37%	6%	**17%**	39%	10%	27%
East Central	**50%**	**21%**	**42%**	44%	**9%**	**20%**	44%	14%	32%
North Central	46%	15%	33%	42%	9%	**22%**	43%	13%	30%
Northeast	42%	14%	34%	**45%**	10%	**22%**	37%	11%	28%
Northwest	**54%**	**17%**	**32%**	39%	9%	24%	36%	8%	22%
Southeast	**58%**	7%	**12%**	39%	5%	**12%**	38%	8%	22%
Southwest	39%	8%	**20%**	**45%**	10%	**22%**	38%	12%	32%
West Central	36%	14%	**39%**	36%	7%	**21%**	38%	11%	30%

green = 5% or more above statewide average

red = 5% or more below statewide average

Exhibit VIII.3
Rates of Initiation and Engagement for Alcohol and Drug Treatment in CY 2015
By MCE

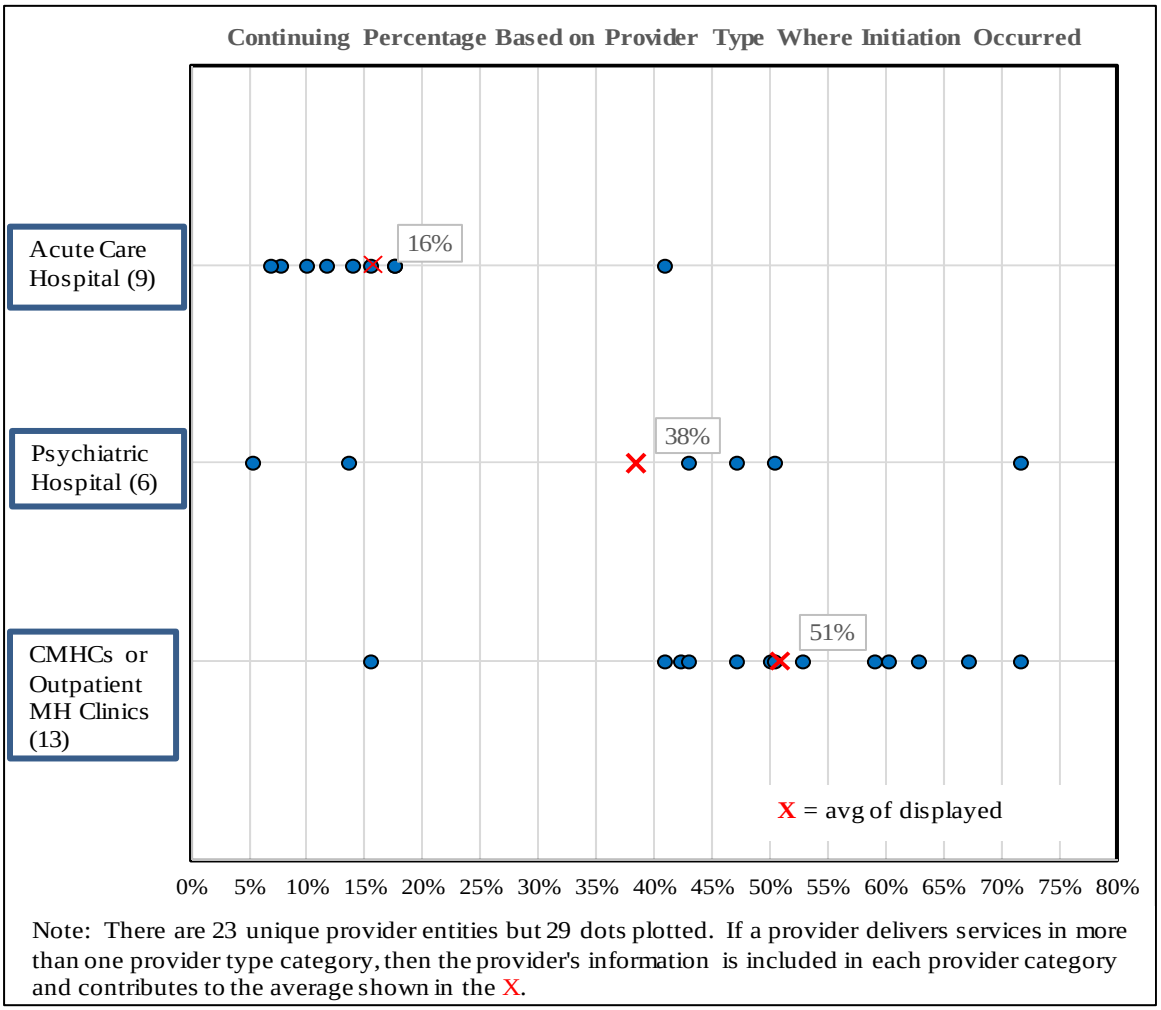
	Anthem			MHS			MDwise		
	Total Identified for Treatment = 7,741			Total Identified for Treatment = 4,695			Total Identified for Treatment = 6,648		
	Percent that Initiated Treatment	**Percent that Engaged in Treatment**	**Percent that Continued Treatment**	**Percent that Initiated Treatment**	**Percent that Engaged in Treatment**	**Percent that Continued Treatment**	**Percent that Initiated Treatment**	**Percent that Engaged in Treatment**	**Percent that Continued Treatment**
	42%	**11%**	**26%**	**38%**	**10%**	**28%**	**39%**	**11%**	**28%**
Age									
13 - 17	46%	12%	**26%**	47%	17%	37%	46%	16%	34%
18 and Over	42%	11%	27%	37%	10%	26%	40%	10%	26%
Gender									
Male	39%	11%	27%	37%	11%	29%	37%	11%	29%
Female	44%	11%	26%	39%	10%	27%	41%	11%	27%
Race/Ethnicity									
Caucasian	42%	12%	27%	38%	11%	28%	40%	11%	29%
African American	39%	9%	23%	38%	8%	22%	39%	8%	20%
Hispanic	43%	10%	**22%**	**35%**	9%	27%	38%	13%	**35%**
Other	**51%**	12%	**23%**	**35%**	15%	**43%**	40%	11%	29%
Age Range									
13 - 17	46%	12%	**26%**	47%	17%	37%	42%	16%	38%
18 - 20	44%	9%	**21%**	38%	12%	30%	38%	12%	31%
21 - 29	47%	13%	27%	40%	11%	27%	44%	11%	25%
30 - 39	42%	12%	30%	38%	12%	32%	38%	12%	31%
40 - 49	40%	10%	25%	35%	9%	27%	38%	10%	27%
50 - 59	36%	9%	24%	31%	5%	**16%**	36%	8%	21%
60 and Older	37%	7%	**18%**	38%	4%	11%	37%	2%	**7%**
Region									
Central	42%	11%	27%	37%	10%	28%	39%	9%	23%
East Central	47%	13%	28%	42%	14%	33%	44%	16%	36%
North Central	**49%**	14%	29%	40%	13%	32%	41%	11%	27%
Northeast	37%	10%	27%	41%	12%	29%	40%	12%	29%
Northwest	41%	10%	25%	**32%**	7%	22%	41%	10%	24%
Southeast	43%	7%	16%	42%	6%	15%	38%	10%	**28%**
Southwest	40%	13%	31%	36%	11%	29%	36%	10%	27%
West Central	41%	11%	26%	34%	12%	34%	36%	11%	31%

B&A also reviewed the providers that served the most members in the sample. Specifically, the focus was on providers who had more than 100 members in the sample where the initiation of treatment began. In total, 23 provider entities were found. These providers were then organized into three subgroups—acute care hospitals, psychiatric hospitals, and community mental health centers (CMHCs) or other outpatient mental health clinics. Some provider entities are affiliated (e.g., a hospital and CMHC), so the 23 entities translate to 29 provider service areas.

Exhibit VIII.4 compares the continuing percentage rates only across the provider service areas. A member did not have to receive both initiation and engagement at the same provider. However, the continuing percentage rate (engaged as a percent of initiated) placed each member in the denominator of the provider where the member initiated treatment.

The exhibit shows that the continuing rate is lowest among members who initiated with acute care hospitals and much higher for members who initiated with CMHCs or other mental health clinics. There is also a wide variation of continuing rates among individual providers within a provider type (as seen by the location of the blue circles along the row which represent each provider).

Exhibit VIII.4
Array of Continuing Percentage Rates for Providers with More than 100 Initiating Members in CY 2015
N = 23 Unique Provider Entities



Note: There are 23 unique provider entities but 29 dots plotted. If a provider delivers services in more than one provider type category, then the provider's information is included in each provider category and contributes to the average shown in the X.

Approach to Obtaining Qualitative Feedback

A key part of the focus study was to gain a better understanding of how the MCEs approach AOD treatment and the factors that lead to effective treatment by visiting providers that serve the most members with AOD. Through our discussion with providers, we anticipated that we would gain a greater understanding of the issues or actions that could be taken by the MCEs and the OMPP to have the greatest positive impact on members.

The first step was to have introductory meetings with each MCE. These meetings occurred July 27 and 28, 2015. B&A provided the first round of analytics presented here in the Findings section as well as more detailed information about specific providers that deliver IET services. From the MCE meetings, B&A learned more about provider affiliations and characteristics of providers, e.g., if their target was to serve primarily adolescents, the homeless population, etc. By sharing provider-specific results on the rate of initiation, engagement and continuing treatment, B&A received feedback from the MCEs about reasons why the rates may differ across providers.

As a follow-up to these meetings, each MCE provided B&A with contact information for its (MCE's) top 10 providers based on the number of members initiated.

After the introductory meetings concluded, B&A made outreach calls to the high-volume providers for each MCE in an effort to arrange for a face-to-face meeting at the provider's office. As part of the phone outreach, B&A explained the focus study and the purpose of the meeting, namely, that it was important to obtain the perspective from the providers on-the-ground that provide treatment to HHW, HCC and HIP members. The OMPP provided a letter to B&A endorsing the study so that providers knew that this was more of an information gathering study as opposed to an audit of their services.

From this outreach, B&A arranged face-to-face meetings with 16 high-volume providers. These meetings took place from August 15-25, 2015. A phone interview was set up with the 17th provider the week of September 5.

A site visit packet was emailed to each provider in advance of the face-to-face meeting. The packet consisted of a description of the study, the purpose for the visit, the specific questions that were intended to guide the semi-structured interview, and reports that provided background information and statewide results of initiation and engagement of AOD. In addition, each provider received their own report summarizing demographic information at the provider level of its initiation and engagement of AOD. The questions sent in advance of the meeting included:

1. Do you work most often with one Medicaid managed care entity (Anthem, MHS, MDwise)? If yes, which one?

2. How would characterize your relationship with the MCE?

3. What entities are a part of your organization – are you speaking for all of the entities?

4. How would you describe your model of care?

5. What is the most common way that clients are referred to you?

6. In your experience, does the level of engagement vary by subpopulation? If yes, in what way?

7. What methods have you found most successful related to Initiation? Engagement?

8. Are there any recommendations you would like us to pass on to OMPP with regards to working with the MCEs or with Indiana Medicaid more generally? What is the highest priority of these items?

For each in-person meeting, two members of the External Quality Review (EQR) team participated. The EQR onsite team consisted of four members and the pairs of members were juggled in an effort to gain a variety of perspectives on the providers' feedback. Meetings were scheduled for 60 minutes at each provider site. This time was used for all meetings and, in fact, many meetings exceeded the allotted time. It was evident to the EQR team the level of passion and commitment that the providers have in serving their client base.

Once all of the onsite provider meetings concluded, the EQR team synthesized their notes from each meeting and summarized the provider's feedback into topic areas. The feedback was categorized into items related to MCE processes, items related to concerns that impact access to patient care, innovative models in place in the field, recommendations to the MCEs, and recommendations to the OMPP.

The synthesized feedback was presented to each MCE individually on August 31 and September 1. The EQR field team members and a member of the OMPP Quality team attended each meeting. The purpose of these meetings was to clarify items learned in the provider meetings and to provide the MCEs with the opportunity to respond to concerns expressed by the providers.

Summary of the Qualitative Feedback

The MCE follow-up meetings were helpful because it became clear that one of the key opportunities for the MCEs and the OMPP was additional provider education related to services that are covered, which entity is responsible for services (e.g., the MCE or the OMPP when it relates to MRO services) and what policies are MCE policies versus state policy (or law) or federal policy (or law). The following are examples of findings that illustrate confusion and misinterpretation among providers in the field:

- MRO vs MCE-covered services
- Who can provide/bill for services (licensure/credentialing requirements)
- Coverage of drug testing
- Coverage of 72-hour supply of Suboxone (no PA required)

The feedback from the providers is summarized by themes in the section below. The number in parentheses represents the number of providers (out of 17 total) who mentioned this item.

<u>Feedback Related to MCE Processes</u>

1. *Prior Authorization (12).* The most common issue mentioned by providers during the face to face meetings was difficulty with the prior authorization process. Specific examples include: different processes used by each MCE; not aware of or don't understand the clinical criteria used by the MCE to make a determination of coverage; difficulties with submitting information to the MCE; and difficulties with completing the prior authorization process. In particular, providers were most concerned with the prior authorization of Suboxone. Only one provider was aware

that MCEs participate in the "Gold Card Program" which exempts providers with addictionology credentials from prior authorization requirements for Suboxone. Several providers expressed frustration with having to undergo a concurrent review when they are paid on a DRG basis.

2. *Credentialing and Who Can Bill for Services (8).* Providers expressed concerns with a shortage of qualified professionals to treat AOD, which professional licensure types can currently bill for AOD treatment without supervision, and the length of time that it takes to get qualified professionals credentialed by the MCEs. The most common concern expressed by providers were specific provider types that are not able to bill directly for AOD (e.g., licensed clinical addiction counselor) and that this changes depending upon which program the beneficiary is enrolled in and if the beneficiary has an approved MRO service package.

3. *Member Eligibility for Services (3).* Knowing if and under what program a member is eligible was mentioned as problematic from a coverage and billing standpoint. Several providers stated that they print out eligibility information on the date of service to corroborate billing to the MCEs as member eligibility data changes and poses difficulties when billing for services. In particular, providers mentioned that presumptive eligibility and the difficulties with having members complete the application process are key issues for them as members return to get services and don't realize that they are no longer eligible as they failed to complete the Medicaid application. To address this issue, some providers stated that they either have contracted with companies or have staff members dedicated to obtaining the necessary documentation to complete the eligibility process.

4. *MCE Case Management Activities (2).* In general, providers expressed frustration that MCE case management was telephonic in nature and that "boots on the ground" is what is needed. Providers were not aware that in some instances the MCEs have case managers in the field or out-stationed at community mental health centers.

5. *Inconsistencies in Forms (5).* Providers communicated that each MCE has their own set of forms for prior authorization, treatment plans and other assessments and that this leads to an increase in time that they spend on non-patient care activities. Several providers indicated that they design their business processes to meet the requirements of the predominant MCE in their book of business in an effort to at least meet the requirements of one MCE. This still means that they will have to spend more time working with the remaining MCEs to fix what they didn't get right.

6. *Timely Payment and Rate of Payment (5).* A number of examples were provided by providers around the issue of timely payment and the rate of payment for AOD treatment services. Notable examples include: the level of receivables; receiving differing methods to bill for the same service as a result of the member being eligible under different programs; the length of time that it has taken to get an adjustment resulting from a rate change; and that rates are inadequate for the level of service intensity. In addition, providers of inpatient services pointed out that a recent change in payment methodology from per diem to DRG resulted in a significant decrease in reimbursement on a daily basis to their organizations. On a positive note, a number of providers expressed appreciation for having the Revenue and Billing Committee as a venue to resolve billing issues or concerns with the MCEs.

<u>Feedback Related to Items that Impact Access to Patient Care</u>

1. *Long Wait Times for Appointments (5).* While only five providers specifically identified that wait times for appointments with outpatient AOD treatment professionals could run as long as four to

six weeks, providers overwhelming expressed concerns with staff shortages and the inability to "strike while the iron is hot" with a member who is willing to enter treatment but there is no immediate availability of a treating provider.

2. *Denials for Needed Services (4)*. The primary service that providers expressed concern over was denial of Suboxone and that their perception is that the MCEs have varying policies around emergency prescriptions.

3. *Services Not Covered (5)*. Services specifically mentioned by the providers as not being covered by the MCEs that could positively impact recovery include: drug screening tests; psych testing; day care; parenting skills; telehealth; coverage of provider based transportation; life skills; coping skills; medications such as methadone replacement; peer to peer support; residential treatment; and wrap-around services such as those provided through Recovery Works. While drug screening tests in particular were mentioned as a motivator for members to continue with treatment, most providers did not realize it was a covered benefit, with only quantitative drug screening tests being identified by the MCEs as requiring prior authorization.

4. *Information on the Benefit Package (2)*. While this item was specifically mentioned by only two providers, the majority of providers expressed that it was unclear: what services are part of the benefit package for HCC, HHW and HIP; who could provide and bill for services; whether the service was part of the MRO set of services; and what was carved into or out of the MCE.

5. *Provider Staff Shortages (12)*. Providers overwhelmingly expressed that this is the biggest issue that impacts access to care for beneficiaries and that it is not just a question of not having enough providers, but that there are limitations on who can bill for services.

6. *Timely Eligibility Information for Member Coverage (8)*. Providers shared that their patients who have presumptive eligibility are experiencing delays in getting prescriptions filled because the member's eligibility information is not in the point of sale system. Providers also expressed that they would like to see the patient's history follow them so that they are not starting over each time a member changes which MCE they are enrolled in.

<u>Innovative Models in the Field</u>

1. *Pilot Programs (5)*. The MCEs and several providers are involved in pilot programs related to AOD treatment. Both Anthem and MDwise were complimented for their willingness to participate in and initiate pilot programs. Examples provided during the provider and MCE interviews include: neonatal abstinence; ambulatory detoxification; health coaching and use of apps to improve success rates of recovery; transition home project with 7 and 30 days in home visits after discharge from an inpatient setting; navigation program in emergency department in four counties; and co-location with primary care providers to provide adult preventive services along with AOD services.

2. *Pay for Performance (4)*. Several providers expressed interest in either going at risk or being paid under a pay for performance model for the patient population they care for. One provider in particular is developing metrics to measure the value of the services tied to outcomes.

Recommendations to the MCEs and to the OMPP

Based on the results of the findings in the quantitative analysis as well as the feedback described in the qualitative portion of the study, B&A offers the following recommendations to the MCEs and to the OMPP.

Recommendations to the MCEs

1. Misunderstanding among providers related to drug testing was pervasive. The MCEs are encouraged to develop educational materials about this coverage to give to providers, specifically:
    a. When qualitative vs. quantitative tests are covered
    b. Under what conditions prior authorization is required
    c. When a physician's standing orders are considered permissible for interpretation of tests

2. There is also misunderstanding in the provider community related to dispensing an emergency (72-hour) supply of Suboxone. B&A recognizes that each MCE has clear policies in place related to authorizing and dispensing of Suboxone, but providers either do not know about these policies or have misinterpreted them. The MCEs should consider specific outreach to providers regarding:
    a. When and how to obtain an emergency supply of Suboxone
    b. What providers should do to request coverage beyond the emergency supply
    c. What the MCE's policy is on maintenance (e.g., when does the maintenance period kick in, how long does it last, what are the authorization requirements)
    d. Helpful Hints as to what are the most common reasons that a request for Suboxone is denied (e.g., lack of specific documentation)
    e. How providers can participate in the OMPP Gold Card program (this recommendation can potentially be completed in conjunction with the OMPP as an all-MCE effort)

3. Beyond prior authorization for Suboxone, frustration with prior authorization processes was commonly shared by providers with the EQR team. In follow-up with the MCEs, many of the ad hoc comments about denial rates mentioned by providers were not substantiated by the MCEs. One example was the rate of denials for inpatient stays for initial versus concurrent review. The MCEs may want to provide additional education to hospitals, particularly those that may have a lower approval rate for admissions than their peers, to help explain the root cause of these denials and to educate them about the "path to approval".

4. Initiation of treatment that starts in the hospital setting was shown to have the lowest rates of continuation of treatment when compared to community-based providers such as CMHCs. Separately, many hospital-based treatment providers voiced concerns regarding a change in the reimbursement for inpatient stays for AOD treatment. The MCEs may want to consider developing a pilot program that utilizes a value-based reimbursement methodology for this select set of patients. If considered, a methodology such as this should take into account current concerns from providers on the standard reimbursement rate, but should also build in incentives for treatment outcomes in exchange for any enhanced reimbursement.

5. A specific recommendation is being made to MHS with regard to participation in pilot programs. Many providers complimented Anthem and MDwise for their participation in multiple pilot programs, but providers cited that MHS's participation was lacking.

Recommendations to the OMPP

1. The credentialing of providers, and the misunderstanding of which providers can and cannot bill for services based on their credentialing status, came up in multiple provider meetings. There also appears to be a difference of opinion among providers about who can (and should) bill for specific services, particularly in the MRO suite of services. Many of the providers believed that this is an MCE issue when it appears to be an issue with credentialing under the Indiana Health Coverage Program (IHCP) at OMPP. B&A is aware of guidance materials that were distributed to providers at the introduction of the MRO program (IHCP Provider Bulletin BT201015 dated May 21, 2010 is one example). The OMPP may want to consider reviewing and refining these educational materials, as necessary, and reissue information on this matter to convey to providers what is the responsibility of the OMPP as opposed to the MCEs. Specifically, there should be emphasis to describe that Intensive Outpatient services (IOP) is covered by the MCEs, whereas Intensive Outpatient Therapy (IOT) is an MRO (OMPP) service.

2. Alternative services currently not covered by the MCEs or in the MRO program were cited by providers as an opportunity to test new modalities for treatment. The OMPP may want to consider developing pilot programs (or allowing the MCEs to do so) related to some of these services such as telehealth, enhanced transportation service, parenting classes, education in coping skills, and peer-to-peer support.

3. Concern about obtaining immediate pharmacy scripts (e.g., same day) when a member becomes presumptively eligible was cited by providers as a barrier for members to obtain access to needed care. To address this issue, the OMPP should consider including a phone number on the member's presumptive eligibility approval letter that a pharmacist can call to confirm a member's presumptive eligibility who is not yet in the online point of sale system.

4. Recognizing that the rate of initiation, engagement and continuation of treatment for AOD could be significantly improved, B&A recommends that the OMPP consider requiring that the MCEs build a Quality Improvement Project (QIP) around IET for Calendar Year 2017. The MCEs are already engaged in some pilot programs which could serve as potential interventions upon which success could be measured. The compilation of this information across MCEs could be unified by the OMPP in a learning collaborative. Because the emphasis on this population has reached a crisis level, if QIPs were to be developed by the MCEs, B&A would further recommend that quarterly progress reports be provided to or presented by each MCE at OMPP-sponsored Quality Strategy meetings to further accelerate the process of lessons learned.

5. Related to the QIP recommendation, the OMPP may want to consider creating a Pay for Outcomes (P4O) program related to the HEDIS IET measure. This could be similar to P4O programs that the OMPP has in place for other HEDIS measures. Targeted funds could be set aside based on performance such as the engagement rate or the continuing rate, and the MCEs could develop programs to share in the P4O savings achieved with providers.

6. Nationally, the trend for addiction services and behavioral health is towards integrated delivery systems which follows the trend for health care on the whole. For addiction services, this has been somewhat complicated as the benefits (detoxification, treatment services and medication) associated with treatment have often been administered through different delivery systems. States are employing a variety of integrated delivery models to coordinate physical and behavioral health, either through vertical (management of consumers) or horizontal management

(management of benefit services)[16]. At present, Indiana uses both fee-for-service and managed care delivery systems to provide addiction services to Medicaid eligible members based on diagnosis and level of need. The fee for service delivery model pays for services for those members with the most intensive needs through MRO, while their care coordination is provided by the MCEs. Building upon recommendations 4 and 5, B&A is recommending that OMPP consider carving MRO services into managed care so that both services and care coordination are the responsibility of the MCEs.

[16] "What State Medicaid Plans Carve-Out Addiction Treatment Services?", an Open Minds Market Intelligence Report, June 2016, www.openminds.com.

