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

Due date	Last edited	Edited by	Status
09/27/2023	05/06/2024	Cinthia Gonzales Cruz	Submitted

Indicator	Response
Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Indiana
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Cinthia Gonzales
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	cinthia.gonzalescruz@fssa.in.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Cinthia Gonzales Cruz
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	cinthia.gonzalescruz@fssa.in.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	05/06/2024

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	04/01/2022
A5b	**Reporting period end date** Auto-populated from report dashboard.	03/31/2023
A6	**Program name** Auto-populated from report dashboard.	Hoosier Care Connect

Add plans (A.7)

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

	Indicator	Response
	Plan name	Anthem United Healthcare Managed Health Services

Add BSS entities (A.8)

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

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

Indicator	Response
BSS entity name	Maximus Heath Services, Inc

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled.	2,247,432
BI.2	**Statewide Medicaid managed care enrollment** Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or more than one managed care plan.	1,812,323

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	State actuaries EQRO Other third-party vendor

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities.	The State and our MCE SIU partners underwent a focused CMS audit on our activities (Summer and early Fall of 2022). The audit assessed the state's compliance with 42 CFR Part 438, Subpart H, for FY 2019-2021. As a result, CMS identified fourteen findings that create risk to the Indiana Medicaid program related to managed care program integrity oversight. Indiana is currently developing an action plan for CMS. Additionally, the state's PI team has been focusing on member eligibility verification based upon feedback we received in our exit interview. Additionally, with the state adopting a new MLTSS model, LTSS services have been under focus.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Scope of Work Section 7.4 "Program Integrity Overpayment Recovery" (page 156)
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether	In cases involving wasteful or abusive provider billing or service practices, including overpayments, identified by the OMPP PI Section, OMPP may recover any identified overpayment directly from the provider or may

	the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	require Contractor to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by the OMPP PI Section. The OMPP PI Section may also take disciplinary action against any provider identified by Contractor or the OMPP PI Section as engaging in inappropriate or abusive billing or service provision practices. If the fraud referral from the MCE generates an action that results in a monetary recovery, the reporting MCE does get a share of the final monetary amount (the contracts allow for the State and MFCU to retrain the cost of pursuing the final action)
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	The MCEs submit monthly, quarterly, and yearly reports that detail the ongoing activities and status on overpayments. Additionally, members of the PI staff meet with each MCE monthly to discuss ongoing activities.

BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	The Contractor shall be responsible for verifying member eligibility data and reconciling with capitation payments for each eligible member. The Contractor shall reconcile its eligibility and capitation records monthly. If the Contractor receives either enrollment information or capitation, the Contractor is financially responsible for the member. In accordance with 42 CFR 438.608(c)(3), if the Contractor discovers a discrepancy in eligibility or capitation information, the Contractor must notify FSSA and the State fiscal agent within thirty (30) calendar days of discovering the discrepancy and no more than ninety (90) calendar days after FSSA delivers the eligibility records. The Contractor must return any capitation overpayments to FSSA within forty-five (45) calendar days of discovering the discrepancy. If the Contractor receives either enrollment information or capitation for a member, the Contractor is financially responsible for the member. The Contractor must accept enrollment data in electronic format, currently via secure file transfer protocol ("FTP"), as directed by FSSA and as detailed in the Indiana Health Coverage Program Companion Guide – 834 Contractor Benefit Enrollment and Maintenance Transaction ("834 Companion Guide), which shall be updated by FSSA.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes

BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	No
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy,	The state did not conduct any audits during the contract year, 2022, to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the

truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	plans. The most recent encounter data audit in CY 2020, focused on claims adjudication timeliness as well as encounter timeliness and completeness. (https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/) . The next encounter data audit will be completed during CY 2023. During CY 2022, Indiana's independent evaluator, Qsource, conducted an audit of the MCEs' claims and encounter systems. Qsource found that all MCEs were capable of reporting measures and had the capacity to produce accurate and complete encounter data. (https://www.in.gov/fssa/ompp/files/OMPP_Technical_Report_2022.pdf)