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

Introduction

The timeliness and frequency of prenatal and postpartum visits for pregnant women in the Hoosier Healthwise (HHW) program was one of the Office of Medicaid Policy and Planning's (OMPP's) quality strategy objectives for Calendar Year (CY) 2015. Timely prenatal care can help to mitigate pre-term births, complicated deliveries, low birth weight babies and infant death. With the introduction of the Hoosier Care Connect (HCC) and Healthy Indiana Plan (HIP) 2.0 programs in CY 2015, there will be an emphasis on this quality objective in these programs as well. In HHW, the goal was to achieve at or above the 90th percentile among Medicaid managed care plans nationally on two Healthcare Effectiveness Data and Information Set (HEDIS) measures:

- The frequency of prenatal care (HEDIS FPC), specifically, the percent of women who had 81 percent or more of their expected visits
- The timeliness of a postpartum care visit (HEDIS PPC), specifically, the percent of women who had a visit at some time between 21 and 56 days after delivery

The American College of Obstetricians and Gynecologists (ACOG) recommends that women with an uncomplicated pregnancy receive visits every four weeks for the first 28 weeks of pregnancy, every two to three weeks until 36 weeks of pregnancy, and weekly thereafter. For example, for a 40-week pregnancy, this would be 14 visits[17]. A managed care entity's (MCE's) ability to manage and track prenatal visits will obviously depend on the number of months that the woman is enrolled with an MCE. So, for example, although 14 visits are expected for a 40-week pregnancy, if the woman did not enroll with the MCE until the fifth month, then the expected visits while with the MCE would be nine (14 total minus 5 in the first five months).

The study in this EQR focuses on examining the ratio of prenatal visits per weeks that the mother was enrolled during her pregnancy. In addition to understanding the overall trend in HHW and HCC, the study examines the prenatal visit rate among cohorts within the population stratified by: the MCE she is enrolled with, the age of the mother, her race/ethnicity, the region where she lives, the type of delivery (vaginal or Cesarean) and the outcome of the baby's birth (normal newborn or complications). The subpopulations were examined for the HHW cohort only due to the low sample size in CY 2015 in HCC. In future years, it is anticipated that this study would also include the HIP population as more mothers become enrolled in this program.

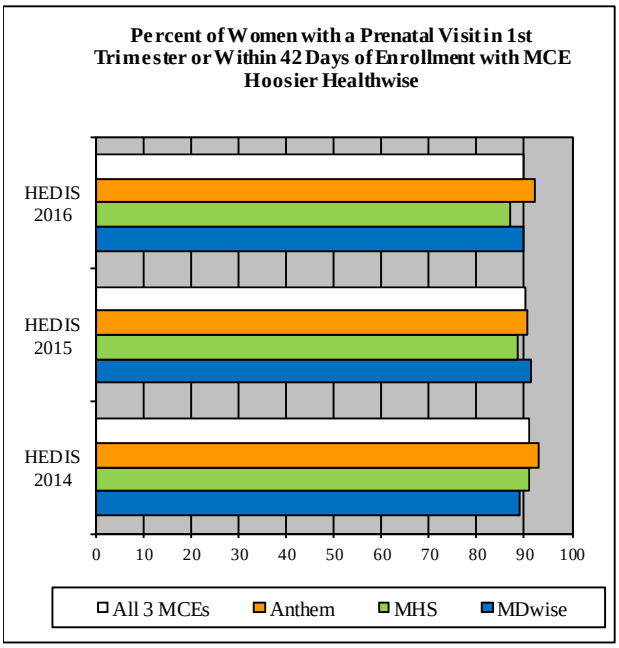
Background

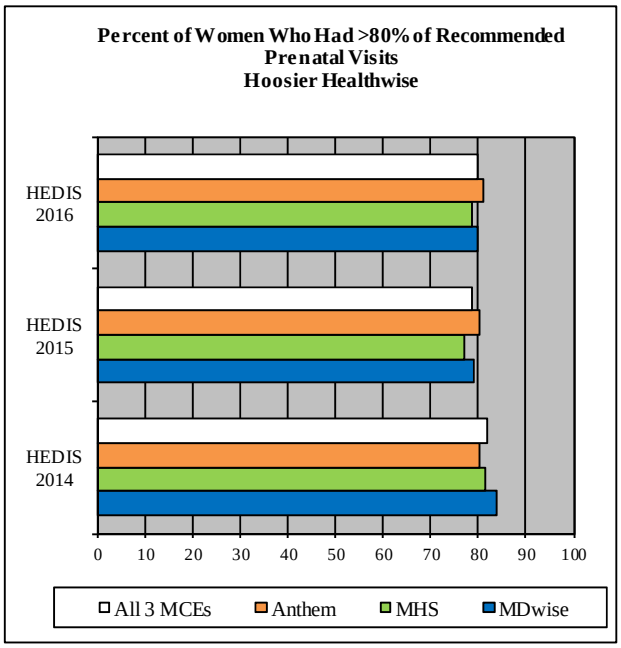
The OMPP requires the MCEs to hire an external certified HEDIS auditor to annually collect results on dozens of HEDIS measures and to assess whether or not each measure is reportable to the National Committee on Quality Assurance (NCQA). Among these measures are the prenatal care measures that are a part of this study. Exhibit IX.1 on the next page shows the results reported by the HEDIS auditors in each of the last three reporting years for the FPC and PPC measures in the HHW program. The reporting years are HEDIS 2016, HEDIS 2015 and HEDIS 2014. This means that the results are based on deliveries that occurred from November 6 of the year prior to the measurement year and November 5 of the measurement year. These measures are considered hybrid measures, meaning that compliance with the measure could be determined either by claims experience or by medical record abstraction.

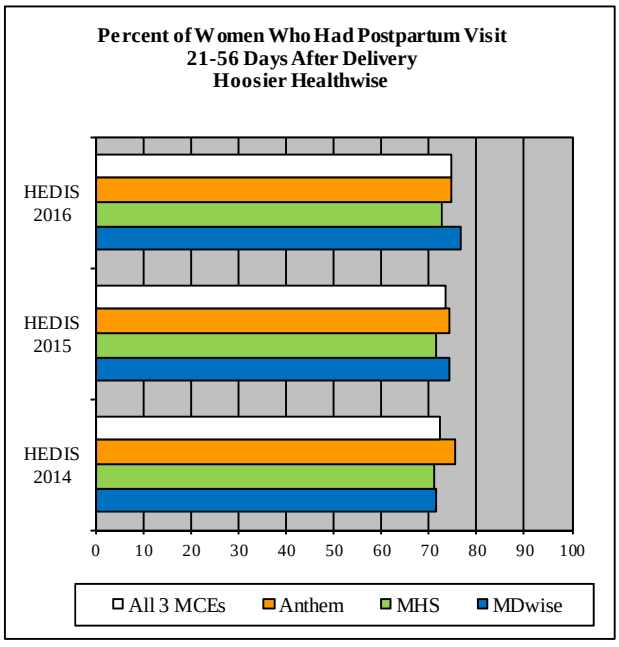
[17] National Committee for Quality Assurance (NQCA) specification for HEDIS 2016 measure Frequency of Ongoing Prenatal Care (FPC)

The exhibit shows that the rates reported by each MCE are very similar to each other on all three measures and have been consistent in each of the last three years. The timeliness of the first prenatal visit (upper left box) is near 90 percent of the eligible population. The percent of women with more than 80 percent of their recommended prenatal visits (based on their enrolled time) is near 80 percent of the eligible population. The percent of women with a timely postpartum visit is near 74 percent of the population.

Exhibit IX.1
Prental and Postpartum Visit Measure Results







Pct of Women with a Prenatal Visit in 1st Trimester or Within 42 Days of Enrollment with the MCE				
	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2014	90.9	93.1	91.1	89.1
HEDIS 2015	90.2	90.7	88.6	91.2
HEDIS 2016	89.8	92.1	87.2	90.0

Pct of Women Who Had >80% of Recommended Prenatal Visits				
	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2014	82.0	80.3	81.4	83.9
HEDIS 2015	78.8	80.4	77.0	78.9
HEDIS 2016	80.0	81.2	78.6	80.0

Pct of Women Who Had Postpartum Visit 21-56 Days After Delivery				
	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2014	72.3	75.4	71.0	71.5
HEDIS 2015	73.3	74.1	71.6	74.2
HEDIS 2016	74.6	74.7	72.6	76.6

Methodology for Defining the Study Sample

For this study, Burns & Associates (B&A) started by considering all eligible members in HHW or HCC for the PPC and FPC HEDIS measures by using the HEDIS parameters to define the population. The definition of who meets the definition in the denominator is the same in both HEDIS measures. Specifically, this includes women who:

- Delivered a child (or children) between November 6, 2014 and November 5, 2015;
- Were continuously enrolled in HHW or HCC with an MCE at least 43 days prior to delivery and 56 days after delivery; and
- Had a live birth

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

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

Although unlikely, members could have transitioned between HHW and HCC during their pregnancy, or vice versa. If this occurred, the mother was placed in only one program, namely, the program where she was at the time of delivery. What was more likely was that some HIP members transitioned into HHW. If this occurred, the woman was included in the study and identified as a HHW member provided that she was enrolled in HHW at the time of delivery and met the other eligibility criteria.

The final study includes 28,802 women distributed by program and MCE as follows:

	HHW	**HCC**
Anthem	N= 10,596	N= 82
MHS	N = 7,689	N = 45
MDwise	N = 10,299	N= 91
All 3 Combined	N = 25,584	N= 218

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

For the actual deliveries, the diagnosis related group (DRG) assignment was pulled. In 1.3 percent of the HHW cases, the DRG field was blank. When analytics are shown by DRG, the women with no DRG assignment are excluded. For each woman with a valid DRG, the EDW has a case number on the claim. The case number is a household ID as opposed to a member ID. Using the mother's case ID, B&A searched for DRGs related to their babies. For the mothers with a delivery DRG, their baby's DRG was found 99 percent of the time.

Using the anchor claim for the delivery date, B&A then assigned the month that the delivery occurred in as the "delivery month". From here, B&A counted back nine months in order to capture all enrollment records and all claims that occurred for the member during the delivery month and the previous nine months.

One limitation of the data is the specificity related to enrollment. B&A received a file that identified the member's enrollment in an MCE rounded to the month. If a woman had a record of being enrolled in an MCE for the month, we assumed four weeks of enrollment during the pregnancy.

In the delivery month, the date of the actual delivery was known. Therefore, the delivery month could be parsed into weeks counting up to the delivery. The following logic was used:

- If the delivery date occurred between the 1st and 7th day of the month, 1 week was assigned.
- If the delivery date occurred between the 8th and 15th day of the month, 2 weeks were assigned.
- If the delivery date occurred between the 16th and 23rd day of the month, 3 weeks were assigned.
- If the delivery data occurred on the 24th day of the month or later, 4 weeks were assigned.

The weeks assigned to the delivery month and all prior months that the woman was enrolled with the MCE were summed together. In this study, a woman could have a maximum of 40 weeks (9 months, or 36 weeks, prior to the delivery month and 4 weeks in the delivery month). A woman had to have had enrollment during the delivery month. However, this could be as little as one week (if the delivery occurred between the 1st and 7th day of the month), so the minimum weeks of enrollment in the study was one week.

B&A compiled all of the prenatal value set definitions in the HEDIS FPC measure to determine which services could be counted as a prenatal visit. In the HEDIS definition for FPC, the counting of prenatal visits to be numerator compliant is a combination of the type of visit and when it occurred during the pregnancy. B&A did not limit when the service occurred to count it as a prenatal visit. Instead, the visits were assigned to one of the months of pregnancy that the woman was enrolled in (going back as far as 9 months prior to the delivery month). All prenatal visits that occurred during the delivery month were also included.

Once all of the data was tabulated, an average visits per week metric was computed. The following is an example of this computation.

A woman delivered on September 14, 2015. She would have been assigned 2 weeks during her delivery month. The woman was also a member of the MCE for the five months prior to her delivery month. Therefore, another 20 weeks (5 months x 4 weeks) was added to her tenure, for a total of 22 weeks.

During the five months prior to her delivery month and during her delivery month, she had a combined 17 prenatal visits. Therefore, her ratio of prenatal visits per week is 0.77 (17 visits / 22 weeks).

The value was computed for every woman in the study. The results were then compared across a number of subgroups in the study based on demographic or other attributes.

Findings

One of the challenges for obtaining 100 percent compliance with the PPC and FPC measures is that the member is not enrolled in the MCE over the entire course of her pregnancy. B&A compared the average number of weeks enrolled during the pregnancy for all women in the study. The average was 24.4 weeks (refer to Exhibit IX.2 on the next page). This average was also compared across MCEs, across race/ethnicities and across the combination of the two. There was very little difference in the average number of weeks enrolled. Excluding the 977 members in the "Other" race/ethnicity category (3.4% of the total, the average enrollment range for all other members was between 22.9 weeks (MHS/Hispanics) and 25.7 weeks (MDwise/African-Americans).

Exhibit IX.2
Average Number of Weeks Enrolled During Pregnancy
Hoosier Healthwise and Hoosier Care Connect Programs

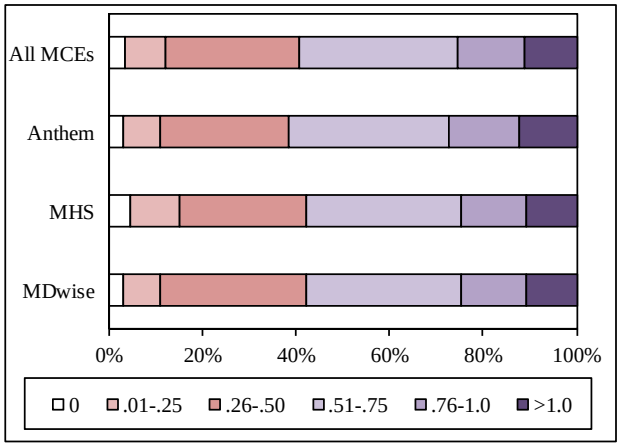
Race/Ethnicity	Number in Sample - All MCEs	Average Number of Weeks Enrolled			
		All MCEs	Anthem	MHS	MDwise
All Women	28,802	24.4	24.7	23.5	24.8
Caucasian	19,964	24.2	24.6	23.2	24.6
African-American	5,849	25.4	25.4	25.1	25.7
Hispanic	2,012	24.1	25.0	22.9	24.3
Other	977	23.0	23.9	21.5	22.6

B&A then compared the average prenatal visits per week between the HHW and HCC members. This was reviewed for all MCEs combined as well as for the members in each MCE within each program.

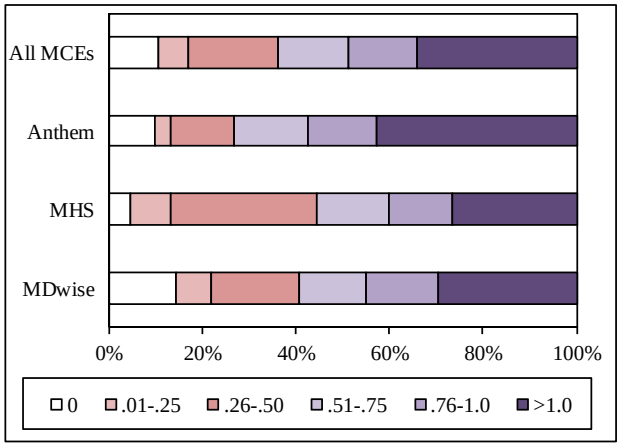
Exhibit IX.3 shows the percent of women who met specific visit targets. On the left side of the exhibit, the HHW population (n= 28,584 members) was analyzed. In reviewing the rows across, the left-most side shows women with zero visits. In HHW, this was three percent of the total population (the portion of the bar colored white). Focusing on the All MCE row at the top, going across, nine percent of the women had a visit-to-week ratio between 0.01 and 0.25 (light pink). Another 29 percent had a ratio of 0.26 to 0.50 (dark pink). There were 34 percent with a ratio of .51 to .75 (light purple), 14 percent with a ratio of .76 to 1.0 (middle purple) and 11 percent with a ratio of more than one visit per week on average (dark purple). These trends were consistent across the MCEs. On the right side of the exhibit, the HCC population had more visits per week overall. However, it should be noted that this is a small sample (n=218).

Exhibit IX.3
Average Prenatal Visits Per Weeks Enrolled by Program

Hoosier Healthwise



Hoosier Care Connect



	Number of Women (n=28,584)					
	0	.01-.25	.26-.50	.51-.75	.76-1.0	>1.0
All MCEs	995	2,470	8,208	9,604	4,085	3,222
Anthem	335	815	2,932	3,633	1,572	1,309
MHS	357	807	2,084	2,535	1,082	824
MDwise	303	848	3,192	3,436	1,431	1,089

	Number of Women (n=218)					
	0	.01-.25	.26-.50	.51-.75	.76-1.0	>1.0
All MCEs	23	14	42	33	32	74
Anthem	8	3	11	13	12	35
MHS	2	4	14	7	6	12
MDwise	13	7	17	13	14	27

Exhibits IX.4 through IX.9 appear on the following pages and are presented in the same manner as Exhibit IX.3. In these exhibits, only the HHW population was considered because the women are divided into subgroups and the HCC population in the study was too small for this further breakout to be meaningful. The exhibits compare the average visits per week enrolled across a number of dimensions:

- Exhibit IX.4 examines the population based upon enrollment duration (expressed in terms of the number of trimesters the member was enrolled with the MCE)
- Exhibit IX.5 examines the population by maternal DRG (vaginal delivery or Cesarean section, with or without complications)
- Exhibit IX.6 examines the population by newborn DRG (well baby or "normal newborn" compared to all other birth DRGs of varying degrees of complications)
- Exhibit IX.7 examines the population by the mother's age
- Exhibit IX.8 examines the population by the mother's race/ethnicity
- Exhibit IX.9 examines the population by the mother's MCE and region

A summary of all of these exhibits is listed below.

- Exhibit IX.4 shows that women enrolled only in the third trimester were more likely to have had zero prenatal visits as well as having more prenatal visits than the overall average (compare bottom right box to upper left box). Overall, three percent of women had no prenatal visits (upper left box). For women enrolled full pregnancy, the total is one percent (upper right box). For those enrolled 2nd and 3rd trimesters only, two percent (lower left box). For women enrolled in 3rd trimester only (which may include only part of the trimester), 12 percent had no prenatal visits (bottom right box). Conversely, 20 percent of the 3rd trimester only women had an average of more than one visit per week, compared to 11 percent in the overall study.

- Exhibit IX.5 shows that women with a vaginal delivery with complications or Cesarean delivery without complications were more likely to have had more than one prenatal visit per week (in both populations, this was 14%). Women with Cesarean deliveries with complications had the most visits (19% had more than one visit per week, on average).

- Exhibit IX.6 shows that women who delivered a baby in a DRG that was not in the normal newborn category had more visits (20% averaged more than one visit per week) than the women that delivered a baby in the normal newborn DRG (9% averaged more than one visit per week).

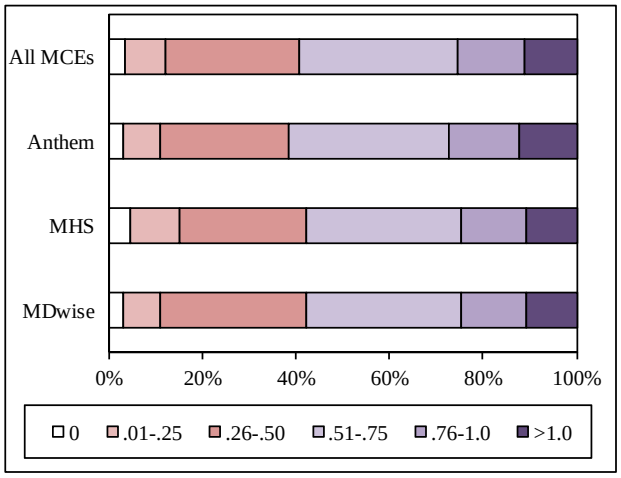
- Exhibit IX.7 shows that as the mother's age increases, there are more women in the age cohort that received one (or more) visits per week. Specifically, the rate increase from 7 percent for individuals aged 19 and under up to 21 percent for individuals aged 36 and above.

- Exhibit IX.8 shows that there is not a significant difference between the number of prenatal visits per week when comparing across race/ethnicity, with more than 75 percent of the population in all race/ethnicity categories receiving between 0.26 and 1.00 visits per week (approximately 2 to 4 visits per month).

- Within Exhibit IX.9, there is not a significant difference in the number of prenatal visits when compared across the MCEs and region. There is no MCE/region where more than seven percent of the women in the cohort had no prenatal care visits. Among the women with the most prenatal care visits (average of more than one per week enrolled), the lowest percentage was found to be in the West Central Region for all three MCEs.

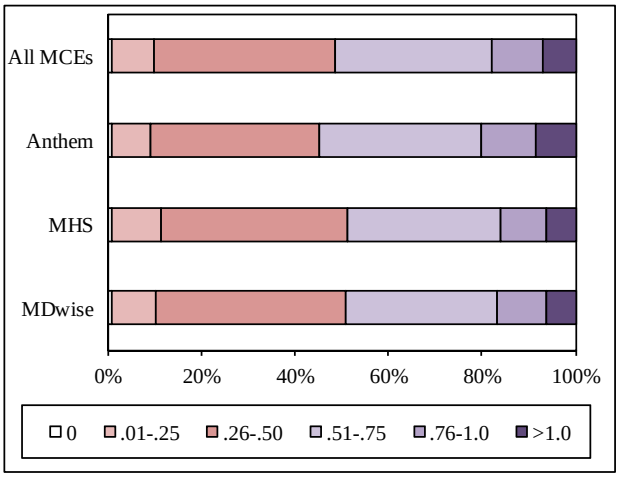
Exhibit IX.4
Average Prenatal Visits Per Weeks Enrolled by Trimesters Enrolled

All Hoosier Healthwise Members in Study



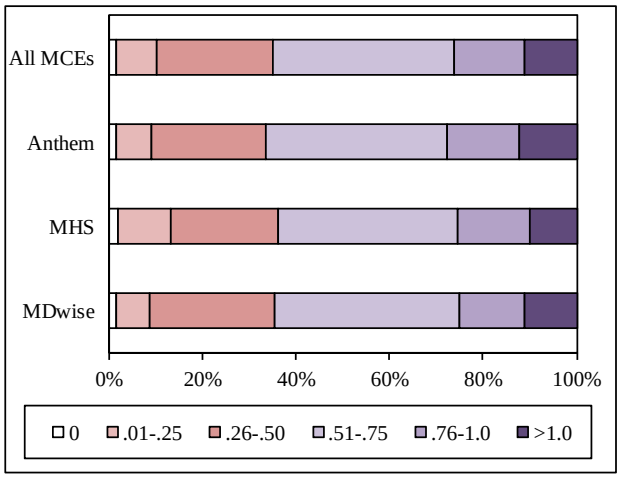
	Number of Women (n=28,584)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	995	2,470	8,208	9,604	4,085	3,222
Anthem	335	815	2,932	3,633	1,572	1,309
MHS	357	807	2,084	2,535	1,082	824
MDwise	303	848	3,192	3,436	1,431	1,089

Members Enrolled for Full Term



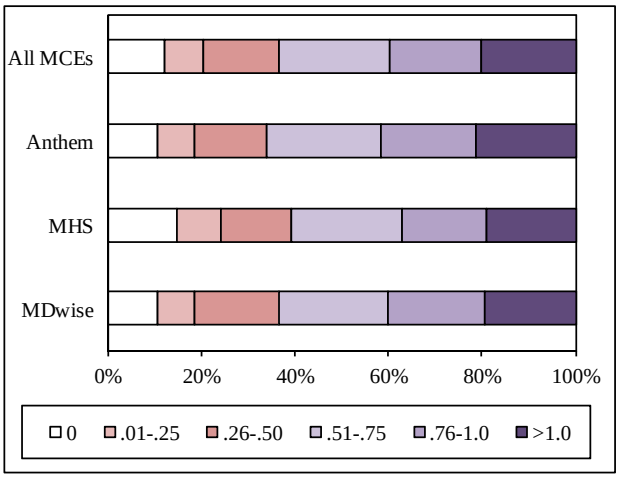
	Number of Women (n=11,390)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	102	1,035	4,420	3,797	1,236	800
Anthem	46	355	1,605	1,544	527	373
MHS	25	279	1,078	881	258	169
MDwise	31	401	1,737	1,372	451	258