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Professional Services Contract
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	04/01/2021
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-	Behavioral health Dental Transportation

	service should not be listed here.	
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1I.5	**Program enrollment** Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	100,952
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	Enrollment increasing due to the COVID-19 PHE that did not allow Indiana to disenroll beneficiaries.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data corrections Overall data accuracy (as determined through data validation) Other, specify – Completeness of Encounter Claims Data
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract	8.6.3 Encounter Claims Quality

	section references, not page numbers.	
C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	Exhibit2: Encounter Data Quality Report
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	Exhibit 2: Incentive Payment Potential -During each measurement year, FSSA will withhold a portion of the approved capitation payments from Contractor. Contractor may be eligible to receive some or all of the withheld funds based on Contractor's performance. Exhibit 2: Non-Financial Incentives -FSSA may recognize managed care plan contractors that attain superior performance and/or improvement by publicizing their achievements.
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A- HCC does not cover LTSS.
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	The Contractor shall make a decision on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal.
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the	The Contractor shall resolve each expedited appeals within forty-eight (48) hours after the Contractor receives notice of the appeal.

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

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	The HCC MCEs experienced difficulty meeting the orthodontia, OB/GYN, home health, durable medical equipment requirements outlined in their contract. The shortage of orthodontia providers appears to be a statewide issue.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	Indiana provides MCEs with access to the IHCP Portal to find Medicaid providers in the geographic areas with a provider shortage. Every year, Gainwell, Indiana's financial vendor, develops a report for FSSA with provider deficiency areas. This report is a recruitment opportunity for FSSA to identify providers that are not currently participating in the Indiana Health Coverage Programs (IHCP). FSSA's provider relations team works with other IHCP stakeholders to increase provider participation, with the goal of enrolling new qualified providers in the IHCP, thus expanding the scope of providers available to meet the needs of Indiana's Medicaid population.

Access Measures

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

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

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

Access measure total count: 14

Complete

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

1 / 14

C2.V.2 Measure standard

The transport distance to a hospital from the member's home shall be the usual and customary, not to exceed thirty (30) miles

C2.V.3 Standard type

Maximum distance to travel

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

2 / 14

C2.V.2 Measure standard

The transport distance to a hospital from the member's home shall be the usual and customary, not to exceed sixty (60) miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

Hospital	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

3 / 14

C2.V.2 Measure standard

Regardless of if a PMP model is utilized, the Contractor must ensure the availability of a physician to serve as the ongoing source of care appropriate to the member's clinical condition within at least thirty (30) miles of the member's residence.

C2.V.3 Standard type

Maximum distance to travel

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

4 / 14

C2.V.2 Measure standard

Each PMP must be available to see members at least three (3) days per week for a minimum of twenty (20) hours per week at any combination of no more than two (2) locations

C2.V.3 Standard type

Hours of operation

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

5 / 14

C2.V.2 Measure standard

The Contractor must provide, at a minimum, two (2) specialty providers within sixty (60) miles of the member's residence : Anesthesiologists, Cardiologists, Endocrinologists, Gastroenterologists, General surgeons, Hematologists, Nephrologists, Neurologists, OB/GYNs, Occupational therapists, Oncologists, Ophthalmologists, Optometrists, Orthopedic surgeons, Orthopedists, Otolaryngologists, Physiatrists, Physical therapists, Podiatrists, Psychiatrists, Pulmonologists, Speech therapists, Urologists, Diagnostic testing

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

specialty care	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

The Contractor must provide, at a minimum, one specialty provider within ninety (90) miles of the member's residence: Prosthetic suppliers, Cardiothoracic surgeons, Dermatologists, Infectious disease specialists, Interventional radiologists, Neurosurgeons, Non-hospital-based anesthesiologist (e.g., pain medicine), Pathologists, Radiation oncologists, Rheumatologists

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
specialty care	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

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

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
medical equipment	county or contiguous county	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

C2.V.2 Measure standard

Two (2) home health providers must be available to provide services to the Contractor's members in each county or contiguous county

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
home health	all counties or contiguous counties	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

9 / 14

C2.V.2 Measure standard

The Contractor must provide at least one (1) behavioral health provider able to treat adults and children within thirty (30) minutes or thirty (30) miles from the member’s residence.