Members Enrolled Only in 2nd & 3rd Trimesters



	Number of Women (n=11,467)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	204	959	2,865	4,447	1,714	1,278
Anthem	73	298	1,018	1,598	636	503
MHS	67	363	741	1,233	501	317
MDwise	64	298	1,106	1,616	577	458

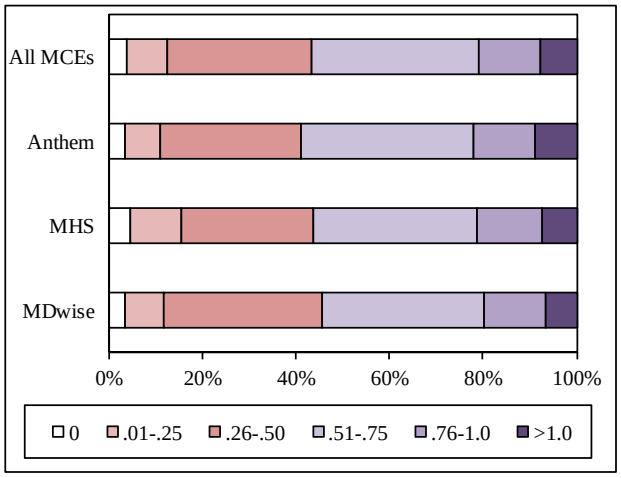
Members Enrolled Only in 3rd Trimester



	Number of Women (n=5,727)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	689	476	923	1,360	1,135	1,144
Anthem	216	162	309	491	409	433
MHS	265	165	265	421	323	338
MDwise	208	149	349	448	403	373

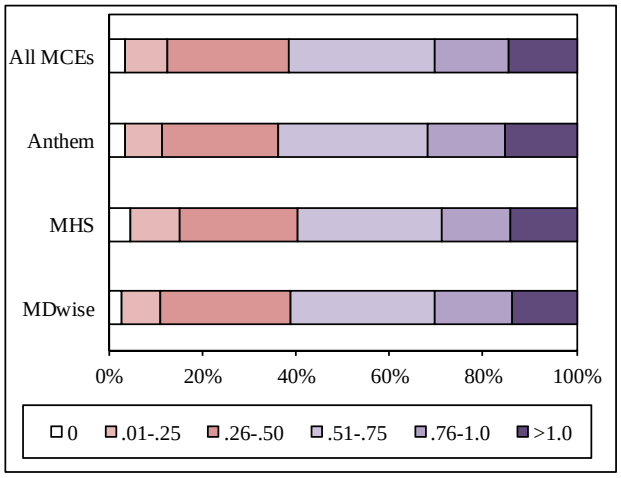
Exhibit IX.5
Average Prenatal Visits Per Weeks Enrolled by Maternity DRG

Vaginal Deliveries, without complications



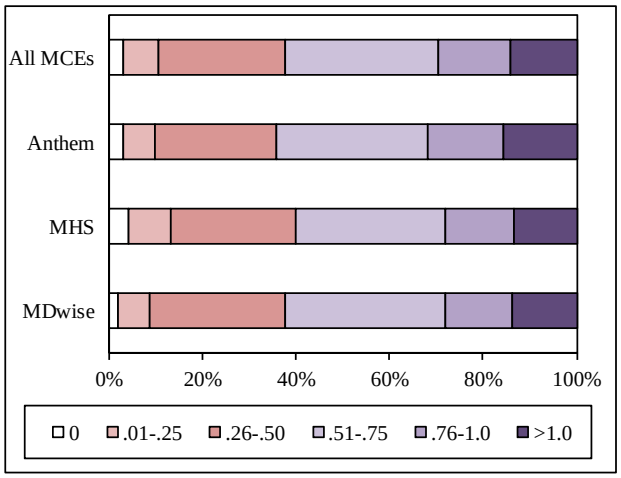
	Number of Women (n=12,615)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	467	1,119	3,900	4,483	1,678	968
Anthem	146	343	1,317	1,622	576	392
MHS	167	393	1,037	1,267	507	267
MDwise	154	383	1,546	1,594	595	309

Vaginal Deliveries, with complications



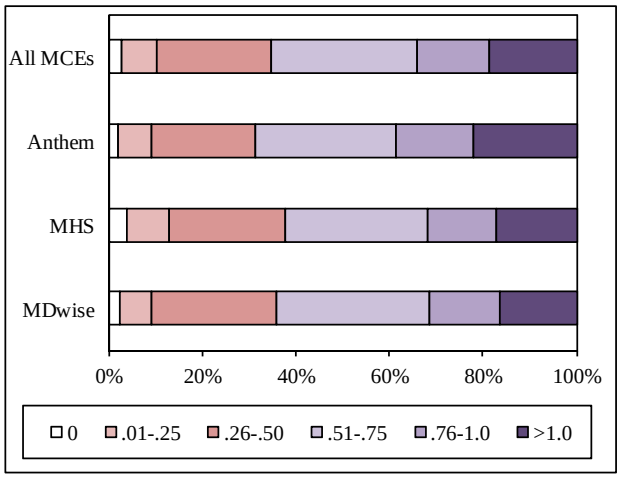
	Number of Women (n=4,984)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	178	440	1,293	1,558	802	713
Anthem	62	138	428	561	289	263
MHS	68	149	360	436	210	202
MDwise	48	153	505	561	303	248

Cesarean Deliveries, without complications



	Number of Women (n=5,014)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	155	371	1,365	1,646	762	715
Anthem	56	131	488	602	308	291
MHS	63	130	379	462	212	191
MDwise	36	110	498	582	242	233

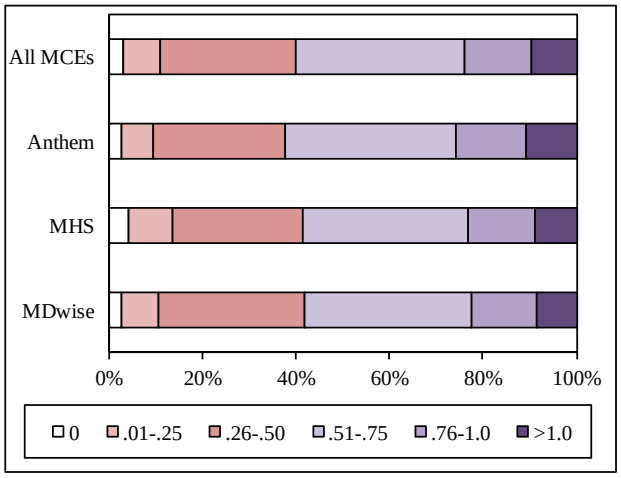
Cesarean Deliveries, with complications



	Number of Women (n=2,659)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	72	198	654	829	411	495
Anthem	21	68	214	290	162	211
MHS	28	62	172	211	102	119
MDwise	23	68	268	328	147	165

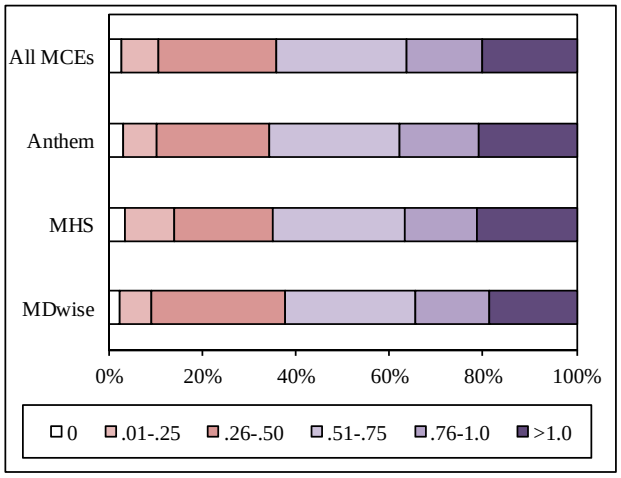
Exhibit IX.6
Average Prenatal Visits Per Weeks Enrolled by Baby DRG

Normal Newborn



	Number of Women (n=20,747)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	644	1,642	6,038	7,488	2,973	1,962
Anthem	210	551	2,216	2,917	1,183	846
MHS	234	547	1,595	2,047	822	504
MDwise	200	544	2,227	2,524	968	612

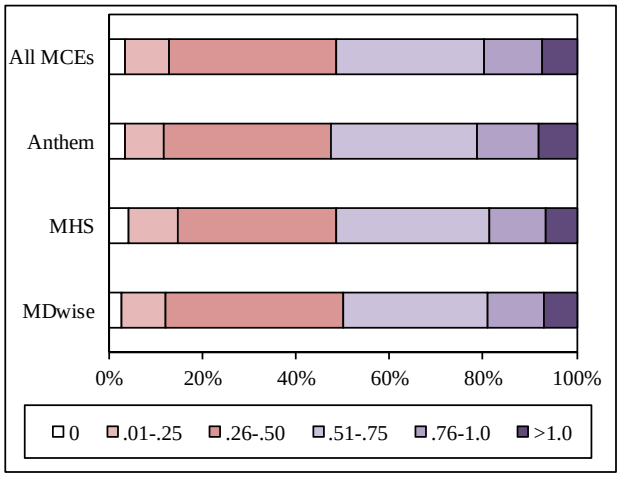
Other than Normal Newborn



	Number of Women (n=4,292)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	123	336	1,082	1,196	691	864
Anthem	48	107	370	422	260	318
MHS	37	114	232	307	165	233
MDwise	38	115	480	467	266	313

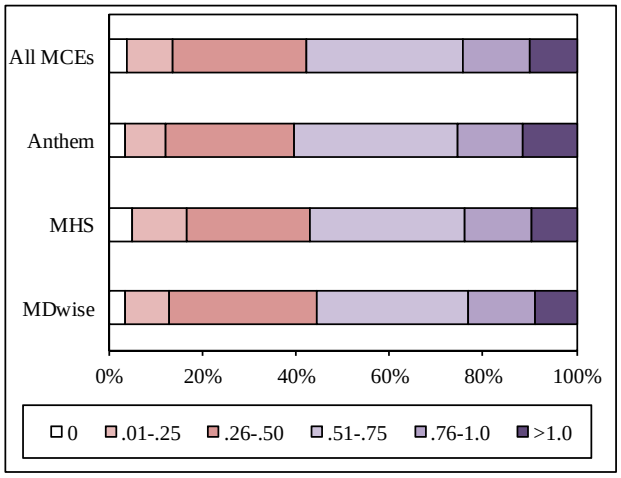
Exhibit IX.7
Average Prenatal Visits Per Weeks Enrolled by Mother's Age at Delivery

Age 19 and Under



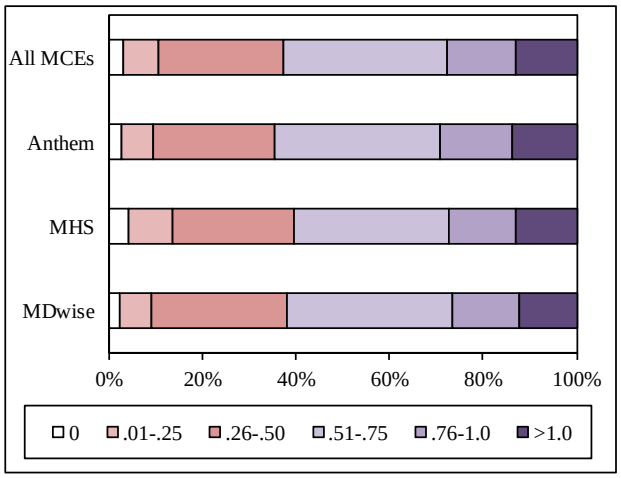
	Number of Women (n=3,677)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	128	342	1,322	1,163	459	263
Anthem	44	101	440	387	165	99
MHS	45	115	371	358	132	70
MDwise	39	126	511	418	162	94

Age 20 to 25



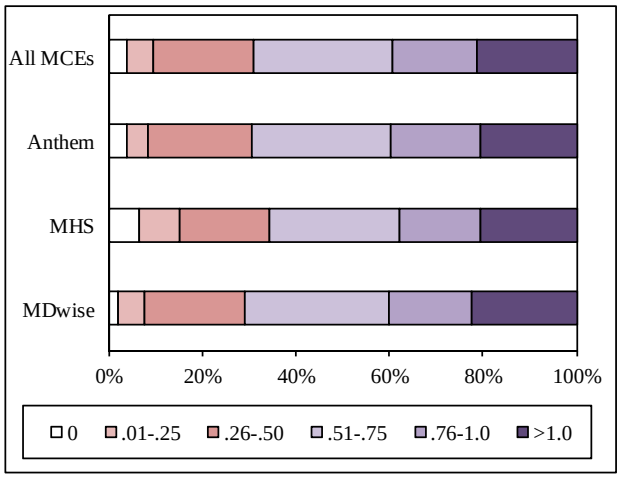
	Number of Women (n=12,905)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	501	1,244	3,722	4,329	1,816	1,293
Anthem	157	404	1,303	1,632	658	535
MHS	178	408	937	1,180	504	336
MDwise	166	432	1,482	1,517	654	422

Age 26 to 35



	Number of Women (n=10,732)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	318	809	2,894	3,735	1,579	1,397
Anthem	115	286	1,074	1,462	650	569
MHS	114	258	717	911	393	355
MDwise	89	265	1,103	1,362	536	473

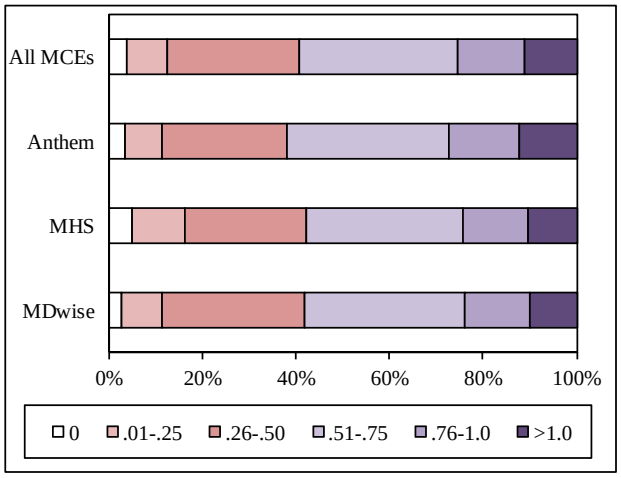
Age 36 and Above



	Number of Women (n=1,270)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	48	75	270	377	231	269
Anthem	19	24	115	152	99	106
MHS	20	26	59	86	53	63
MDwise	9	25	96	139	79	100

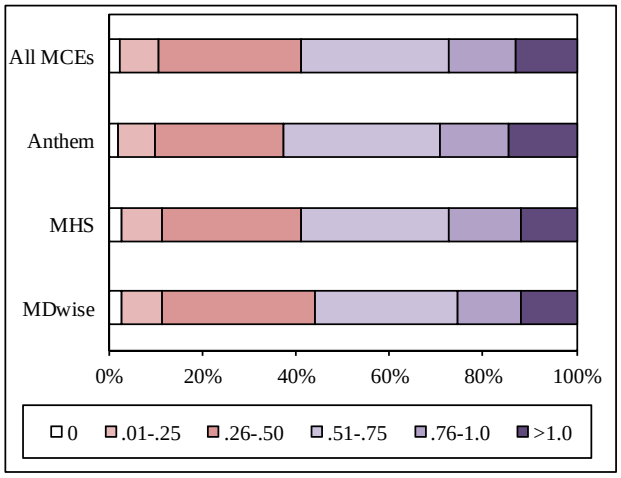
Exhibit IX.8
Average Prenatal Visits Per Weeks Enrolled by Mother's Race/Ethnicity

Caucasian



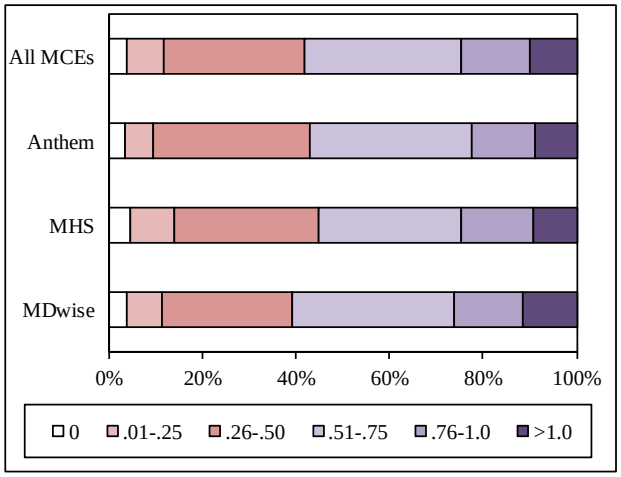
	Number of Women (n=19,832)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	740	1,771	5,532	6,782	2,836	2,171
Anthem	257	582	1,988	2,564	1,122	904
MHS	283	616	1,443	1,856	761	582
MDwise	200	573	2,101	2,362	953	685

African-American



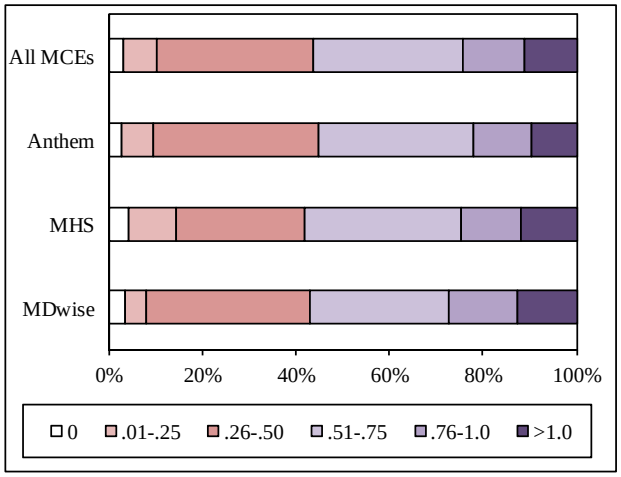
	Number of Women (n=5,773)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	146	475	1,742	1,841	827	742
Anthem	44	165	577	707	310	306
MHS	39	113	403	429	204	162
MDwise	63	197	762	705	313	274

Hispanic



	Number of Women (n=2,009)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	77	157	609	670	294	202
Anthem	20	36	196	204	80	52
MHS	26	56	178	177	89	54
MDwise	31	65	235	289	125	96

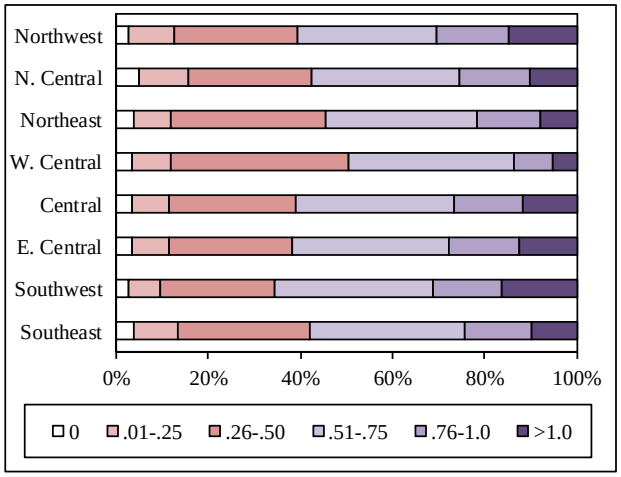
Other



	Number of Women (n=970)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
All MCEs	32	67	325	311	128	107
Anthem	14	32	171	158	60	47
MHS	9	22	60	73	28	26
MDwise	9	13	94	80	40	34

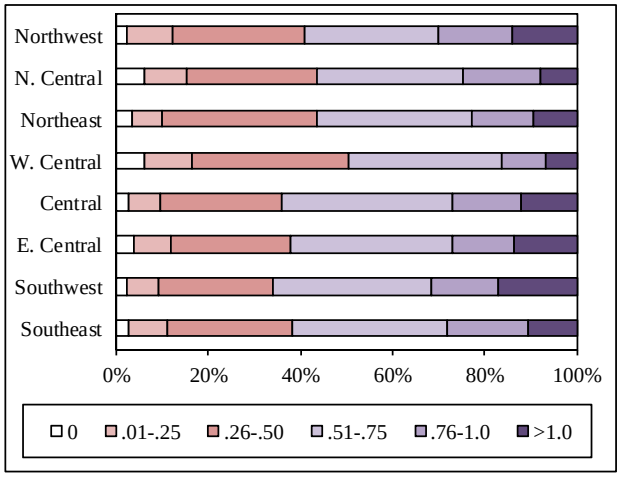
Exhibit IX.9
Average Prenatal Visits Per Weeks Enrolled by MCE/Region

All MCEs



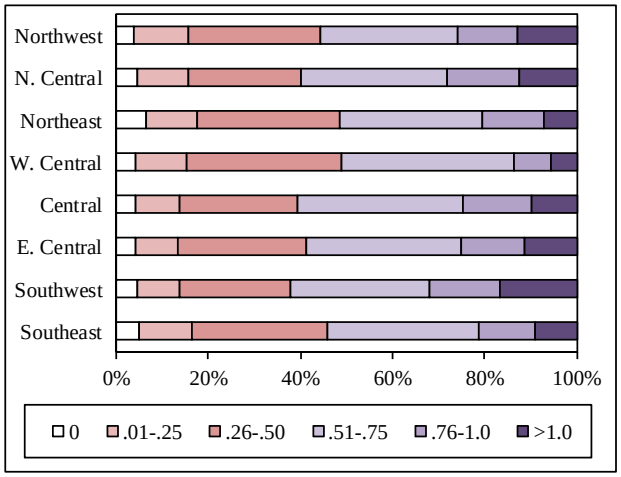
	Number of Women (n=28,584)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
Northwest	94	342	926	1,052	541	507
N. Central	151	335	823	1,001	464	317
Northeast	133	282	1,181	1,161	475	276
W. Central	74	191	858	800	193	111
Central	282	682	2,322	2,915	1,240	983
E. Central	81	195	654	825	370	306
Southwest	83	202	732	1,003	438	479
Southeast	97	241	712	847	364	243

Anthem



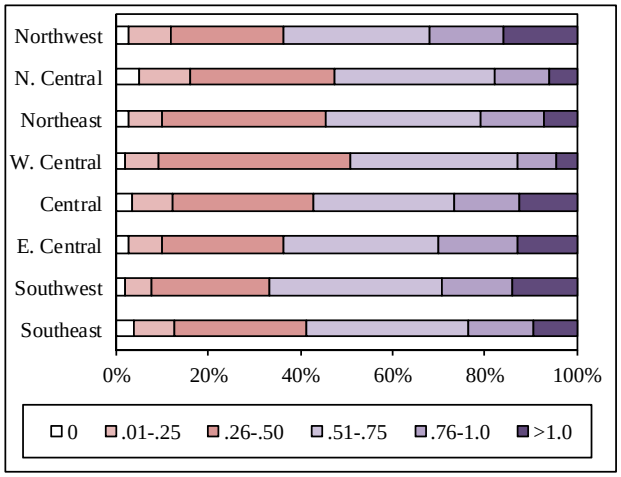
	Number of Women (n=10,596)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
Northwest	34	143	418	427	231	206
N. Central	35	50	156	174	94	43
Northeast	39	75	378	380	151	107
W. Central	30	49	165	160	46	32
Central	107	269	1,008	1,419	577	461
E. Central	24	52	171	226	88	88
Southwest	42	108	414	570	241	284
Southeast	24	69	222	277	144	88

MHS



	Number of Women (n=7,689)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
Northwest	19	57	138	142	64	61
N. Central	85	214	470	606	296	237
Northeast	54	87	248	249	108	57
W. Central	18	47	141	158	34	23
Central	82	181	488	677	283	188
E. Central	28	62	190	228	93	76
Southwest	28	57	149	186	96	102
Southeast	43	102	260	289	108	80

MDwise



	Number of Women (n=10,299)					
	0	**.01-.25**	**.26-.50**	**.51-.75**	**.76-1.0**	**>1.0**
Northwest	41	142	370	483	246	240
N. Central	31	71	197	221	74	37
Northeast	40	120	555	532	216	112
W. Central	26	95	552	482	113	56
Central	93	232	826	819	380	334
E. Central	29	81	293	371	189	142
Southwest	13	37	169	247	101	93
Southeast	30	70	230	281	112	75

With few exceptions, Exhibits IX.3 through IX.9 showed consistency in the average number of visits per week enrolled for numerous subpopulations in the sample. This statistic measured women over the course of the entire pregnancy. As shown in Exhibit IX.2, the average enrolled period in an MCE for women in the study sample was 24.4 weeks. This means that the average visits per week encompassed women enrolled their full term (40 weeks) through those enrolled just the week of their delivery.

To test the consistency further of the average visits per week, B&A limited the enrollment period and the visits to just the month of delivery and the month prior to delivery. In this analysis, it meant that for a single member the number of weeks of enrollment and visits could be between five and eight weeks. For example, if the woman delivered on the 6th day of the month, then her total was five weeks (1 week in delivery month and 4 weeks for the month prior). For another member, if she delivered on the 25th of the month, then her total weeks was eight (since she delivered in week 4 of her delivery month).

After controlling for the period just prior to delivery, the average visits per member was still consistent across MCE, race/ethnicity, region and delivery DRG with the overall average at 1.0 visit per week (which is the recommendation from ACOG). Refer to Exhibit IX.10 below.

Exhibit IX.10
Average Number of Prenatal Visits Per Week
During Month of Delivery and Month Prior to Delivery Only
Hoosier Healthwise Program Only

Sample Group	Number in Sample - All MCEs	Average Number of Visits Per Member			
		All MCEs	Anthem	MHS	MDwise
All Women	28,584	1.0	0.9	1.0	1.0
Caucasian	19,832	1.0	0.9	1.0	1.0
African-American	5,773	0.9	0.9	0.9	1.0
Hispanic	2,009	1.0	1.0	1.1	1.0
Other	970	1.0	1.1	1.0	1.0
Northwest	3,462	0.8	0.8	0.9	0.8
North Central	3,091	1.0	1.1	1.0	1.2
Northeast	3,508	1.1	1.0	1.2	1.1
West Central	2,227	1.2	1.2	1.2	1.2
Central	8,424	1.0	0.9	1.0	1.0
East Central	2,431	1.0	1.0	1.0	1.0
Southwest	2,937	0.9	0.8	0.9	0.9
Southeast	2,504	1.0	1.0	1.1	1.0
Vaginal Delivery, w/o complications	12,615	1.1	1.0	1.1	1.1
Vaginal Delivery, with complications	4,984	0.9	0.9	0.9	0.9
Cesarean Delivery, w/o complications	5,014	0.9	0.8	0.9	0.9
Cesarean Delivery, with complications	2,659	0.8	0.8	0.9	0.9

MCE Initiatives Related to Promoting Prenatal Care

As part of the EQR, B&A requested documents from the MCEs related to the delivery of prenatal care services to women to better inform our study. Specifically, we requested examples of relevant internal policies or procedures, communications or guidance distributed to providers, and communications or guidance distributed to members. A summary of B&A's desk review of the information provided appears below.

Policies and Procedures

Each of the three MCEs have developed programs that are targeted to ensuring that women receive prenatal care in a timely and comprehensive manner. All three MCEs provided information related to their internal care and case management services available to pregnant women.

Anthem's pregnancy care management program is called "My Advocate". As a part of this program, all identified pregnant women are contacted and screened using a risk screening tool comprised of 20 questions. Based on the responses to the screening tool, pregnant women are designated as urgent risk, high risk, medium risk or low risk. Members determined urgent, high, or medium risk are assigned a case manager who specializes in obstetrics. Low risk members are not assigned a case manager. Pregnant members that are determined to be low risk receive educational materials only and are monitored through claims data for changes in status.

The case manager contacts assigned members according to their level of priority of risk. In their interactions with the member, the case manager will assist the member with multiple pregnancy-related topics including the importance of prenatal visits.

MHS uses a three-level care management system. All pregnant women are eligible for a program titled "Start Smart for Your Baby®". This program is intended for members deemed low to medium risk in their pregnancy. Members receive educational materials through the mail. Women in this program deemed to be medium risk are eligible for care management support from a case manager who specializes in obstetrics. These women receive an initial assessment and periodic phone calls throughout their pregnancy to assure that they are receiving prenatal care and that they have an opportunity to ask questions.

Members that are determined to be of high risk are enrolled in the program titled "Special Deliveries". Members enrolled in this program are managed by high risk obstetrical registered nurses and receive one or more home visits and frequent telephonic follow up. Members may be determined high risk based on clinical factors such as prior pre-term delivery, other health conditions, or age (less than age 16 or over age 40).

The care management program through MDwise is titled "Pregnancy INcontrol Program". Pregnant women are passively enrolled unless they choose to opt out. Based on a pregnancy diagnosis, women are determined for placement in a risk group. Pregnant women may be determined to be high risk based on risk factors such as age (under age 16 or over age 34), inpatient stay while pregnant, previous pre-term delivery or other clinical indicators. If the pregnant member chooses to opt-out of the program, she is classified as low-risk and only receives educational mailings.

All pregnant women receive educational materials throughout their pregnancy. The risk level of the member will determine the frequency and intensity of the interactions. Members that are classified as moderate risk receive care management services which include telephone support and education.

Members that are classified as high risk receive complex case management which includes more frequent contact with the assigned complex case manager.

Communication or Guidance to Providers

Each of the MCEs supplied information to B&A that described the P4O program offered by the OMPP. In turn, each MCE has a program to share P4O dollars earned with their providers. There are some differences in the type of information that each MCE makes available to providers as tools to assist the provider in earning their P4O.

Anthem maintains a provider score card which is provider-specific and allows physicians to view their panel size and current rate on measures that are a part of the P4O program. The score card includes the current year calculated measure, prior year rate, health plan average, and target rate. Additionally, Anthem has produced a guide titled "HEDIS® Benchmarks and Coding Guidelines for Quality Care". This guide describes the purpose of the HEDIS measure, how it is calculated, and a listing of CPT, HCPCS and diagnosis codes that are applicable to the described service. A listing of tips is included to assist providers in encouraging members in their panel to receive the recommended preventive care.

MHS and MDwise both offer a document to providers that contains a narrative describing HEDIS Quality Measures pertaining to women's health as well as the CPT, HCPCS and diagnosis codes that are applicable to the described measures. MHS's document is titled "HEDIS Quick Reference Guide – Women" and MDwise's document is titled "Billing for Pregnancy". Of note, both MCEs' documents show in their guides the ICD-9 diagnosis codes which need to be updated to reflect the current ICD-10 codes.

Communication or Guidance to Members

Each of the MCEs provided a number of documents targeted to members related to prenatal and postpartum care. Each of the MCEs has a member incentive program. A brief description of each of the MCE's communications efforts is described below.

Anthem

All identified pregnant women are enrolled in Anthem's "New Baby, New Life" program. Some of the components of this program include:

- Access to a 24/7 NurseLine –The NurseLine is a toll-free number where a nurse may be reached 24/7 to provide answers to concerns or questions.

- Prenatal Checkup incentive program information –Anthem offers a $25 gift card to women who receive a prenatal checkup within the 1st trimester or within 42 days of enrollment in Anthem. In order to receive the reward, the member must receive the checkup during the specified timeframe and have their doctor sign/stamp a First Trimester Brochure indicating that the visit was completed.

- Educational Materials –All pregnant women receive a Prenatal Packet containing educational materials pertaining to pregnancy. Topics include healthy behaviors such as the necessity to attend scheduled prenatal visits and, if applicable, to quit smoking. Additionally, Anthem includes information related to CenteringPregnancy. CenteringPregnancy is a model of care which promotes group support during pregnancy. In this model, women receive their prenatal

care in a group setting. The model encourages women to educate and support each other throughout the pregnancy.

Other materials related to prenatal care available to Anthem members include:

- Having a Healthy Baby brochure- This brochure discusses the Text4baby program, avoiding early deliveries, CenteringPregnancy, and protecting the baby from the flu.
- Incentives brochures- These brochures describe the $25 prenatal visit and the $50 postpartum visit incentives.
- Labor, delivery, and beyond- This booklet explains delivery, Cesarean sections, vaginal birth after C-section and postpartum depression.
- Prenatal flyer- This flyer introduces women to the "New Baby, New Life" program.
- Postpartum flyer- This flyer reminds members about check-ups for mother and baby and provides phone numbers.
- My Advocate flyer- This flyer describes the electronic assistance available to new mothers.
- Third trimester brochure- This brochure provides reminders for before and after delivery.
- During and After brochure- This brochure discusses member benefits and text4baby.
- Health tips- These documents provide tips for a health pregnancy and how to work with a doctor during pregnancy.

MHS

MHS provides educational materials to pregnant women based on their level of risk. The educational materials are organized by trimester. These educational booklets discuss changes that should be expected in the mother's body and explains the development of the baby based on the week of the pregnancy. There are multiple other topics covered in the materials including the importance of scheduling and keeping physician appointments, the importance of not smoking while pregnant, and information related to healthy behaviors during pregnancy.

Other materials related to prenatal care available to MHS members include:

- First trimester mailing- The mailing explains why prenatal care is needed, changes of pregnancy, depression, proper eating, health problems during pregnancy, when to call the doctor and smoking in pregnancy.
- Second trimester mailing- This mailing explains second trimester pregnancy changes and how the baby is developing each month.
- Third trimester mailing- This mailing explains third trimester pregnancy changes, how the baby is developing each month, fetal movement, identifying signs and stages of labor, managing labor pain, inducing labor and Group B Strep.
- Guide to the Baby's First Year- This 34 week mailing discusses breastfeeding and crib safety. This also includes the Centene corporate booklet "A Guide to Baby's First Year".
- Postpartum Mailing- This includes feeding information and crib safety.

MDwise

BLUEBELLEbeginnings Program is the name of the pregnancy program managed by MDwise. This program was launched in 2004 to improve access and care for pregnant women and to improve the health of babies. There are multiple aspects of this program including:

- Health education materials –All pregnant women receive educational materials including a guide titled "Your Pregnancy Month by Month". This guide covers multiple topics related to

pregnancy including the importance to regularly attend prenatal care doctor appointments and to practice good health habits such as the importance to stop smoking.

- MDwise Reward Program –This program awards points for completing healthy activities such as attending prenatal appointments. Members have the opportunity to earn points which can be redeemed for gift cards to a variety of stores. The maximum value of the reward cards that any member can receive in a year is $50.
- Bluebelle's community baby showers –MDwise holds community baby showers throughout the state for pregnant members.

Other materials related to prenatal care available to MDwise members include:

- Gestational Diabetes Information- This document provides an explanation of gestational diabetes, how it is treated, and follow-up recommendations for the post-pregnancy period.
- Pregnancy-Induced Hypertension (PIH) Information- This document describes PIH, risks for the mother and baby, how it is treated and symptoms.
- A page in the Member Handbook- This page describes care during pregnancy, scheduled delivery recommendations and the BLUEBELLEbeginnings program.
- Pregnancy postcards.
- Rewards Flyer- This explains how members can earn Rewards Points for prenatal care. These points can be used to obtain gift cards.

Recommendations

This focus study using just claims data supports the prenatal visit results that have been reported by the MCEs in the last three years in their HEDIS submissions where claims data is used along with medical record abstraction. In the HEDIS FPC measure, 80 percent of women, on average, received 81 percent or more of their recommended prenatal visits. Among the study population, the overall average visits per week enrolled were consistent across subpopulations and across MCEs, including the weeks just before giving birth. In fact, the average visits per week result of 1.0 is in line with the ACOG recommendations.

The recommendations provided here, therefore, are intended for all three MCEs and are provided in the spirit of aiming towards continuous quality improvement.

1. Women enrolled with the MCE in only their third trimester (or some portion thereof) are most different from women enrolled for longer time periods in one of two ways—either the women have had no prenatal visits (implying that they enrolled just prior to delivery) or the women had, on average, more than one prenatal visit per week enrolled (implying that they were enrolled for most of the third trimester and the recommended visits just prior to delivery is one per week). The MCEs may want to consider additional modes to obtain rapid-response turnaround to identify these "late entrants" into their health plan in an effort to reduce the percentage of women who had no prenatal visits prior to delivery (currently at 12% of the total enrolled in just the third trimester).

2. Another area of opportunity for the MCEs to consider is to work more closely with OB/GYN practitioners in the identification of high-risk pregnancies. There appear to be inroads on this already by the fact that women with vaginal deliveries with complications and Cesarean deliveries with complications both have a higher rate of prenatal visits per week than their peers in the respective DRGs without complications. What had not been reviewed in this study specifically, which is also an opportunity for the MCEs, is to cross-tabulate the woman's enrollment into the MCE, the notification or awareness of a high-risk pregnancy, and the timing

of the prenatal visits. This could provide improved health outcomes for both the mother and her newborn.

SECTION X: FOCUS STUDY ON THE DELIVERY OF WELL CARE AND PRIMARY CARE TO CHILDREN

Introduction

One of the Office of Medicaid Policy and Planning's (OMPP's) quality strategy objectives for Calendar Year (CY) 2015 was to improve the results for child and adolescent well care visits. For Hoosier Healthwise (HHW) in particular, the goal was to achieve at or above the 90th percentile among Medicaid managed care plans nationally on each of the following Healthcare Effectiveness Data and Information Set (HEDIS) measures:

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

The OMPP has a Pay for Outcomes (P4O) program in its contracts with the managed care entities (MCEs). One component of the P4O program is related to these three HEDIS measures. In particular, the MCEs are paid annual performance bonuses based on the results of their HEDIS W15, W34 and AWC measures. The bonus is stair-stepped in a manner based on the MCE's percentile ranking compared to other Medicaid health plans nationally.

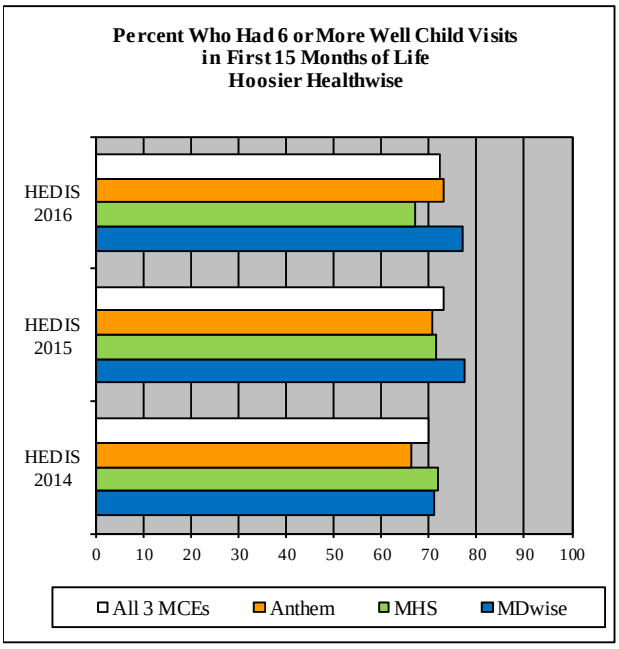
The study in this EQR focused on examining the utilization of both well care visits (as defined by the HEDIS measures) as well as other primary care visits to the children and adolescents in the HHW, Hoosier Care Connect (HCC) and Healthy Indiana Plan (HIP) 2.0 programs in CY 2015. Analyses were conducted to examine who delivers well care and primary care services to the members, the differences in the rate of well care and primary care visit utilization, and the percentage of members in each program that received neither well care nor primary care services in CY 2015. Variances in these trends were also examined by gender, by region in the state, by race/ethnicity and by age.

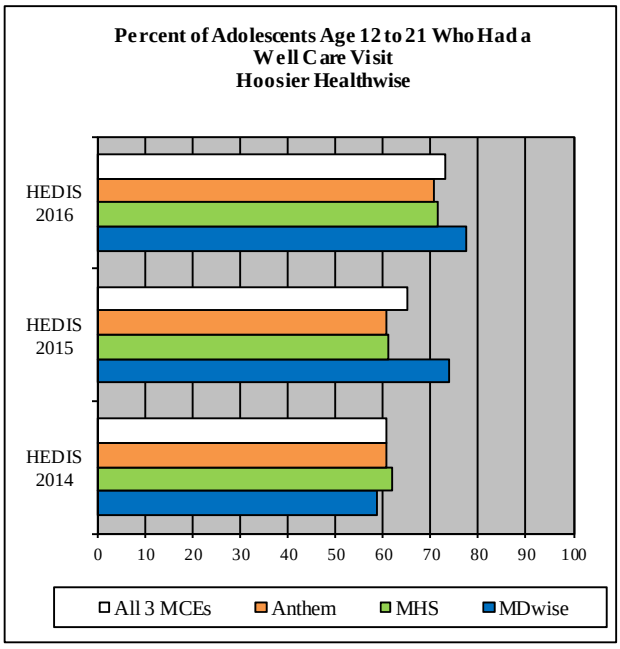
Background

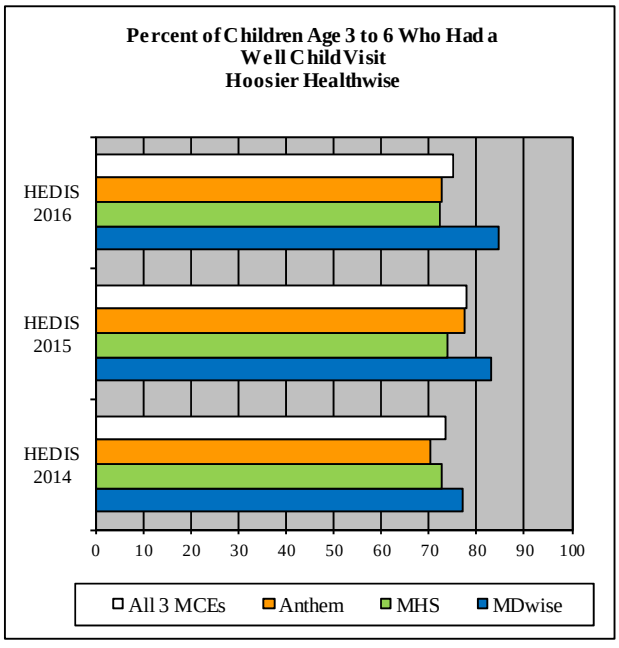
For both ongoing monitoring as well as establishing verifiable results for its P4O program, the OMPP requires the MCEs to hire an external certified HEDIS auditor to annually collect results on dozens of HEDIS measures and to assess whether or not each measure is reportable to the National Committee on Quality Assurance (NCQA). Among these measures is the three well care measures that are a part of this study. Exhibit X.1 on the next page shows the results reported by the HEDIS auditors in each of the last three reporting years for the W15, W34 and AWC measures in the HHW program. The reporting years are HEDIS 2016, HEDIS 2015 and HEDIS 2014. This means that the results are based on utilization and enrollment from the previous calendar year (CYs 2015, 2014 and 2013). All three measures are considered hybrid measures, meaning that compliance with the measure could be determined either by claims experience or by medical record abstraction.

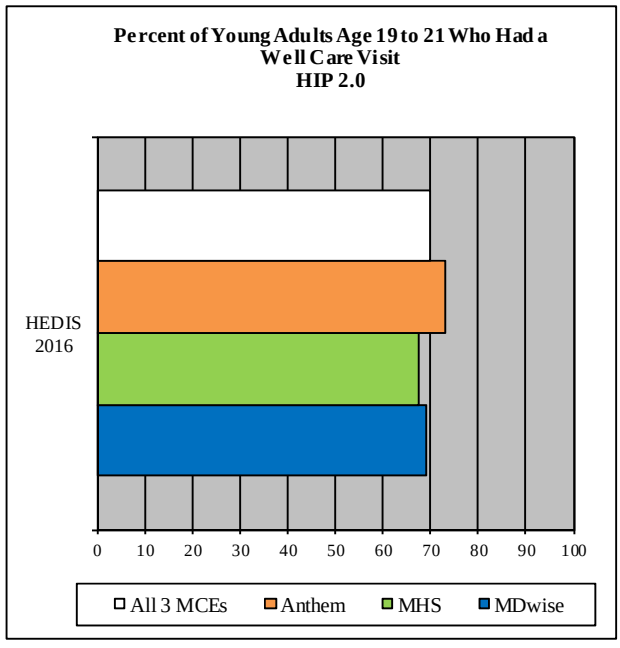
With the introduction of the HCC and HIP 2.0 in CY 2015, the HEDIS auditors also computed results of HEDIS measures for these programs. Also on Exhibit X.1 is the results reported by the auditors for the AWC measure in HIP. The other two measures (W15 and W34) are not applicable to HIP since the HIP population is only comprised of adults. In fact, although the AWC measure is defined as members between the ages of 12 and 21, the HIP 2.0 results only include members between the ages of 19 and 21. There are not reportable results available yet for the HCC program across all MCEs. Therefore, no HCC HEDIS results are shown.

Exhibit X.1
Well Child Visit Measure Results









W15	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2014	70.0	66.4	71.7	71.1
HEDIS 2015	72.9	70.6	71.6	77.4
HEDIS 2016	72.4	73.1	67.1	77.1

W34	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2014	73.5	70.4	72.6	76.9
HEDIS 2015	77.8	77.6	74.0	83.2
HEDIS 2016	75.1	72.7	72.1	84.6

AWC HHW	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2014	60.7	60.9	62.0	58.9
HEDIS 2015	65.1	60.8	61.3	73.8
HEDIS 2016	72.9	70.6	71.6	77.4

AWC HIP	All 3 MCEs	Anthem	MHS	MDwise
HEDIS 2016	69.9	73.3	67.6	69.3

In the HHW program, the HEDIS results in the W15 measure have shown varying degrees of year-over-year improvement among the three MCEs. MHS's results in HEDIS 2016, however, declined from the previous year. As a result, the average across all MCEs was flat from HEDIS 2015 to 2016 at 72.4 percent compliance.

The HEDIS results in the W34 measure in HHW were also mixed in HEDIS 2016. While MDwise saw improvement in its result from HEDIS 2015, both Anthem and MHS saw a decline. There is also a wide variation in the results between MDwise and the other two MCEs. MDwise reported a result of 84.6 percent compliance which was 12 percentage points higher than Anthem and MHS.

All three MCEs have seen significant improvement in the AWC measure among the HHW population in the last three HEDIS reporting years and all MCEs reported improvement in HEDIS 2016 over HEDIS 2015. Once again, however, MDwise's results (77.4% compliance) were greater than Anthem's (70.6% compliance) and MHS's (71.6% compliance) results.

In the first year of reporting AWC results among the HIP population, Anthem reported compliance slightly higher in HIP than in HHW whereas both MHS and MDwise reported lower compliance in HIP than in HHW.

The US Department of Health and Human Services releases an annual report of state Medicaid agency results of the national child core measures. These three HEDIS measures are among the child core measures. The 2015 Annual Report is the latest report available[18]. The 2015 report examine the results submitted by state Medicaid agencies in Federal Fiscal Year 2014, which would be HEDIS 2014 (CY 2013 experience). In this report, Indiana Medicaid's rate ranked 11th highest out of 41 states reporting on the W15 measure; for the W34 measure, Indiana's rate ranked 15th highest out of 46 states reporting; for the AWC measure, Indiana's rate ranked 6th highest out of 44 states reporting. It should be noted that although Indiana is clearly in the top quartile or third among states on these measures, exact rankings should be considered with caution due to the fact that states report differing methodologies (administrative vs. hybrid) and denominators (all enrolled members in the age group vs. a sample).

Methodology for Defining the Study Sample

For this study, Burns & Associates (B&A) started by considering all eligible members in HHW, HCC or HIP for each of the HEDIS measures (W15, W34 and AWC) by using the HEDIS parameters to define the population. To do this, B&A used the enrollment file from the state's Enterprise Data Warehouse to determine (a) eligibility of a member within a program (HHW, HCC and/or HIP) and for what duration and (b) eligibility within an MCE. Members could meet the continuous enrollment requirement either by:

- Being enrolled continuously within the same program and MCE (e.g., a four year old was enrolled with Anthem in HHW during the entire year) or
- Being enrolled continuously within the same MCE but across programs (e.g., An Anthem member turned age 19 during the year. Although he was continuously enrolled with Anthem throughout CY 2015, he transitioned from the HHW program to the HIP program.)

Members who transitioned to a new program were assigned to the program that they were enrolled with on December 31, 2015. Members could only be assigned to one program and one MCE in the study. Exhibit X.2 on the next page outlines the requirements for member eligibility in the study.