C2.V.3 Standard type

Minimum number of network providers

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

10 / 14

C2.V.2 Measure standard

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

C2.V.3 Standard type

Maximum distance to travel

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

11 / 14

C2.V.2 Measure standard

The Contractor must ensure the availability of an adult general dentistry provider and pediatric dentistry provider within thirty (30) miles of the member's residence.

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
dental care	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

12 / 14

C2.V.2 Measure standard

The Contractor shall affiliate or contract with urgent care clinics. Urgent care clinics shall be made available no less then eleven (11) hours each day Monday through Friday and no less than five (5) hours each day on the weekend.

C2.V.3 Standard type

Hours of operation

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
urgent care	statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

13 / 14

C2.V.2 Measure standard

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

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
pharmacy	all counties regardless of size	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

14 / 14

C2.V.2 Measure standard

The Contractor shall offer to enter into contracts with Indian health care providers participating in Medicaid.

C2.V.3 Standard type

Service fulfillment

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://www.in.gov/medicaid/partners/medicaid-partners/maximus/
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	The Contractor shall maintain and manage the existing Helplines for the Hoosier Care Connect program to address problems and answer questions that members and potential members have about the programs. The Contractor must staff the Helplines to provide sufficient “live voice” access to its members for, at a minimum, fifty-five (55) hours a week, Monday through Friday 8:00 AM to 7:00 PM, Eastern Time zone. The Helpline must offer language translation services for members whose primary language is not English. There must be at least 1 fluent Spanish speaker physically present (i.e., not via a language line) to answer calls during all “live” operating hours. The Contractor must provide members oral interpreter services, either through their own interpreters or telephone services. For example, the Contractor shall provide Telecommunications Device for the Deaf (TDD) services for hearing impaired members, oral interpreters and signers.
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals	N/A LTSS does not apply to HCC.

	or critical incident data? Refer to 42 CFR 438.71(d)(4).	
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	Oversight of Maximus is completed by a state official that serves as the contract manager. The contract manager ensures that Maximus is completing all the deliverables outlined in the contract and submits quarterly reports to leadership on Maximus' performance. Additionally, Maximus must submit monthly reports to the state, including a performance standard report. This report includes data on helpline performance, staff turnover, and timely reporting.

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	**Anthem** 60,632 **United Healthcare** 5,928 **Managed Health Services** 34,392
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Anthem** 2.7% **United Healthcare** 0.3% **Managed Health Services** 1.5%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Anthem** 3.3% **United Healthcare** 0.3% **Managed Health Services** 1.9%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	**Anthem** 93% **United Healthcare** 0% **Managed Health Services** 90%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Anthem** Program-specific statewide **United Healthcare** Other, specify – UHC did not onboard as an MCE for HCC until 2021. Given that the MLR lags 18 months, there is no MLR for HCC available at this time. **Managed Health Services** Program-specific statewide
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS	**Anthem** N/A **United Healthcare**

	or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	N/A **Managed Health Services** N/A
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Anthem** Yes **United Healthcare** No **Managed Health Services** Yes
N/A	Enter the start date.	**Anthem** 01/01/2019 **United Healthcare** Not applicable **Managed Health Services** 01/01/2019
N/A	Enter the end date.	**Anthem** 12/31/2019 **United Healthcare** Not applicable