[18] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-child-sec-rept.pdf

Exhibit X.2
Enrollment Criteria Used for Member Inclusion in the Study

	W15	W34	AWC
Age	15 months old during the measurement period	3 to 6 Years as of the end of the measurement period	12 to 21 Years as of the end of the measurement period
Measurement Period	Analyzed claims from 10/1/13 – 12/31/15, as needed, based on the date the member turned 15 months old during the measurement period	Analyzed claims from 1/1/15 – 12/31/15	Analyzed claims from 1/1/15 – 12/31/15
Continuous Enrollment	From 31 days after birth to 15 months of age	The entire measurement year	The entire measurement year
Allowable Gap	No more than one monthly segment within the MCE during the continuous enrollment period	No more than one monthly segment within the MCE during the continuous enrollment period	No more than one monthly segment within the MCE during the continuous enrollment period
Anchor Date	The day the child turns 15 months old	December 31, 2015	December 31, 2015

The enrollees that met the criteria in Exhibit X.2 were divided by program and by MCE. The final study includes the following count of members which serve as the denominator in many of the calculations:

Hoosier Healthwise

	W15	W34	AWC
Anthem	N= 10,940	N= 33,785	N= 42,771
MHS	N = 7,746	N = 29,776	N= 42,131
MDwise	N = 12,572	N= 44,202	N= 58,985
All 3 Combined	N = 31,258	N= 107,763	N= 143,887

Hoosier Care Connect

	W15	W34	AWC
Anthem		N= 1,601	N= 5,479
MHS		N = 1,268	N= 4,132
MDwise		N= 2,198	N= 7,931
All 3 Combined		N= 5,067	N= 17,542

HIP 2.0

	W15	W34	AWC
Anthem			N= 2,200
MHS			N= 1,614
MDwise			N= 2,267
All 3 Combined			N= 6,081

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

It is also important to define the terms well care and primary care as used in this study. *Well care visits* as used in this study are visits as defined by the HEDIS Well Care Visit measures. These include procedure (CPT/HCPCS) codes (specifically, 99381-99385, 99391-99395, 99461, G0438 and G0439) or diagnosis codes that were reported on the claim. Since the study year was CY 2015 when ICD-10 diagnosis coding began, this meant that B&A looked for the presence of specific ICD-9 and ICD-10 diagnosis codes depending on the date of service (ICD-10 coding began with dates of service October 1, 2015). In all, there were nine ICD-9 diagnosis considered and 22 ICD-10 diagnosis codes. As per HEDIS, a well care visit is identified either through the presence of a CPT code or a diagnosis code.

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

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

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

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

Findings

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

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

- the types of providers delivering each type of service (well care or primary care);
- the cohort of members served (W15, W34 or AWC); or
- the MCE that the member is enrolled with (Anthem, MHS or MDwise).

Exhibits X.3 through X.5 on the following pages show the results of these comparisons for the infants in the W15 measure (Exhibit X.3, blue colored report), the young children age three through six in the W34 measure (Exhibit X.4, green colored report) and the adolescents and young adults age 12 through 21 in the AWC measure (Exhibit X.5, orange colored report).

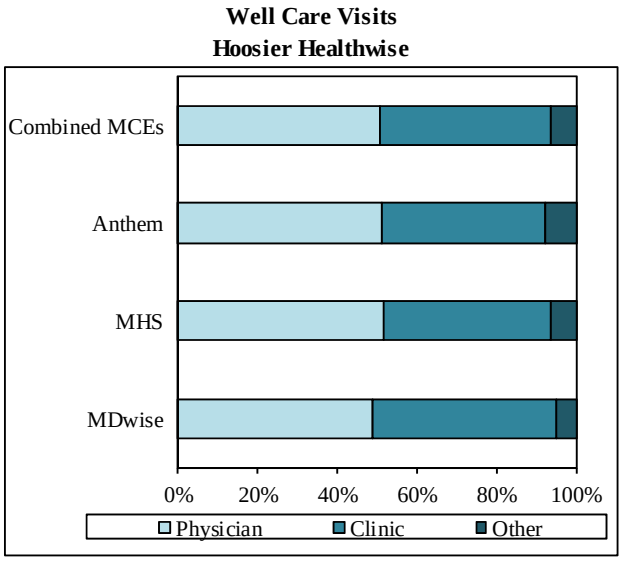
Each exhibit is displayed in a similar manner for easy comparison across the child populations.

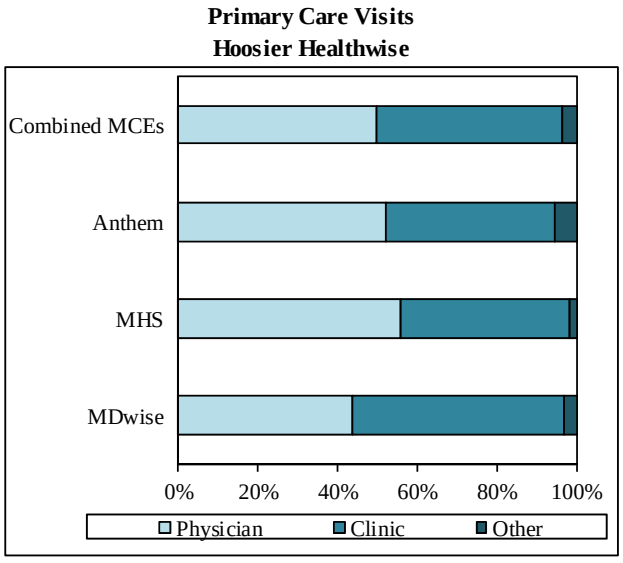
Exhibit X.3 examines the number and percentage of visits different provider types delivered to HHW members in the W15 population. (The same cohort could have been examined for the HCC population, but the sample size of the membership was too small in CY 2015 to report meaningful findings.) The numbers below the bar charts represent the actual number of well care and primary care visits (as defined in the study) that the members in the study population had during the study period.

As previously stated, the total W15 population in HHW in the study is 31,258 members (users and non-users). This exhibit shows all visits (not count of members). The infant population in particular is expected to have six or more visits. In fact, each W15 member had, on average, 24.1 well care *services* and 2.7 primary care *visits*. The reason why the well care services value is so high is because the HEDIS definition was used to define well care visits, which includes both procedure codes and diagnosis codes. When the well visit services were examined closer, 22 percent of them were for the well care visit procedure codes, 69 percent represented either vaccine administration (28 percent) or the vaccine itself (41 percent), four percent represented lab services, and five percent represented other services. If only the well care procedure codes were counted, the ratio would be 5.8 visits per member (near the target of six or more well care visits). The ratio of 2.7 primary care visits per member use only E&M codes to define visits, not diagnosis codes. The visits shown in the right box are *in addition to* the visits in the left box.

As to who is delivering services to the W15 population, there is little difference between the three major categories shown. Fifty-one percent of well care visits overall are delivered by physicians (office-based setting) and 50 percent of primary care visits are delivered by physicians. Clinics deliver 43 percent of well care visits and 47 percent of physician visits. Approximately five percent of visits are delivered by other provider types (hospitals and public health agencies usually). MDwise has a slightly higher percentage of visits delivered by clinics, but otherwise there is little variation across the MCEs.

Exhibit X.3
Who Delivers Well Care and Primary Care Visits to Children in the HEDIS W15 Population





	Visit Utilization (n=754,998)		
	Physician	**Clinic**	**Other**
Combined MCEs	381,352	325,634	48,012
Anthem	130,180	103,613	19,759
MHS	100,653	81,348	12,658
MDwise	150,519	140,673	15,595

	Visit Utilization (n=84,489)		
	Physician	**Clinic**	**Other**
Combined MCEs	41,887	39,588	3,014
Anthem	15,608	12,734	1,645
MHS	11,284	8,597	362
MDwise	14,995	18,257	1,007

Exhibit X.4 (shown on page X-8) and Exhibit X.5 (shown on page X-9) show similar statistics for the W34 and AWC populations, respectively.

In Exhibit X.4, the cohort population in the study is 107,763 HHW members (users and non-users) and 5,067 HCC members (users and non-users). The average number of well care services delivered is 3.0 per HHW member and 1.4 per HCC member; for primary care visits, the averages are 0.5 per HHW member and 1.0 per HCC member. Well care services are generally distributed for both the HHW and HCC members between visit codes (30% of the total), vaccine administration or vaccines (50% of the total), lab tests (12% of the total) and other services (8% of the total).

The percentage of services by provider type in this age group is similar across the MCEs with one exception. There are 48 percent of well care visits delivered by physician offices and 43 percent by clinics. For primary care visits, 53 percent are delivered by physicians and 41 percent by clinics. MHS members in HHW are more likely to receive primary care services by physicians than the other MCEs, and MHS members in HHC are more likely to receive well care visits in hospitals or physician offices than the other MCEs.

Exhibit X.5 presents the statistics for the AWC population in HHW, HCC and HIP. In HHW, the cohort population of 143,887 (users and non-users) had 2.2 well care services delivered per member in the sample and 0.8 primary care services per member. In HCC and HIP (combined population of 23,623 users and non-users), members were more likely to receive a primary care visit (1.2 per member) than a well care visit (0.84 per member). Similar to what was found among the W34 population, 30 percent of all well care services were identified by visit codes, 44 percent were identified by vaccine administration or vaccines, 14 percent were identified through lab tests and 12 percent were found through other services delivered.

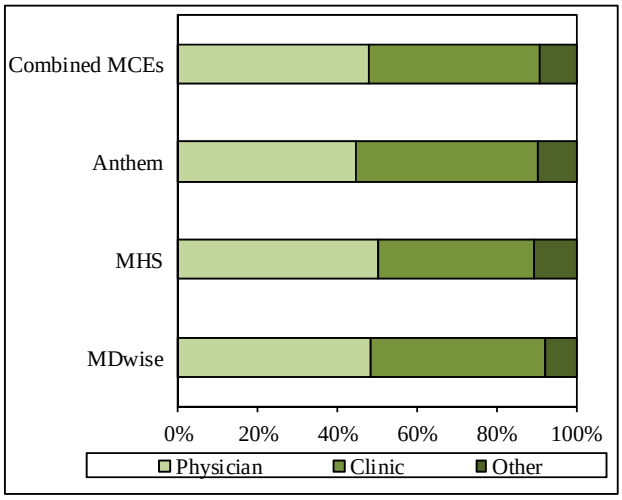
A finding among the AWC populations in all three programs is that more services were delivered from provider types other than physician or clinic. For well care visits, 87 percent were delivered by physicians and clinics in HHW; for HCC and HIP combined, the percentage was 80 percent. The comparable percentages in the W15 and W34 populations were 94 percent and 91 percent, respectively. The most common provider types other than physicians and clinics delivering well care services to AWC members are hospitals, public health agencies and laboratories.

The percentage of primary care visits delivered by physicians and clinics to AWC members is even lower than the percentage of well care services. In HHW, 85 percent were delivered by physicians and clinics; in HCC and HIP combined, it was 77 percent. The most frequent provider type delivering primary care services other than physicians and clinics among the AWC population is mental health providers.

There are small differences in the provider types delivering well care and primary care visits to members across the MCEs among the AWC population other than MDwise members are more likely to use the clinics than the other MCE members.

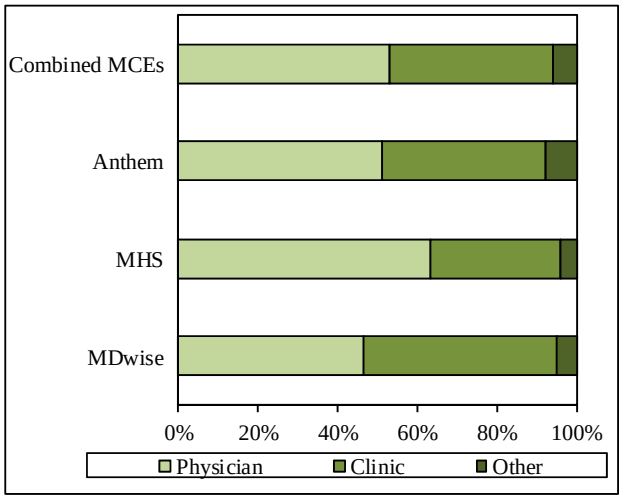
Exhibit X.4
Who Delivers Well Care and Primary Care Visits to Children in the HEDIS W34 Population

Well Care Visits
Hoosier Healthwise



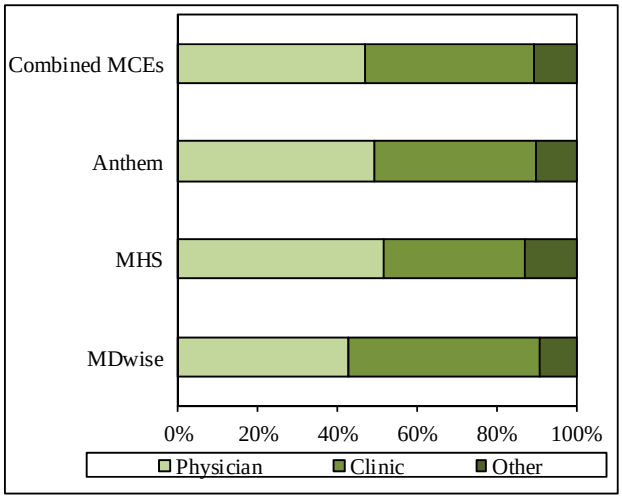
	Visit Utilization		
	Physician	**Clinic**	**Other**
Combined MCEs	153,909	138,163	29,071
Anthem	42,322	43,444	8,887
MHS	45,325	35,331	9,469
MDwise	66,262	59,388	10,715

Primary Care Visits
Hoosier Healthwise



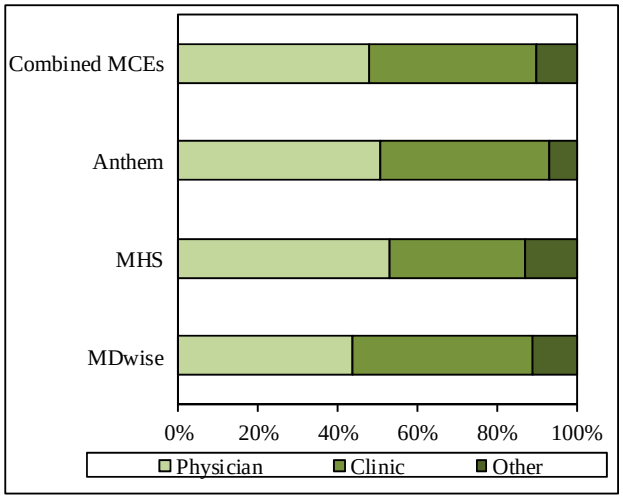
	Visit Utilization		
	Physician	**Clinic**	**Other**
Combined MCEs	26,943	21,080	2,881
Anthem	8,437	6,767	1,310
MHS	9,514	4,892	613
MDwise	8,992	9,421	958

Well Care Visits
Hoosier Care Connect



	Visit Utilization (n=7,226)		
	Physician	**Clinic**	**Other**
Combined MCEs	3,410	3,069	747
Anthem	1,178	975	239
MHS	987	684	245
MDwise	1,245	1,410	263

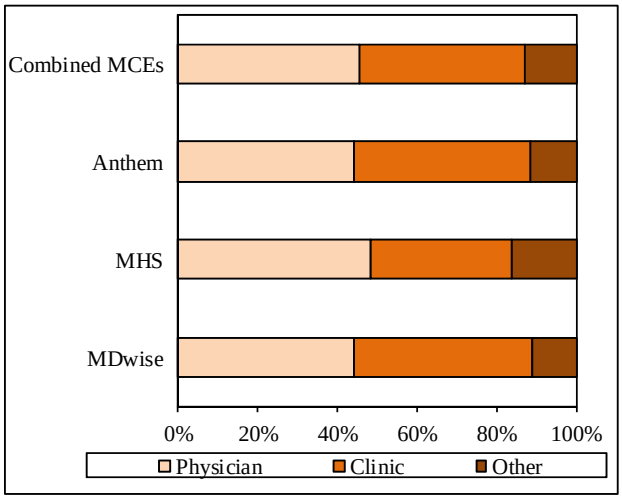
Primary Care Visits
Hoosier Care Connect



	Visit Utilization (n=5,010)		
	Physician	**Clinic**	**Other**
Combined MCEs	2,408	2,097	505
Anthem	780	659	104
MHS	662	425	162
MDwise	966	1,013	239

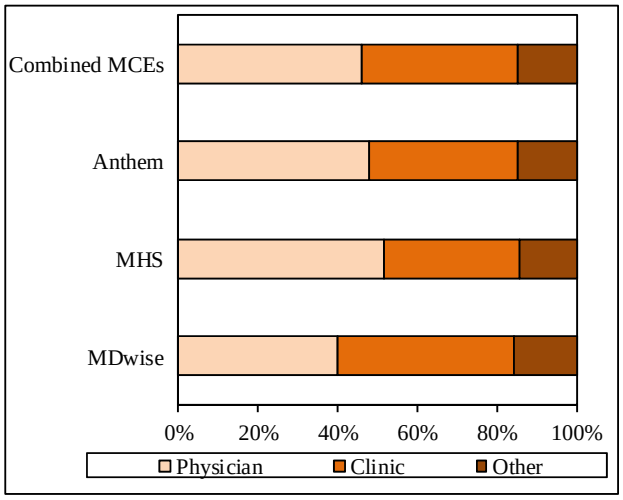
Exhibit X.5
Who Delivers Well Care and Primary Care Visits to Adolescents in the HEDIS AWC Population

Well Care Visits
Hoosier Healthwise



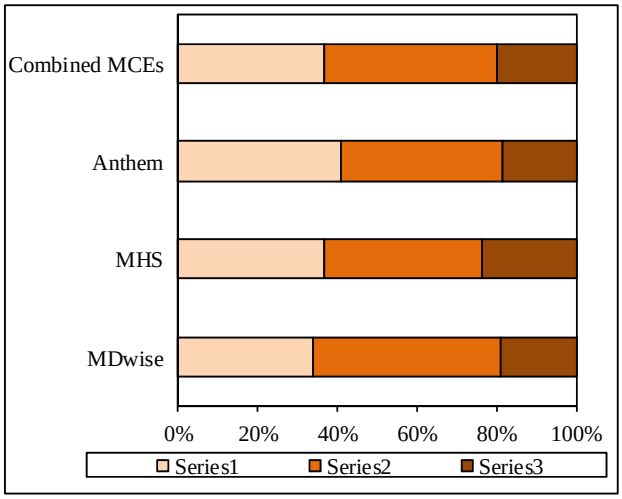
	Visit Utilization (n=316,340)		
	Physician	**Clinic**	**Other**
Combined MCEs	143,679	132,196	40,465
Anthem	36,283	36,468	9,542
MHS	46,218	34,213	15,463
MDwise	61,178	61,515	15,460

Primary Care Visits
Hoosier Healthwise



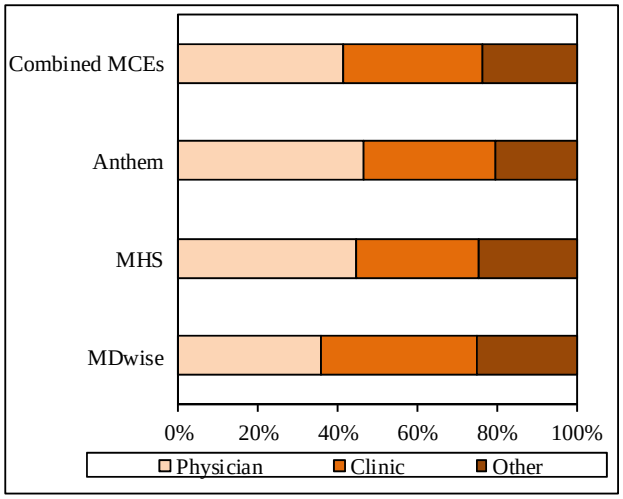
	Visit Utilization (n=121,557)		
	Physician	**Clinic**	**Other**
Combined MCEs	55,796	47,607	18,154
Anthem	18,247	14,232	5,706
MHS	18,696	12,265	5,102
MDwise	18,853	21,110	7,346

Well Care Visits
Hoosier Care Connect and HIP 2.0 Combined



	Visit Utilization (n=19,850)		
	Physician	**Clinic**	**Other**
Combined MCEs	7,312	8,585	3,953
Anthem	2,583	2,573	1,157
MHS	1,854	1,993	1,195
MDwise	2,875	4,019	1,601

Primary Care Visits
Hoosier Care Connect and HIP 2.0 Combined



	Visit Utilization (n=27,824)		
	Physician	**Clinic**	**Other**
Combined MCEs	11,493	9,830	6,501
Anthem	4,421	3,169	1,915
MHS	2,602	1,804	1,445
MDwise	4,470	4,857	3,141

Members with a Well Care Visit

Whereas Exhibits X.3 through X.5 examined the total number of visits received by members, Exhibits X.6 through X.11 examine the percent of eligible members in each population group who received a well care visit.

The exhibits are constructed so that variations in the percent of members receiving a well care visit can be easily discerned when examined by gender, by region, by race/ethnicity, or by age (for the W34 and AWC populations). The exhibits are further broken out in population cohorts by HEDIS population and OMPP program as follows:

- Exhibit X.6 examines the W15 population in HHW
- Exhibit X.7 examines the W34 population in HHW
- Exhibit X.8 examines the W34 population in HCC
- Exhibit X.9 examines the AWC population in HHW
- Exhibit X.10 examines the AWC population in HCC
- Exhibit X.11 examines the AWC population in HIP

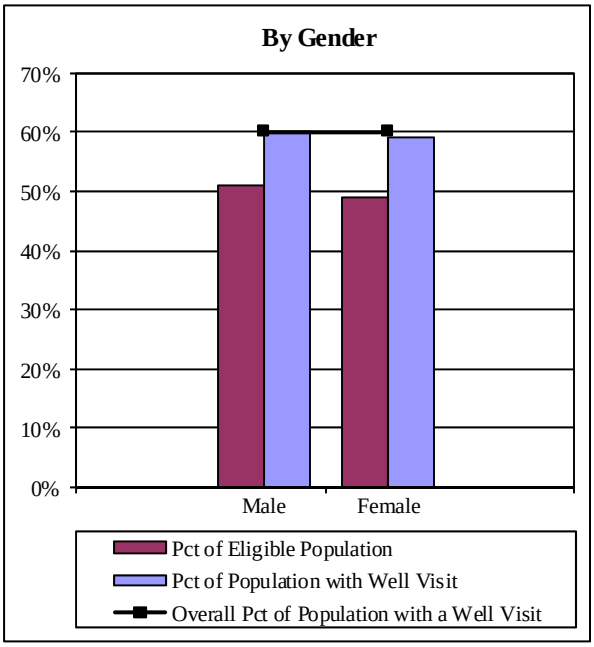
In every exhibit, the populations from all three MCEs are combined. All of the exhibits are constructed in the same manner. The red bars represent the percent of the total population that the subgroup represents. The blue bar represents the percent of that subgroup that had a well care visit. The black line going straight across in each box shows the percentage of the entire population in the exhibit that had well care visit. This is used to compare the subgroup of interest against the total population.

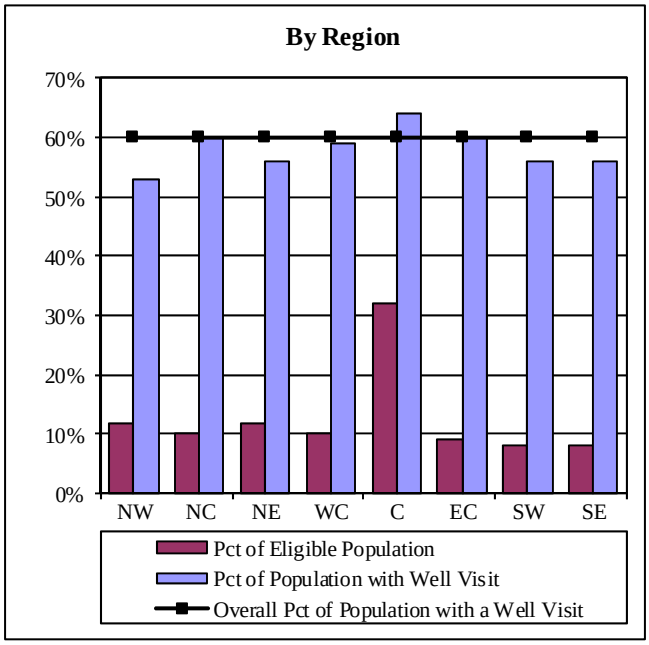
For example, in Exhibit X.6 on the next page, there were 31,258 infants in the study population for W15 in the HHW program. The rate of members with a well care visit was 60 percent (as computed by B&A using the administrative method only). In the upper left box, by gender males represented 51 percent of the total and females 49 percent of the total. The well care visit rate was almost the same for both. In the upper right box, members in the Central Region, for example, represented 32 percent of the total (red bar) and had a well care visit rate of 64 percent (blue bar) as compared to the overall well care rate of 60 percent among the total population of 31,258 (black line going across).

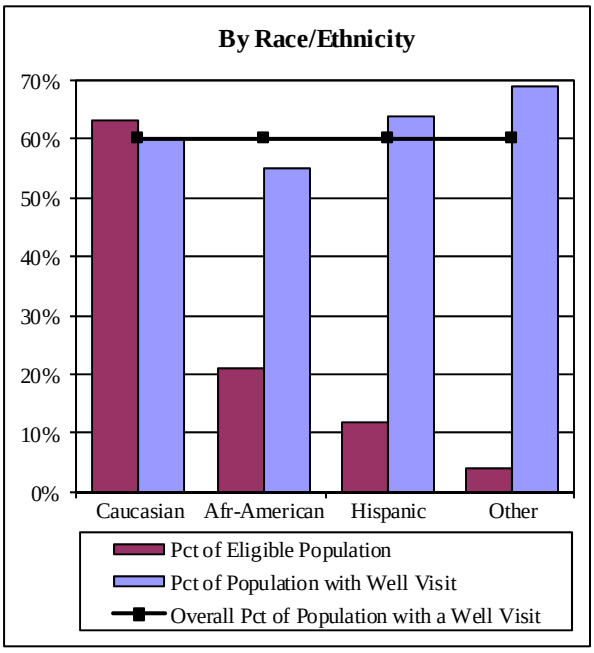
There are some other notable findings when comparing the well care visit rate among subgroups in Exhibit X.6:

- When examined by region, the well care visit rate range was from 53 percent (Northwest) to 64 percent (Central).
- Hispanic children had a higher well visit rate (64%) than the statewide average, but African-American children had a lower well visit rate (55%). Caucasian children were at the statewide average of 60 percent primarily because they comprise most of the population in the study (63% of the total).
- Other exhibits in this series will also break out the well care visit rate by age in years in the lower right box. This is not applicable to the W15 population since all of the children are 15 months old in the study.

Exhibit X.6
Percent of Total Population and Well Child Users by Key Demographic Features, HEDIS W15
Hoosier Healthwise Population
Total W15 Population in CY 2015 = 31,258







Exhibits X.7 – X.11 appear beginning on page X-13. Each exhibit is displayed in the same manner as X.6 showed the W15 population in HHW. The only difference is that a fourth box appears in the lower right which breaks out the well care visit rate by age.

Although the total population varies greatly in the study results in each exhibit (refer to the population count shown in the fourth line of the exhibit title), the proportion of members by gender, by region and by race/ethnicity remains steady across all of the exhibits (the red bars). For the distribution by age, the population is consistent across each age level in the W34 exhibits. In the AWC exhibits, there is a drop off of members in the age 19-21 group in HHW but a spike in members in this age group in HCC. In HIP, the age 19-21 group is the only age group.

A summary of key findings related to all of these exhibits appears below, most notably where the well care visit rate for a subgroup (the blue bars) differ from the statewide average rate (the black line across).

- Among the W34 population in HHW (Exhibit X.7), the well care visit rate is lower in the East Central and Southeast Regions than statewide. The rate among Hispanics is higher than the statewide average and Caucasians are lower than the statewide average. African-American children have a rate at the statewide average. The well care visit rate by age group is the same for three-, four- and five-year-olds but lower for children age six.

- Among the W34 population in HCC (Exhibit X.8), the trends seen by race/ethnicity and by age are similar to what was found in the HHW population in Exhibit X.7. There are differences in the HCC region by region when compared to HHW, but this is more likely due to a much smaller population in HCC (n= 5,067) than in HHW (n= 107,763). This means that the subgroup of members at the region level in HCC is quite small (350-700 children by region except for the Central Region).

- Among the AWC population in HHW (Exhibit X.9), the rate among males and females is almost identical. At the region level, the well care visit rate is from a low range of 49 percent (Southeast) to 56 percent (North Central) which is a small range around the overall average of 53 percent. By race/ethnicity, Hispanic members have a much higher well care visit rate of 62 percent and Caucasians are lowest at 50 percent. In the individual age groups from 12 to 21, as the member age increases, the well care visit rate decreases, most notably among age 19-21 (28% versus the overall average of 53%).

- Among the AWC population in HHC (Exhibit X.10), the trend of similar well care visit rates by gender, by region and by age continue as was seen among HHW members. Among race/ethnicities, the much higher well care visit rate among Hispanics is not as pronounced in HCC as it was in HHW.

- Among the AWC population in HIP (Exhibit X.11), which is only 19-21 year olds, there is a difference in the well care visit rate by gender (13% for males, 26% for females, 21% overall). The East Central Region has a lower rate than other regions, but the sample is only 608 members in the study. Otherwise, the regional rates center closely around the overall average. There is less disparity in the well care visit rate among race/ethnicities in HIP than was seen in HHW or HCC.

Exhibit X.7
Percent of Total Population and Well Child Users by Key Demographic Features, HEDIS W34
Hoosier Healthwise Population
Total W34 Population in CY 2015 = 107,763

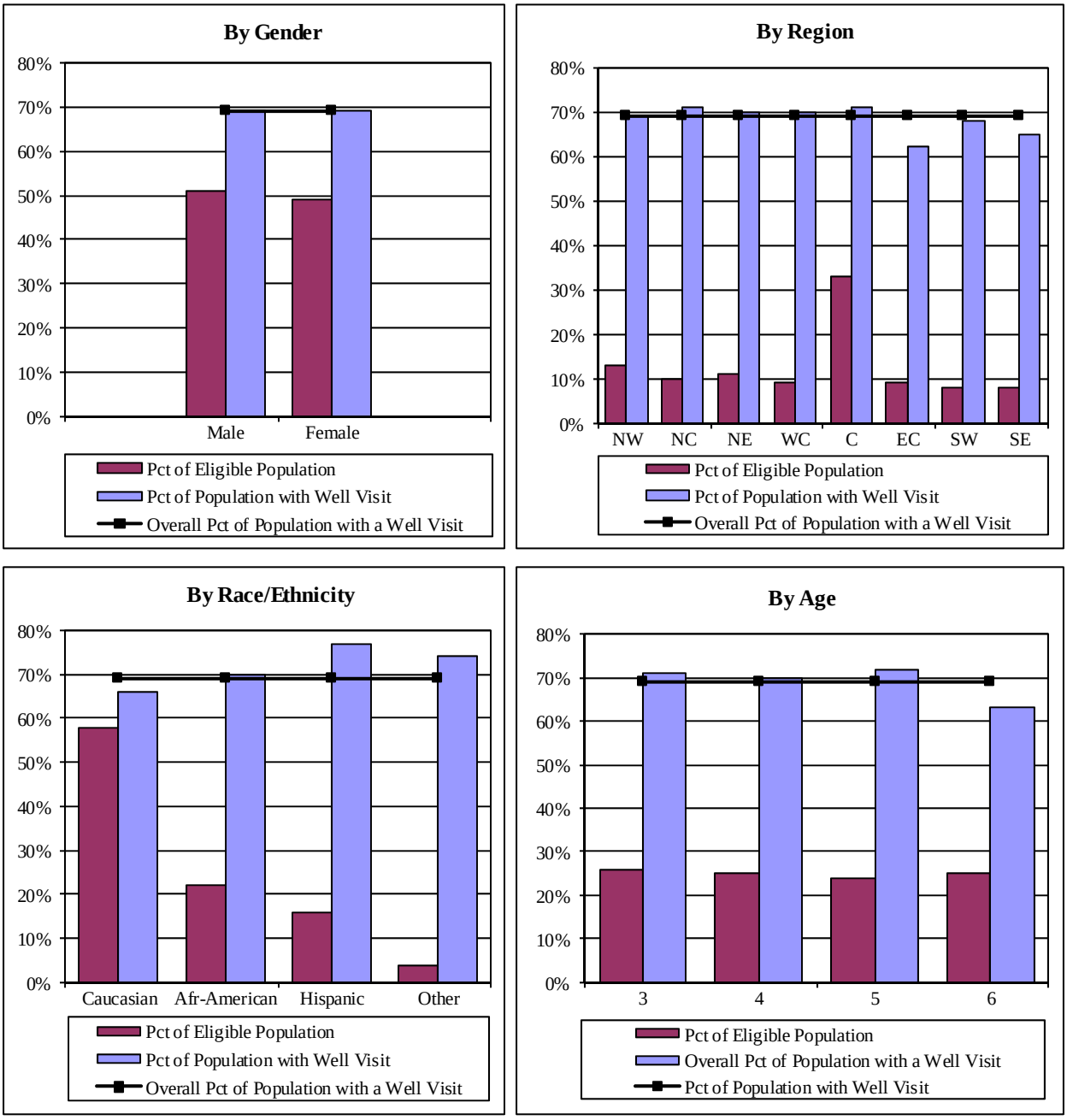


Exhibit X.8
Percent of Total Population and Well Child Users by Key Demographic Features, HEDIS W34
Hoosier Care Connect Population
Total W34 Population in CY 2015 = 5,067

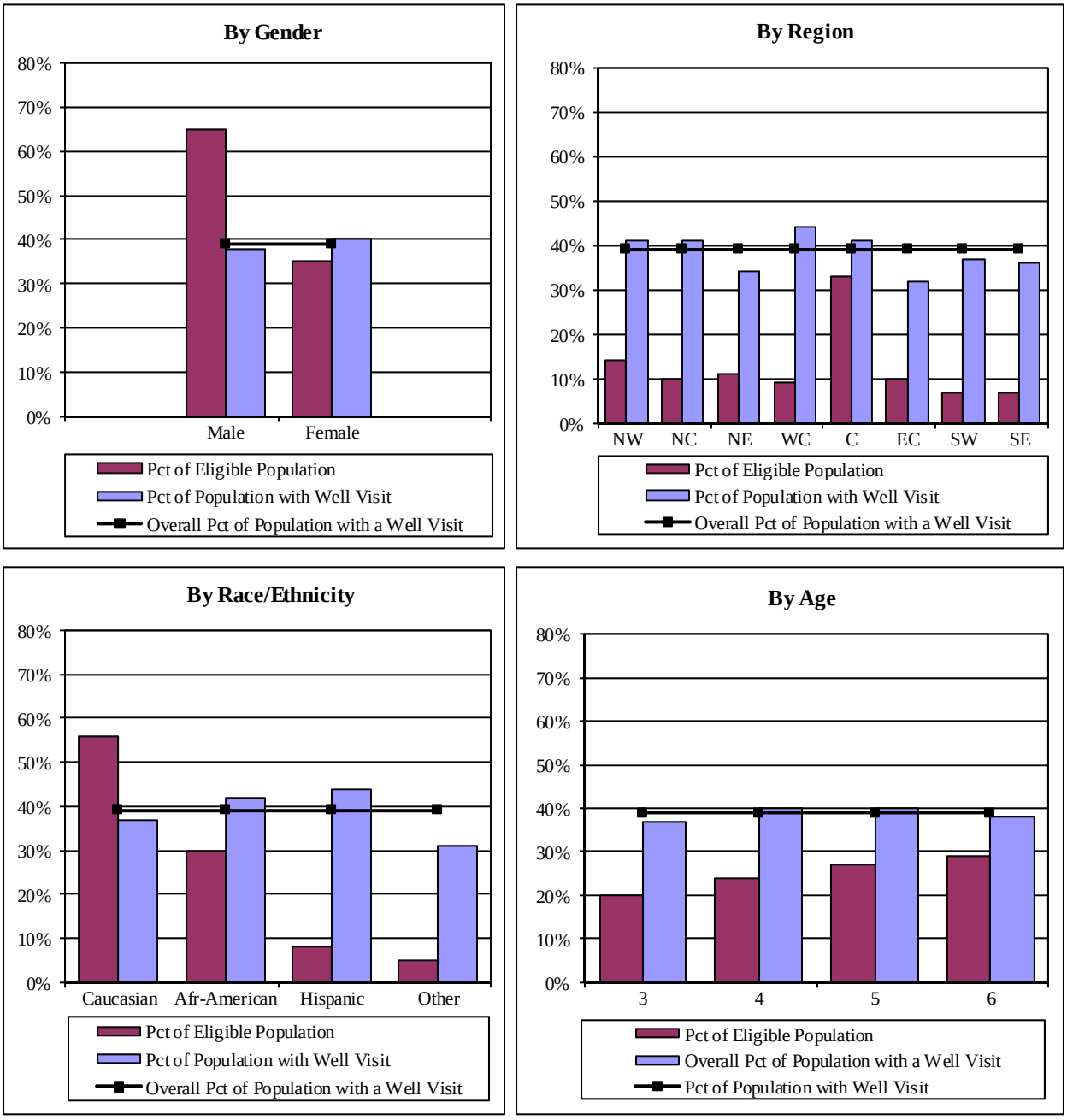


Exhibit X.9
Percent of Total Population and Well Child Users by Key Demographic Features, HEDIS AWC
Hoosier Healthwise Population
Total AWC Population in CY 2015 = 143,887

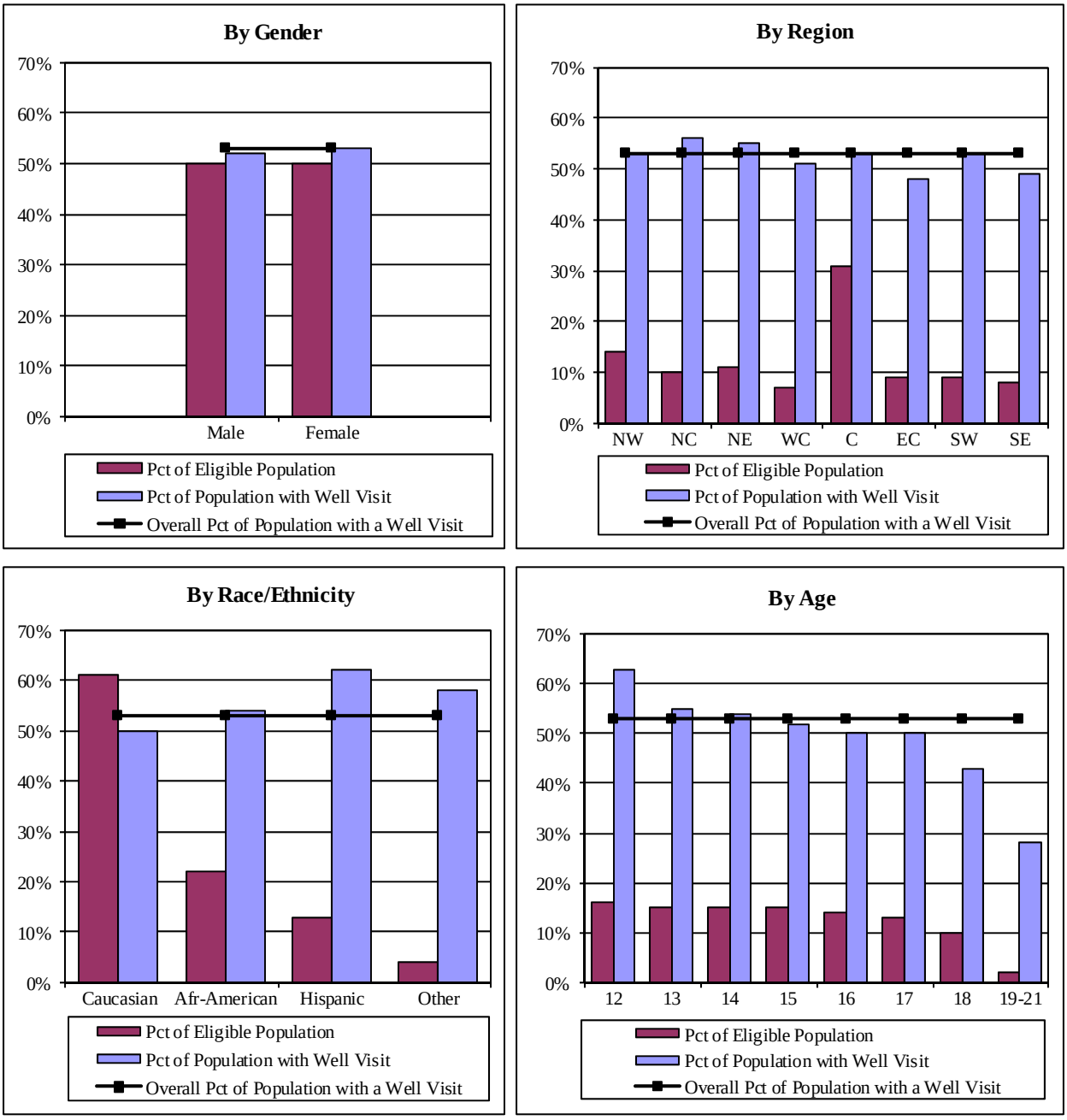


Exhibit X.10
Percent of Total Population and Well Child Users by Key Demographic Features, HEDIS AWC
Hoosier Care Connect Population
Total AWC Population in CY 2015 = 17,542

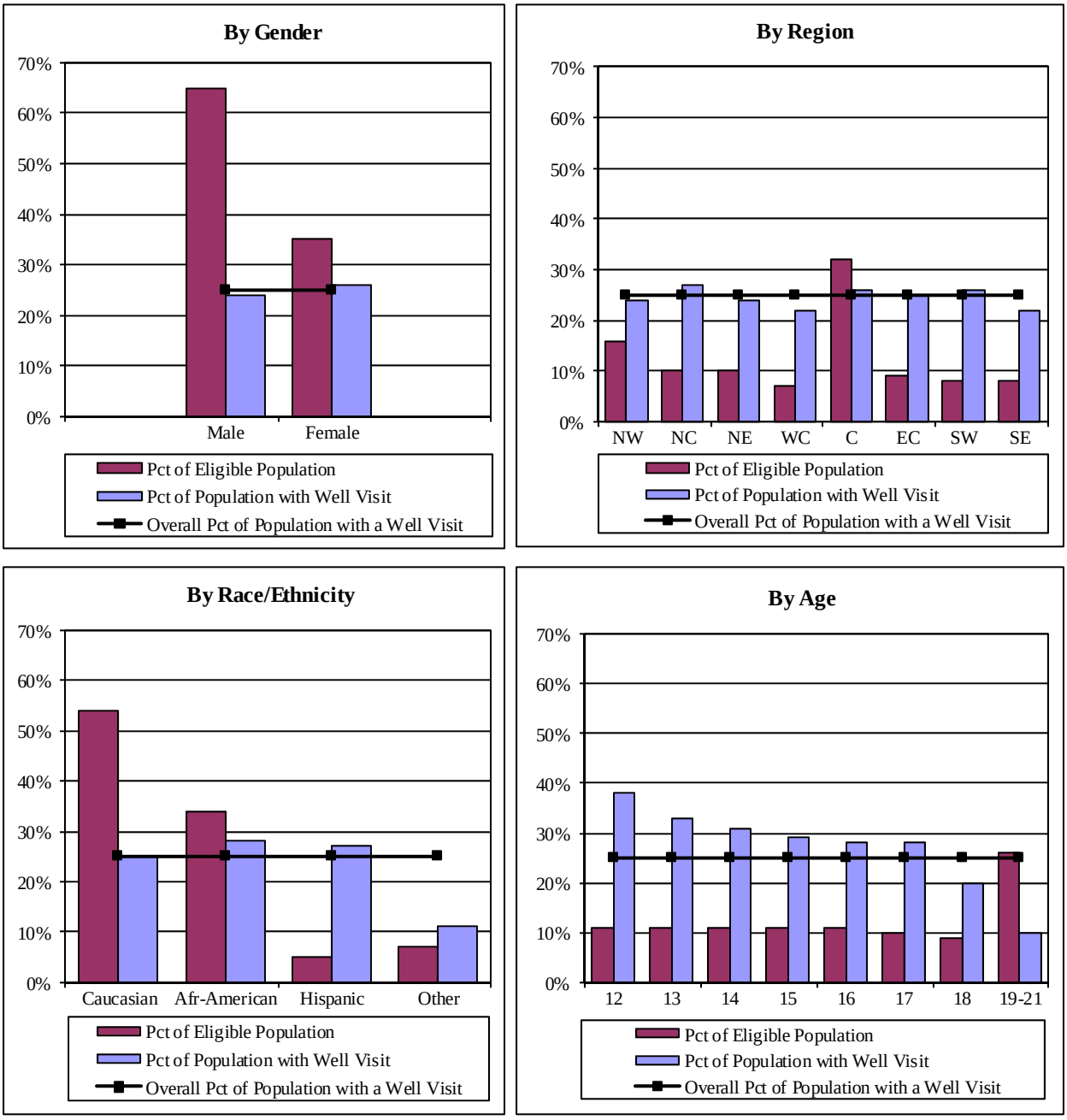
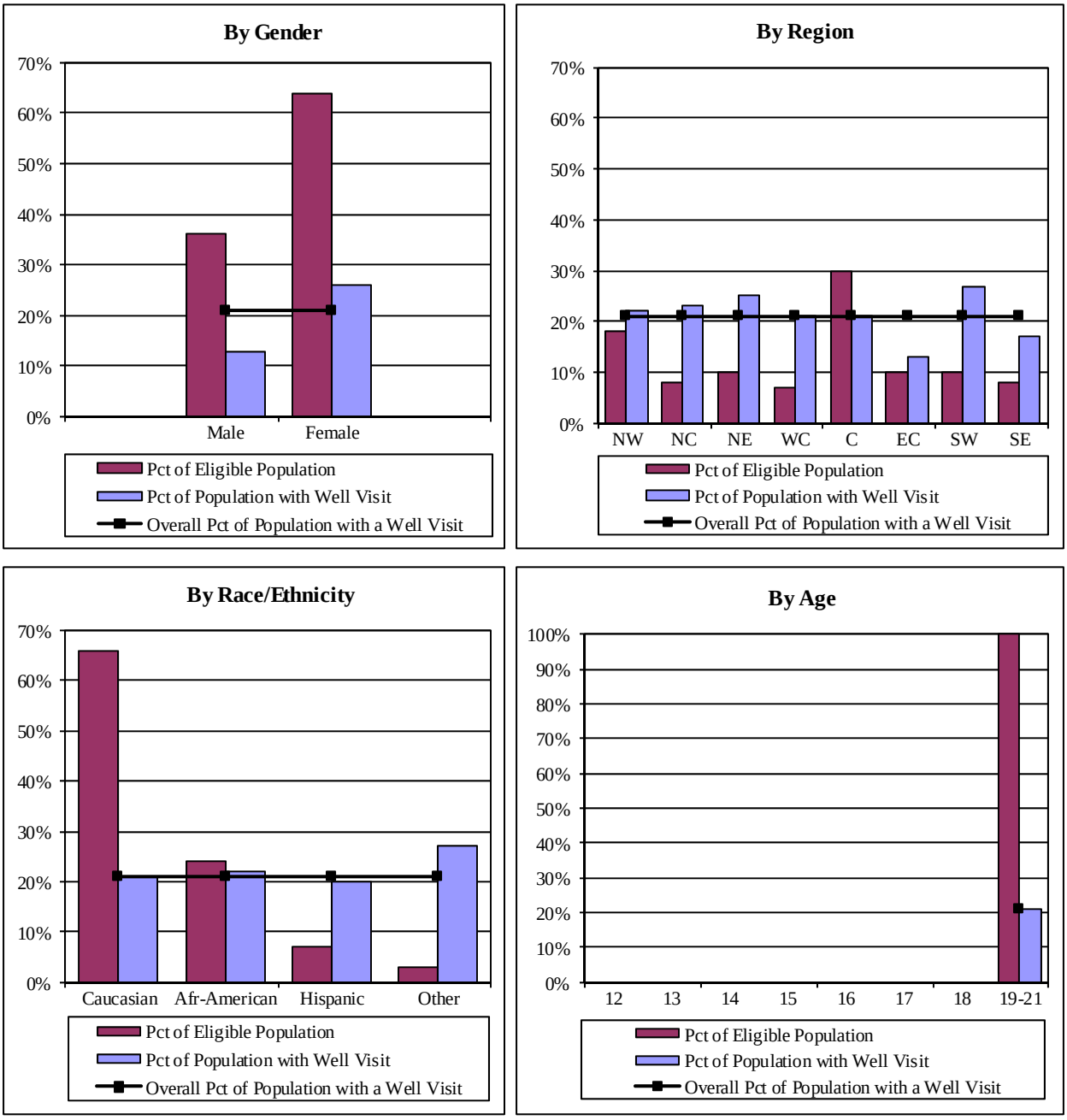


Exhibit X.11
Percent of Total Population and Well Child Users by Key Demographic Features, HEDIS AWC
HIP 2.0 Population
Total AWC Population in CY 2015 = 6,081



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

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

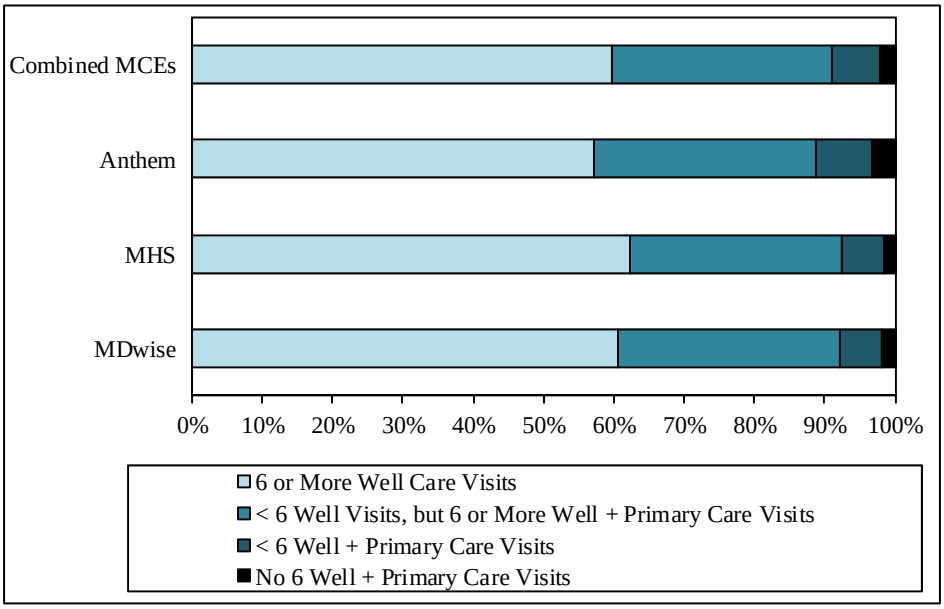
Exhibits X.12 – X.14 on the next pages examine the W15 population (Exhibit X.12), the W34 population (Exhibit X.13) and the AWC population (Exhibit X.14) separately. The horizontal bars are arranged to show, from left to right, the percent of total children in the population who had a well care visit (lightest color) to the percent of children with neither a well care visit or a primary care visit during the study period (darkest color). The color(s) in the middle represent children who did not have a well care visit but did have a primary care visit.