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Anthem** The Contractor shall submit ninety eight percent (98%) of adjudicated claims within fourteen (14) calendar days of adjudication. The Contractor shall submit void/replacement claims within two (2) years from the date of service **United Healthcare** The Contractor shall submit ninety eight percent (98%) of adjudicated claims within fourteen (14) calendar days of adjudication. The Contractor shall submit void/replacement claims within two (2) years from the date of service **Managed Health Services** The Contractor shall submit ninety eight percent (98%) of adjudicated claims within fourteen (14) calendar days of adjudication. The Contractor shall submit void/replacement claims within two (2) years from the date of service
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file	**Anthem** 100% **United Healthcare** 100% **Managed Health Services**

	submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	100%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	**Anthem** N/A **United Healthcare** N/A **Managed Health Services** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved as of the first day of the last month of the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Anthem** 850 **United Healthcare** 99 **Managed Health Services** 574
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Anthem** 62 **United Healthcare** 5 **Managed Health Services** 557
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of	**Anthem** N/A **United Healthcare** N/A **Managed Health Services**

	whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	N/A
D1IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”. Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”. The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were	**Anthem** N/A **United Healthcare** N/A **Managed Health Services** N/A

filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Anthem** 867 **United Healthcare** 54 **Managed Health Services** 561
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Anthem** 78 **United Healthcare** 45 **Managed Health Services** 13
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a	**Anthem** 1,073 **United Healthcare** 103 **Managed Health Services**

	service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	428
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Anthem** 17 **United Healthcare** 0 **Managed Health Services** 0
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Anthem** 0 **United Healthcare** 0 **Managed Health Services** 124
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Anthem** 0 **United Healthcare** 0 **Managed Health Services**

0

D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Anthem** 0 **United Healthcare** 0 **Managed Health Services** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**Anthem** 0 **United Healthcare** 0 **Managed Health Services** 0
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Anthem** 7 **United Healthcare** 0 **Managed Health Services**

0

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Anthem** 42 **United Healthcare** 2 **Managed Health Services** 92
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Anthem** 54 **United Healthcare** 15 **Managed Health Services** 352
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan	**Anthem** 62 **United Healthcare**

	during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	0 **Managed Health Services** 5
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**Anthem** 27 **United Healthcare** 1 **Managed Health Services** 12
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**Anthem** 405 **United Healthcare** 61 **Managed Health Services** 100
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does	**Anthem** 5 **United Healthcare** 0

	not cover skilled nursing services, enter "N/A".	**Managed Health Services** 17
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	**Anthem** N/A **United Healthcare** N/A **Managed Health Services** N/A
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**Anthem** 47 **United Healthcare** 6 **Managed Health Services** 11

D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	**Anthem** 0 **United Healthcare** 0 **Managed Health Services** 0
D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".	**Anthem** 455 **United Healthcare** 18 **Managed Health Services** 0

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	**Anthem** 3 **United Healthcare** 0 **Managed Health Services** 1
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Anthem** 0 **United Healthcare** 0 **Managed Health Services** 1
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Anthem** 3 **United Healthcare** 0 **Managed Health Services** 0

D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) prior to reaching a decision.	**Anthem** N/A **United Healthcare** N/A **Managed Health Services** N/A
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Anthem** 31 **United Healthcare** 0 **Managed Health Services** 2
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external	**Anthem** 74 **United Healthcare** 0 **Managed Health Services** 15

medical review process, enter "N/A".
External medical review is defined and described at 42 CFR §438.402(c)(i)(B).

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Anthem** 922 **United Healthcare** 97 **Managed Health Services** 164
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Anthem** 122 **United Healthcare** 12 **Managed Health Services** 0
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the	**Anthem** N/A **United Healthcare** N/A **Managed Health Services** N/A

	time that the grievance was filed). If this does not apply, enter N/A.	
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the	**Anthem** N/A **United Healthcare** N/A **Managed Health Services** N/A

	reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Anthem** 922 **United Healthcare** 96 **Managed Health Services** 164