Beginning with Exhibit X.12 on the next page, overall 60 percent of children had a well care visit and only two percent had neither a well care nor a primary care visit. The horizontal bars in Exhibit X.12 differ slightly from what is shown in Exhibits X.13 and X.14 due to the HEDIS requirement for W15. In the W15 measure, the threshold is six or more well care visits. Therefore, the lightest color bar (the 60%) represents children that had six or more well care visits. The next darkest color (31% of the total) represents children who had less than six well visits, but six or more visits in the study period when well care and primary care visits are combined. This was done to assess the total visit count in case there were situations where incomplete coding of a visit prevented it from being classified as a well care visit. The next darkest color (7% of the total) represents children who had some visits during the study period, but less than six when considering well care and primary care visits together.

In reviewing each MCE's population against the statewide average, Anthem children are slightly less likely to have had well care visits than the combined MCE average, MHS children are more likely, and MDwise was at the combined MCE average. No MCE had more than three percent of children with no well care or primary care visits reported.

Exhibit X.12
Utilization of Well Care and Primary Care Among HEDIS W15 Population

Hoosier Healthwise



	Number of Children (n=31,258)			
	6 or More Well Care Visits	**< 6 Well Visits, but 6 or More Well + Primary Care Visits**	**< 6 Well + Primary Care Visits**	**No 6 Well + Primary Care Visits**
Combined MCEs	18,688	9,788	2,075	707
Anthem	6,261	3,464	864	351
MHS	4,824	2,346	457	119
MDwise	7,603	3,978	754	237

Combined MCEs	60%	31%	7%	2%
Anthem	57%	32%	8%	3%
MHS	62%	30%	6%	2%
MDwise	60%	32%	6%	2%

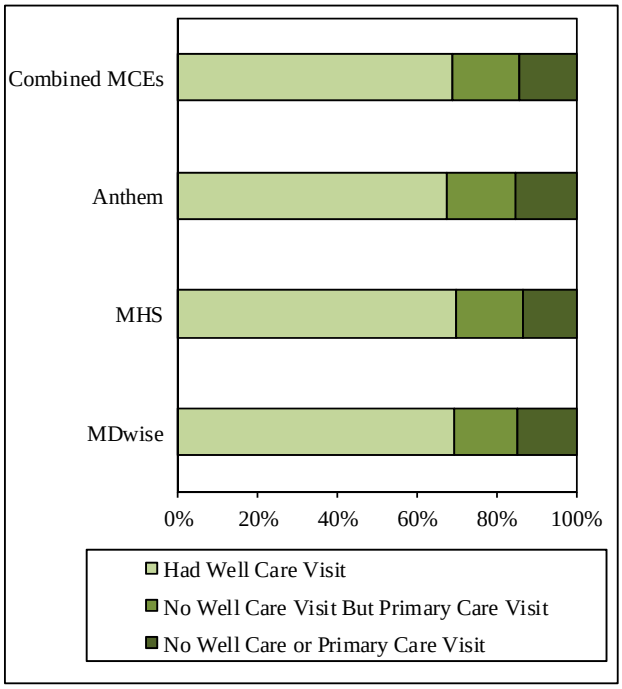
On the next page, similar results are presented for the W34 population in both HHW and HCC in Exhibit X.13. In this exhibit, a member could have both a well care visit and a primary care visit. When this occurs, the child is included only in the "had well care visit" group.

Children in HHW are much more likely to have had a well care visit (69%) than their peers in HCC (39%). Another 17 percent of children in HHW had a primary care visit during the year that was not a well care visit. In HCC, this percentage was 34 percent. The rate of children with neither a well care nor a primary care visit was 14 percent in HHW and 27 percent in HCC.

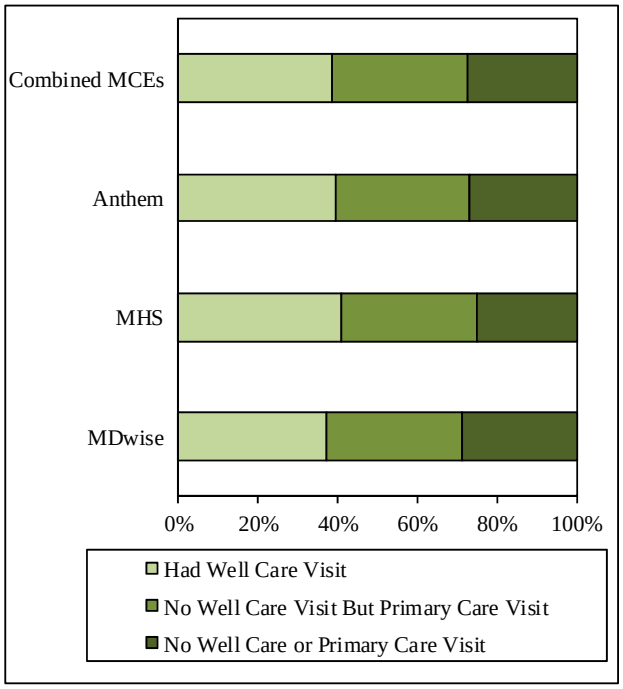
At the MCE level, Anthem's W34 children in HHW are slightly less likely to have had a well care visit than children in the other MCEs. MDwise's W34 children in HCC are slightly less likely to have had a well care visit than children in the other MCEs.

Exhibit X.13
Utilization of Well Care and Primary Care Among HEDIS W34 Population

Hoosier Healthwise



Hoosier Care Connect



	Number of Children (n=107,763)		
	Had Well Care Visit	**No Well Care Visit But Primary Care Visit**	**No Well Care or Primary Care Visit**
Combined MCEs	74,346	17,867	15,550
Anthem	22,797	5,911	5,077
MHS	20,784	5,066	3,926
MDwise	30,765	6,890	6,547
Combined MCEs	69%	17%	14%
Anthem	67%	17%	15%
MHS	70%	17%	13%
MDwise	70%	16%	15%

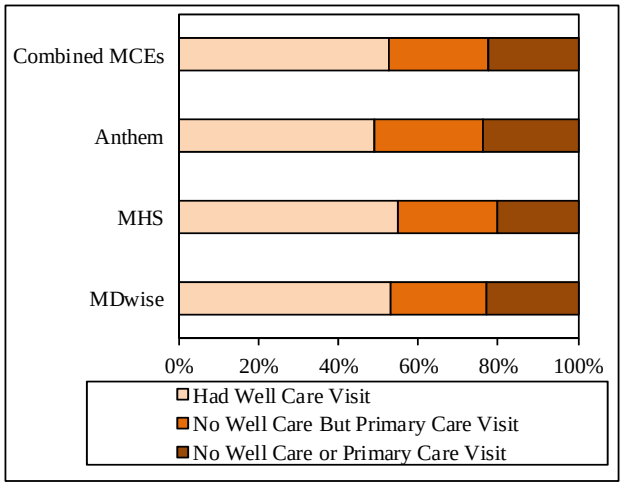
	Number of Children (n=5,067)		
	Had Well Care Visit	**No Well Care Visit But Primary Care Visit**	**No Well Care or Primary Care Visit**
Combined MCEs	1,965	1,726	1,376
Anthem	631	542	428
MHS	521	429	318
MDwise	813	755	630
Combined MCEs	39%	34%	27%
Anthem	39%	34%	27%
MHS	41%	34%	25%
MDwise	37%	34%	29%

Exhibit X.14 on the next page presents the results for AWC in the HHW, HCC and HIP programs. The HHW and HCC results are shown side-by-side at the top. These two programs are most comparable since they both contain children in the age ranges of 12 through 18. The HIP results at the bottom of the exhibit represent only members age 19 through 21.

The large difference in the percentage of members with a well care visit in HHW (53% overall) compared to HCC (25% overall) is similar to what was seen in the prior exhibit among the W34 population. The percentage of HIP AWC members with a well care visit is even lower (21% overall). The percentage of members with neither a well care nor a primary care visit was 23 percent overall for HHW members, 41 percent overall for HCC members, and 36 percent overall for HIP members.

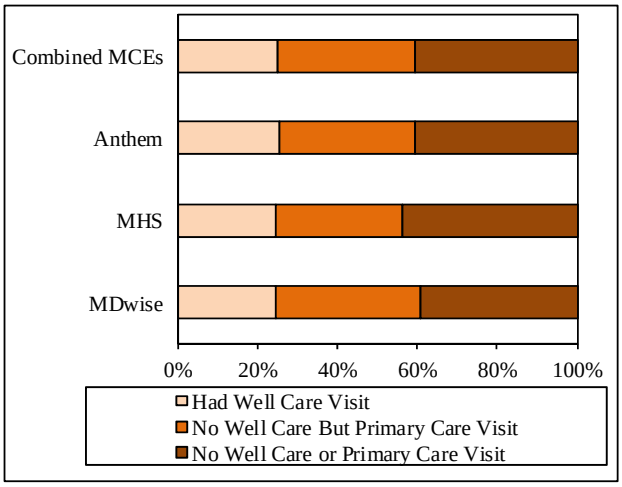
Exhibit X.14
Utilization of Well Care and Primary Care Among HEDIS AWC Population

Hoosier Healthwise



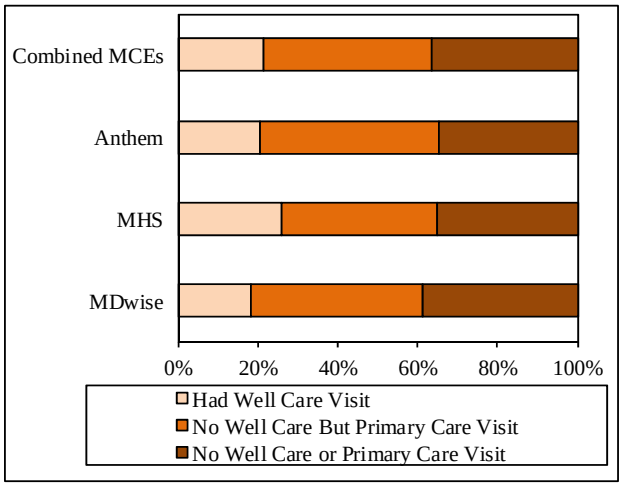
	Number of Adolescents (n=143,887)		
	Had Well Care Visit	**No Well Care But Primary Care Visit**	**No Well Care or Primary Care Visit**
Combined MCEs	75,656	35,806	32,425
Anthem	21,082	11,449	10,240
MHS	23,236	10,320	8,575
MDwise	31,338	14,037	13,610

Hoosier Care Connect



	Number of Adolescents (n=17,542)		
	Had Well Care Visit	**No Well Care But Primary Care Visit**	**No Well Care or Primary Care Visit**
Combined MCEs	4,375	6,055	7,112
Anthem	1,409	1,861	2,209
MHS	1,024	1,301	1,807
MDwise	1,942	2,893	3,096

Healthy Indiana Plan 2.0



	Number of Adolescents (n=6,081)		
	Had Well Care Visit	**No Well Care But Primary Care Visit**	**No Well Care or Primary Care Visit**
Combined MCEs	1,291	2,580	2,210
Anthem	456	979	765
MHS	417	632	565
MDwise	418	969	880

Investigation of Members with Neither a Well Care Nor a Primary Care Visit

Exhibits X.15 through X.20 are presented in a manner resembling Exhibits X.6 through X.11. In the earlier exhibits, subgroups of members were examined to determine the rate of well care visits across the subgroups when compared to the overall average. In Exhibits X.15 through X.20, a similar analysis was completed, but in these exhibits the comparative statistic is the percentage of members with neither a well care nor a primary care visit compared to the overall average of their peers. The exhibits are once again constructed so that variations in the percent of members can be easily discerned when examined by gender, by region, by race/ethnicity, or by age. The exhibits are further broken out in population cohorts by HEDIS population and OMPP program as follows:

- Exhibit X.15 examines the W15 population in HHW
- Exhibit X.16 examines the W34 population in HHW
- Exhibit X.17 examines the W34 population in HCC
- Exhibit X.18 examines the AWC population in HHW
- Exhibit X.19 examines the AWC population in HCC
- Exhibit X.20 examines the AWC population in HIP

A summary of all of these exhibits which focuses on populations which have a greater percentage of no visits than their peers is listed below.

- Among the W15 population in HHW (Exhibit X.15), the percentage of children with neither well care nor primary visits was 2.3 percent overall. When examining all of the subpopulations, there is no group of children with a rate above 2.9 percent except the children in the Southeast Region (4.5%).

- Among the W34 population in HHW (Exhibit X.16), the percentage of children with neither well care nor primary visits was 14 percent overall. The only subpopulation that deviated more than two percentage points from the overall average was African-American children at 18 percent.

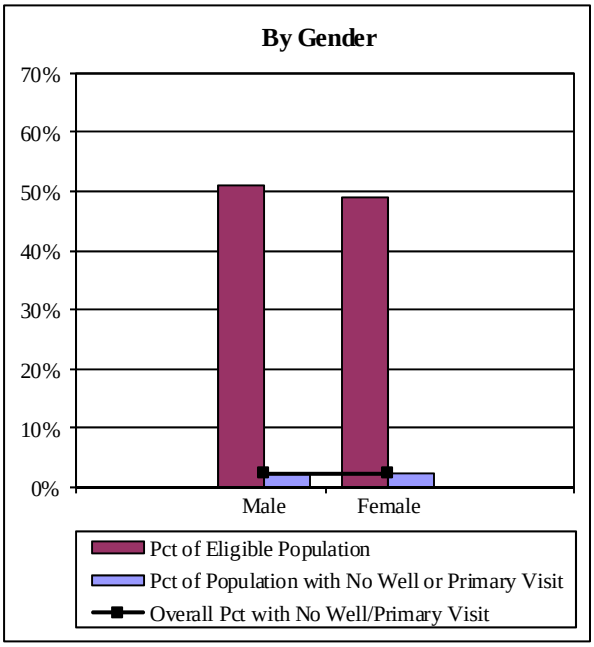
- Among the W34 population in HCC (Exhibit X.17), the percentage of children with neither well care nor primary visits was 27 percent overall. The subpopulation with the most significant variation from this average was once again African-Americans at 34 percent. The Northwest and Northeast Regions had averages of 35 and 32 percent, respectively, but the sample subpopulations in these regions were only 550 to 700 members.

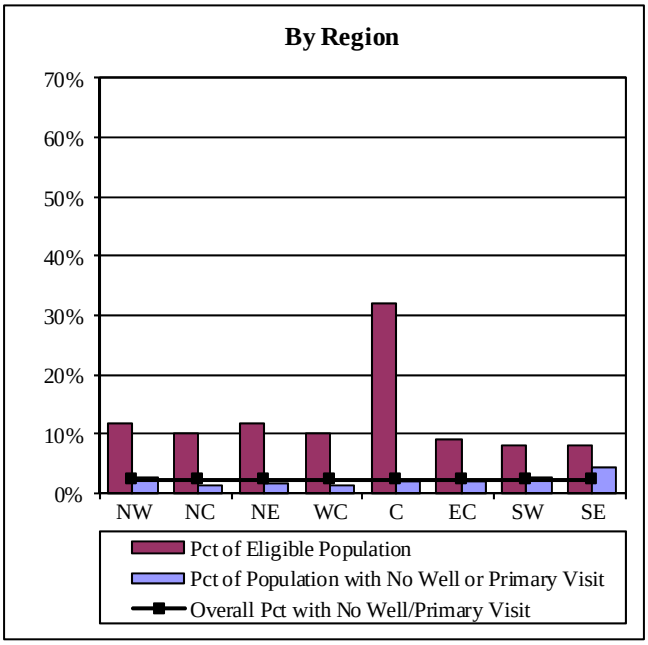
- Among the AWC population in HHW (Exhibit X.18), the percentage of children with neither well care nor primary visits was 23 percent overall. Most subpopulations were within three percentage points of this average. The exceptions were the Southwest Region at 18 percent and African-American adolescents and members age 19-21 (all race/ethnicities) at 29 percent.

- Among the AWC population in HHC (Exhibit X.19), the trend among African-American members continued as having a higher rate of no visits than the overall average. Similarly, members age 19-21 had a much higher rate of non-use. Members in the Northwest Region also had a higher rate of non-use (47%) compared to the overall average (41%).

- Among the AWC population in HIP (Exhibit X.20), males had a much higher rate of non-use of services (52%) than females (27%). Caucasians had a lower non-use rate (33%) than African-Americans (42%) and Hispanics (44%). Regional differences may be largely due to the low sample size of this population (the total n= 6,081).

Exhibit X.15
Percent of Total Population and No Well or Primary Care Users by Key Demographic Features, HEDIS W15
Hoosier Healthwise Population
Total W15 Population in CY 2015 = 31,258





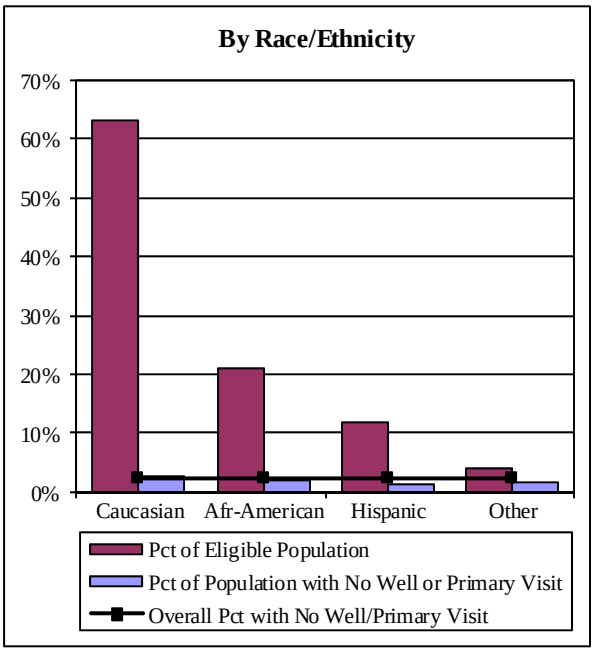


Exhibit X.16
Percent of Total Population and No Well or Primary Care Users by Key Demographic Features, HEDIS W34
Hoosier Healthwise Population
Total W34 Population in CY 2015 = 107,763

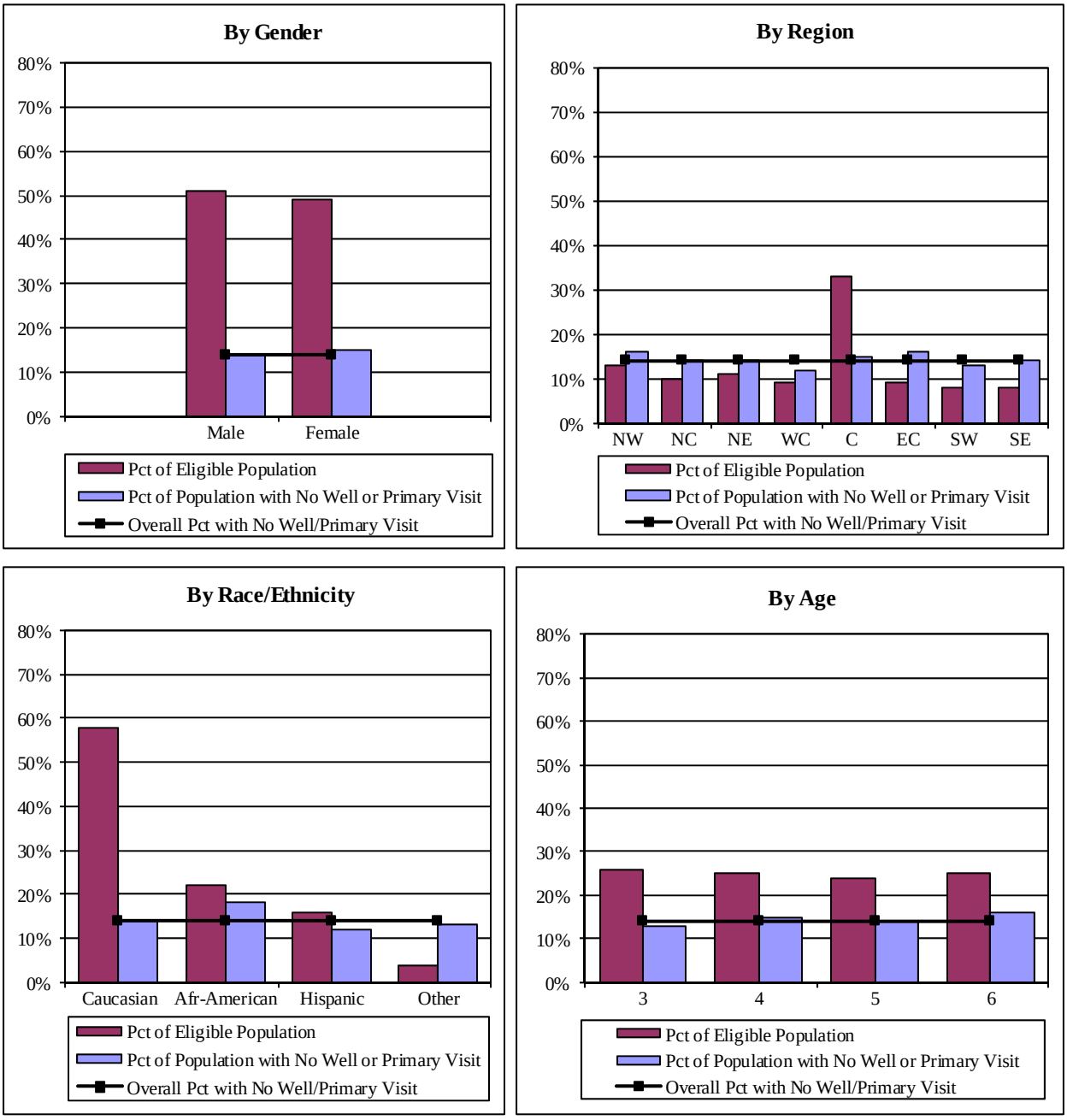


Exhibit X.17
Percent of Total Population and No Well or Primary Care Users by Key Demographic Features, HEDIS W34
Hoosier Care Connect Population
Total W34 Population in CY 2015 = 5,067

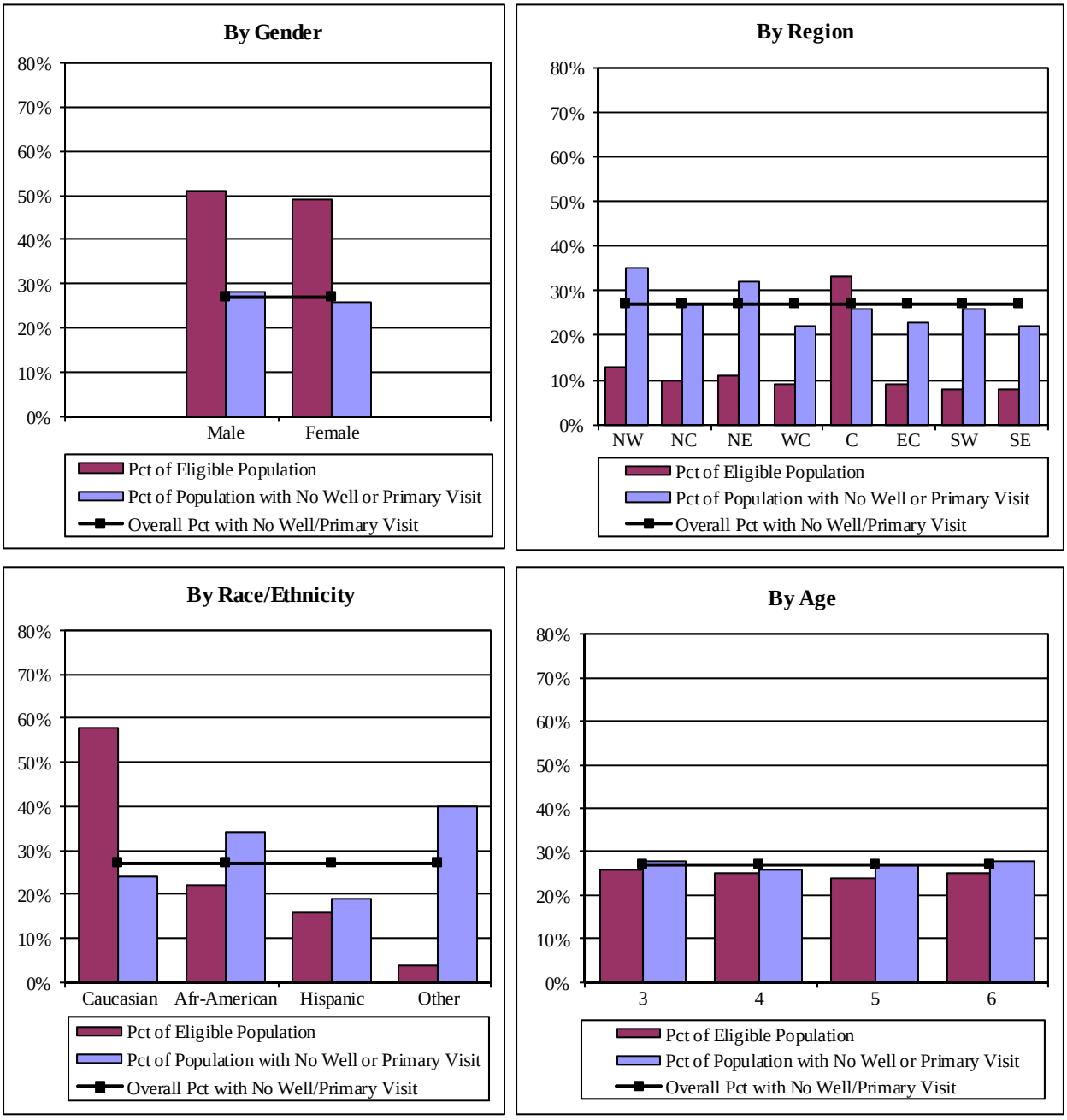


Exhibit X.18
Percent of Total Population and No Well or Primary Care Users by Key Demographic Features, HEDIS AWC
Hoosier Healthwise Population
Total AWC Population in CY 2015 = 143,887

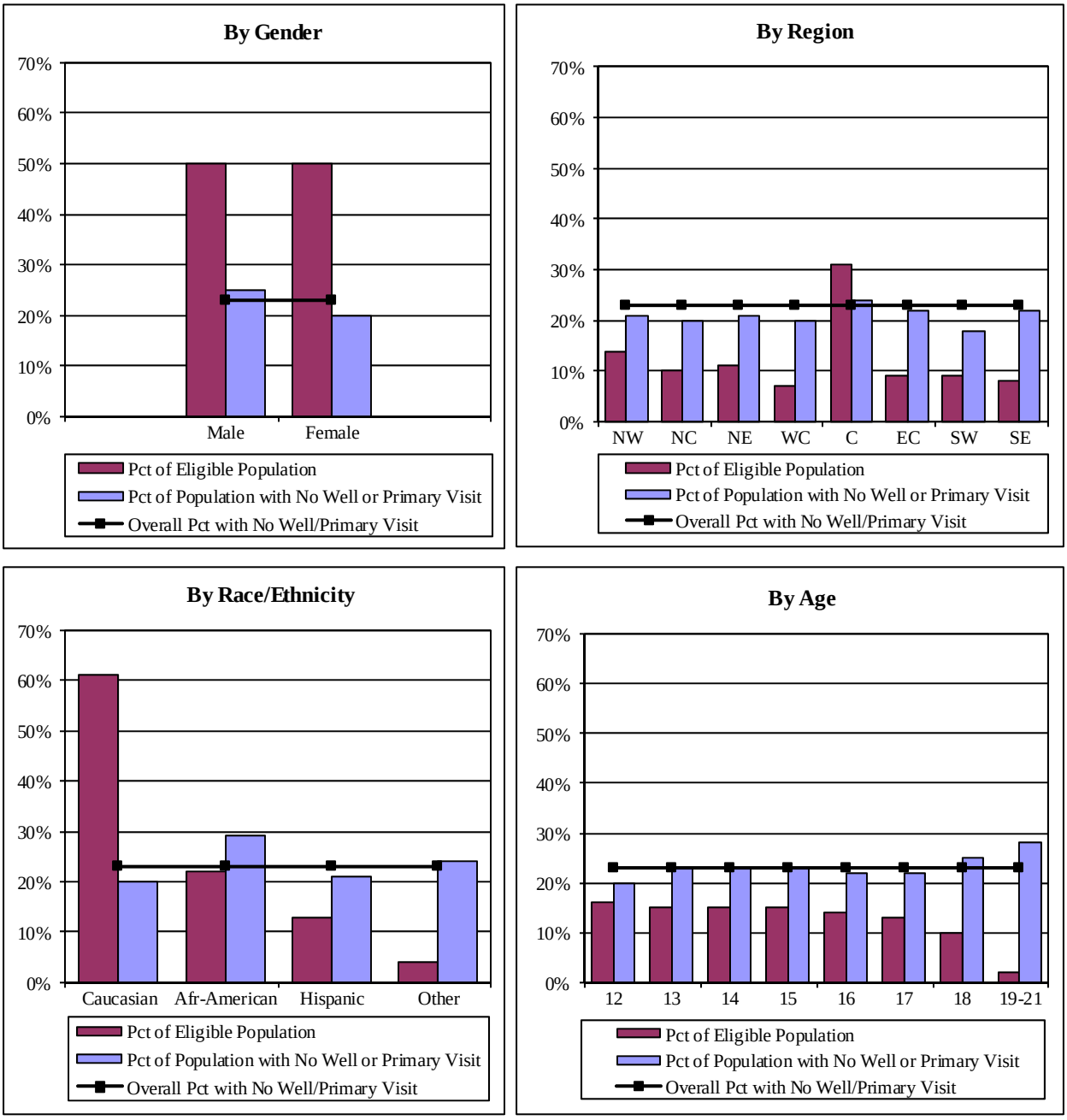


Exhibit X.19
Percent of Total Population and No Well or Primary Care Users by Key Demographic Features, HEDIS AWC
Hoosier Care Connect Population
Total AWC Population in CY 2015 = 17,542

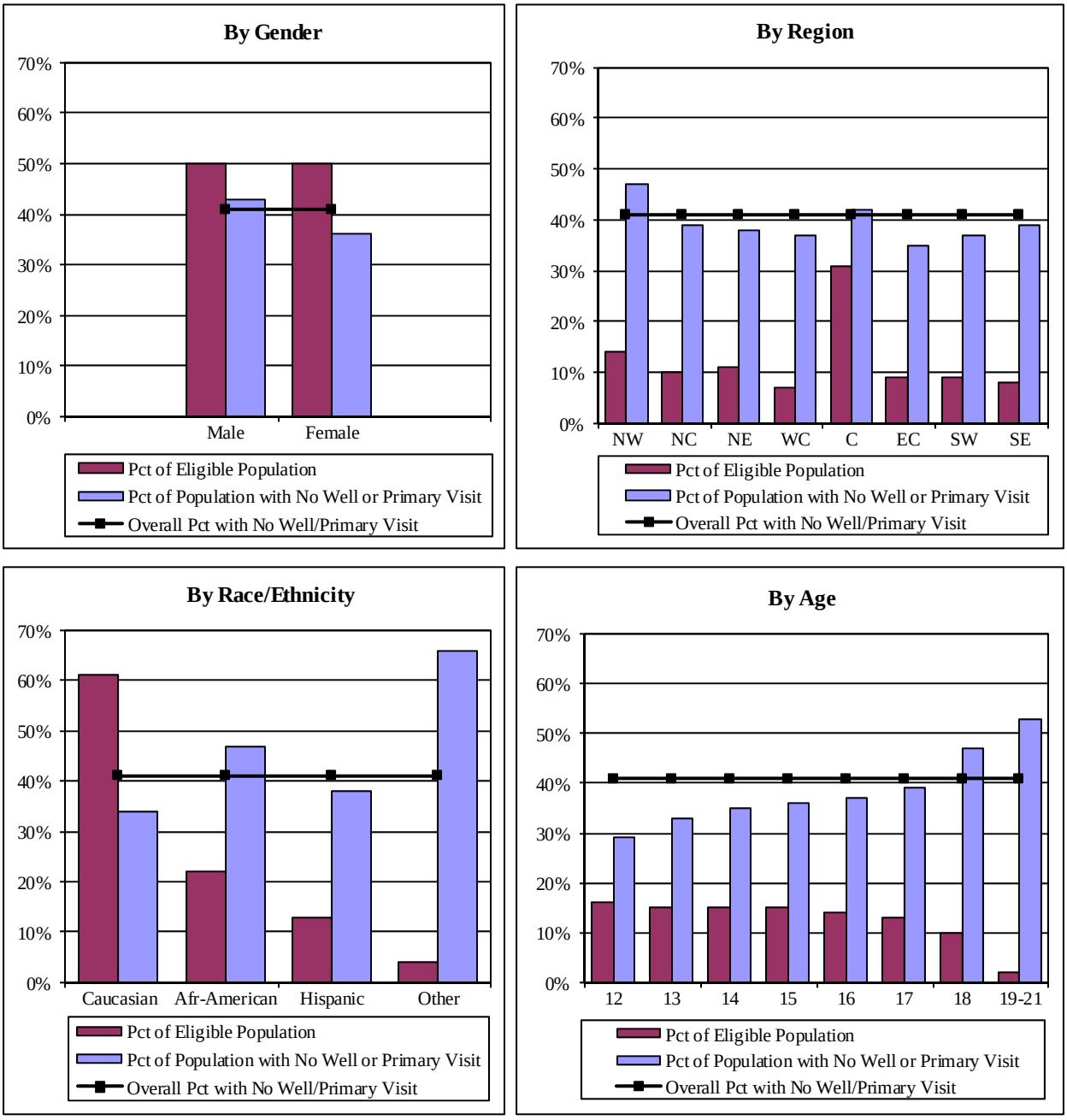
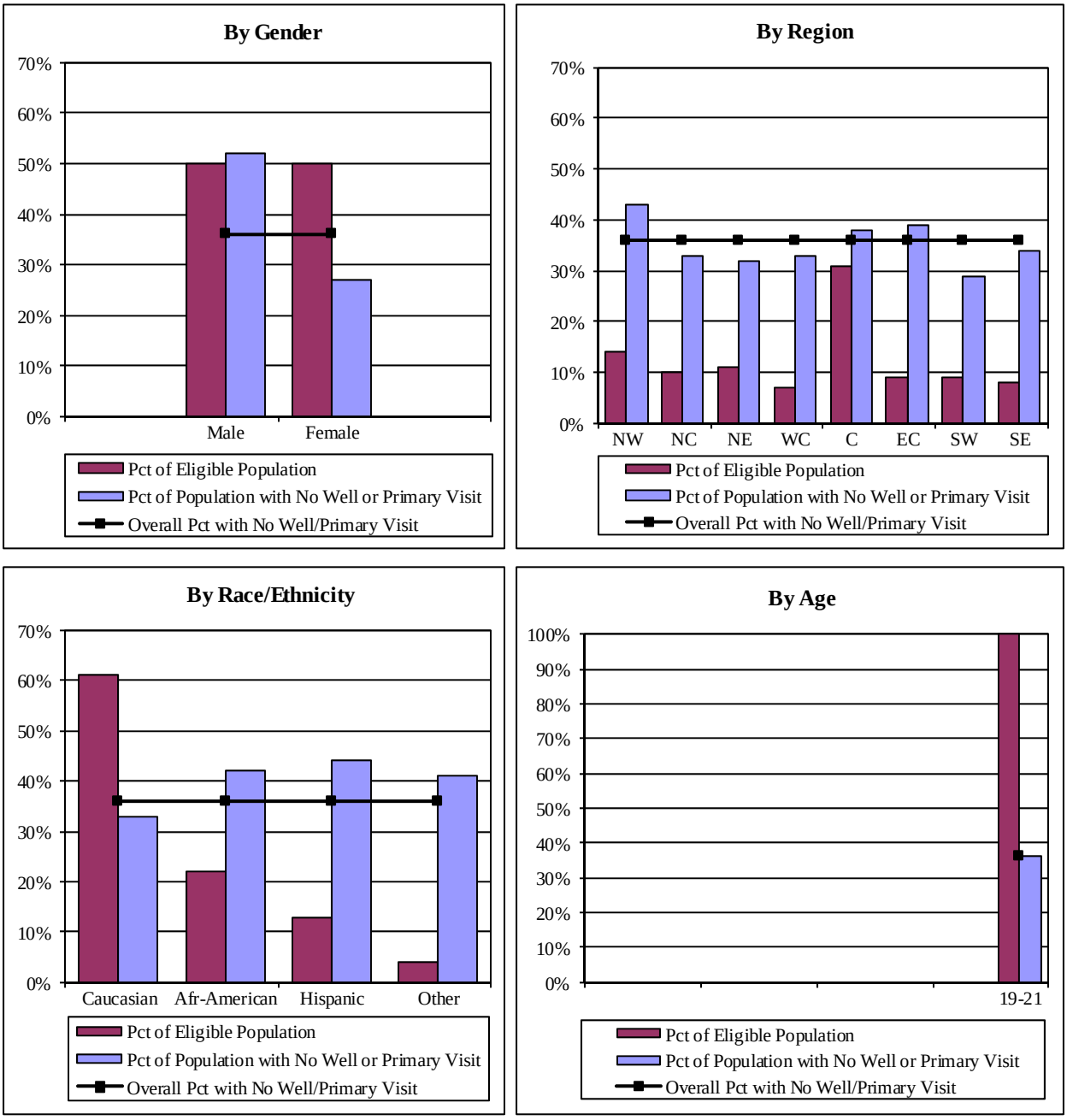


Exhibit X.20
Percent of Total Population and No Well or Primary Care Users by Key Demographic Features, HEDIS AWC
HIP 2.0 Population
Total AWC Population in CY 2015 = 6,081



MCE Initiatives Related to Promoting Well Care Services to Children

As part of the EQR, B&A requested documents from the MCEs related to the delivery of well care services or primary care services to children to better inform our study. Specifically, we requested examples of relevant internal policies or procedures, communications or guidance distributed to providers, and communications or guidance distributed to members. A summary of B&A's desk review of the information provided appears below.

Policies and Procedures

All three MCEs supplied policy and procedure documents that were targeted to their internal staff that address issues related to preventive services for children. Many of these procedures described goals of ensuring that members receive recommended Early Periodic Screening, Diagnosis and Treatment (EPSDT) services. Anthem and MHS specifically offered examples of interventions targeted at increasing EPSDT service utilization.

Anthem has an innovative program titled *Blue Ticket to Health Program*. This program is aimed at ensuring members stay healthy and includes a partnership with the Indianapolis Colts professional football team. In order to participate, members are required to schedule and complete checkups with their primary medical providers (PMPs). The PMPs sign or stamp a brochure which indicates that the visit was completed. Members return the brochures (which have prepaid postage) and are entered into a raffle to win prizes supplied by the Colts organization. Prizes include items such as tours of the stadium, autographed jerseys, or VIP admittance to training camp.

MHS has developed a program called *Healthy Celebration*. This is a program targeted to increase the number of members who receive needed preventive care. This program works in partnership with a PMP office. The PMP office recommends members who need preventive care and then determines a specific day and time for these members to visit the office and receive specialty visits and screenings such as ESPDT well visits. MHS staff bring supplies to create a celebratory atmosphere during the appointment times for the entire family. The celebration includes games, prizes and refreshments following the physician visit. Additionally, each MHS member receives a goody bag of information, giveaways and a healthy snack. MHS staff perform outreach to members to notify them of the appointment and schedule any required transportation. MHS staff place reminder calls and send appointment postcards to help with attendance.

Communication or Guidance to Providers

Each of the MCEs supplied information to B&A that described the P4O program offered by the OMPP. In turn, each MCE has a program to share P4O dollars earned with their providers.

Anthem maintains a provider score card which is provider-specific and allows physicians to view their panel size and their current rate on measures that are a part of the P4O program. The score card includes the current year calculated measure, prior year rate, health plan average, and target rate. Additionally, Anthem has produced a guide titled "HEDIS® Benchmarks and Coding Guidelines for Quality Care". This guide describes the purpose of the HEDIS measure, how it is calculated, and a listing of CPT, HCPCS and diagnosis codes that are applicable to the described service. A listing of tips is included to assist providers in encouraging members in their panel to receive the recommended preventive care.

MHS produces a document titled "P4P HEDIS Pocket Guide". The front side of this document includes the HEDIS measure name, a description of the measure, documentation requirements and the applicable

program (HHW, HCC or HIP). The back side includes specific guidelines related to each referenced measure and in some instances appropriate CPT and diagnosis codes. MHS has created a PowerPoint slide deck to utilize in reviewing EPSDT results with a provider practice. This presentation includes general information related to preventive care for children as well as a place-holder to include provider specific results.

MDwise provides a process to allow PMPs to access certain information specific to their panels through a web portal. Prior to use, the practice must complete an enrollment process and be approved to view quality progress reports. After being granted access, the practice is able to view lists of members in need of services. Additionally, providers can view their current performance measures on a report titled "HEDIS Comparison Report". This report includes the calculated performance measure for each of the individual providers in a practice and includes the MDwise plan total performance. MDwise also produces a guide titled "How to Code Well-Care Visits for Children and Adolescents." This booklet contains information on coding and includes CPT and diagnosis codes that may be used in submitting claims for this service.

Communication or Guidance to Members or their Parents

Each of the MCEs provided a number of documents targeted to members and families related to various preventive health topics. Each of the MCEs has a member incentive program. A brief description of each of the programs is included below.

Anthem's rewards program is based on members receiving annual checkups. Members may receive a $50 gift card after receiving their checkup. In order to receive the reward, the member must receive the checkup during a specified timeframe and have the PMP sign/stamp a Well Child Visit Brochure indicating that the visit was complete. Anthem sends the $50 gift card to the address supplied by the member following receipt of member notification.

Other examples of member communications that Anthem conducts include:

- "Happy healthy birthday!" – Communication sent to members that wishes them a happy birthday and reminds them of the need for an annual visit with their medical provider.
- Age Specific Checkup Reminders – Communications sent to members informing them that new members should make an appointment with their provider soon after becoming a new member.

MHS administers a rewards program titled "CentAccount Rewards". Members receive pre-paid gift cards for completing new member screenings, infant well care visits, and annual well care visits. The program works by awarding members a prepaid gift card that is accepted at select stores and can be used to buy items such as groceries, baby and personal items, and over the counter medicine.

In addition to information on the incentive program, MHS sends information such as a newsletter to members promoting healthy behaviors.

Other examples of member communications that MHS conducts include:

- Checkup reminders – Reminders sent to families of infants prior to each of the six recommended visits for children in their first 15 months of life.
- Wellness Newsletter – Newsletter includes both the routine check-up schedule for children, recommended immunizations for children and adults, and promotion of community events such as healthy lifestyle events and member baby showers.

MDwise has a member reward program titled "MDwise Rewards". This program awards points for completing healthy activities such as receiving well-child exams. Members have the opportunity to earn points which can be redeemed for gift cards at a variety of stores. The maximum value of the reward cards that any member can receive in a year is $50.

Other examples of member communications that MDwise conducts include:

- Checkup reminders – Postcard sent to members including a listing of all recommended checkups for children from the age of newborn through teens.
- Wellness Newsletter – Newsletter includes both the routine check-up schedule for children and a schedule of recommended immunizations.

Recommendations

In general, the findings reported on the rates of well care visits and primary care visits were found to be similar for the W15, W34 and AWC populations when measured across the MCEs. This held true across the three Indiana health coverage programs as well (HHW, HCC and HIP). There were differences, however, in the rate of well care visits and primary care visits for subgroups within the study population. The recommendations provided below, therefore, are being made to all three MCEs regarding these subgroups within the study.

1. The percentage of infants in HHW with no well care or primary care visits reported was in the two to three percent range for all MCEs. Although this is a low percentage overall, it is anticipated that the percentage with no well care or primary care visits would be zero. Therefore, it is important to understand if these infants are in fact receiving and there are other circumstances which caused this finding. The MCEs are encouraged to conduct further analyses into this population (n= 707 in the full study) to better understand if the finding of no visits is a result of (a) the parameters of the study (e.g., limiting to E&M codes only and not clinic codes), (b) missing encounters from the OMPP data warehouse, (c) infants are still inpatients, or (d) other circumstances that would result in these children not having well care or primary care visits reported.

2. African-American members in the W34 and AWC populations had a higher rate of no well care or primary care visits than their peers. The MCEs are encouraged to further analyze if this is simply a reporting issue or, in fact, a concern about lower utilization. If the latter, the MCEs should consider targeted outreach strategies to this subpopulation to increase the rates of well care and primary care visits.

3. The well care visit rate is much lower among males in the AWC HIP population than females. Conversely, males have a much higher rate of non-well care and non-primary care use than females. The MCEs may want to consider targeted outreach to the 19 to 21 year old population in general and males in this population more specifically.