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 23 **United Healthcare** 2 **Managed Health Services** 0
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 310 **United Healthcare** 57 **Managed Health Services** 0
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or	**Anthem** 3 **United Healthcare** 0

	substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Health Services** 0
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 13 **United Healthcare** 5 **Managed Health Services** 0
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 58 **United Healthcare** 7 **Managed Health Services** 6
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 2 **United Healthcare** 1 **Managed Health Services**

0

D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** N/A **United Healthcare** N/A **Managed Health Services** N/A
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 87 **United Healthcare** 18 **Managed Health Services** 17
D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 194 **United Healthcare** 11 **Managed Health Services** 84

D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	**Anthem** 342 **United Healthcare** 2 **Managed Health Services** 57

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Anthem** 167 **United Healthcare** 2 **Managed Health Services** 45
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Anthem** 41 **United Healthcare** 0 **Managed Health Services** 0

D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Anthem** 268 **United Healthcare** 14 **Managed Health Services** 2
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Anthem** 157 **United Healthcare** 49 **Managed Health Services** 10
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an	**Anthem** 18 **United Healthcare** 10 **Managed Health Services** 0

	enrollee's access to or the accessibility of enrollee materials or plan communications.	
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	**Anthem** 142 **United Healthcare** 18 **Managed Health Services** 6
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Anthem** 0 **United Healthcare** 0 **Managed Health Services** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation**	**Anthem** 0

	Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**United Healthcare** 0 **Managed Health Services** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Anthem** 28 **United Healthcare** 0 **Managed Health Services** 2
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a	**Anthem** 0 **United Healthcare** 0 **Managed Health Services** 0

	request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	**Anthem** 211 **United Healthcare** 10 **Managed Health Services** 99

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Quality & performance measure total count: 6

Complete

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

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1516

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-Using HEDIS

Measure results

Anthem

53.61

United Healthcare

49.45

Managed Health Services

51.28

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care (PPC): 1. Timeliness of Prenatal Care 2. Postpartum Care

D2.VII.2 Measure Domain

Maternal and perinatal health

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

1517

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A using HEDIS

Measure results

Anthem

85.66, 72.76%

United Healthcare

85.71, 85.71%

Managed Health Services

80, 68.50 %

Complete

D2.VII.1 Measure Name: Controlling High Blood Pressure (CBP)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0058, 0575

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA- using HEDIS

Measure results

Anthem

64.48%

United Healthcare

60.40%

Managed Health Services

62.77%

D2.VII.1 Measure Name: Antidepressant Medication Management (AMM): 1. Effective Acute Phase Treatment 2. Effective Continuation Phase Treatment

4 / 6

D2.VII.2 Measure Domain

Behavioral health care

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

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

Program-specific rate

0105

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA USING HEDIS

Measure results

Anthem

64.29, 47.75

United Healthcare

80.36, 60.71

Managed Health Services

60.45, 42.24

Complete

D2.VII.1 Measure Name: Annual Dental Visit (ADV) - TOTAL

5 / 6

D2.VII.2 Measure Domain

Dental and oral health services

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

1388

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

NA-USING HEDIS

Measure results

Anthem

50.87

United Healthcare

41.80

Managed Health Services

51.55

Complete

D2.VII.1 Measure Name: Rating of Personal (Primary Care) Doctor (9 + 10)

6 / 6

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

NA

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

Program-specific rate

D2.VII.6 Measure Set

CAHPS

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

No, 04/01/2023 - 06/30/2023

D2.VII.8 Measure Description

CAHPS (Adult): Rating of Personal (Primary Care) Doctor (9+10). Question 18

Measure results

Anthem

63.71

United Healthcare

71.90

Managed Health Services

72.90

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Sanction total count: 16

Complete

D3.VIII.1 Intervention type: Liquidated damages

1 / 16

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
United Healthcare

D3.VIII.4 Reason for intervention

Contractor did not meet quality metrics outlined in contract during quarterly reporting for returned calls the next business day.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$2,310

D3.VIII.7 Date assessed
05/06/2022

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 06/23/2022

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

2 / 16

D3.VIII.2 Intervention topic
failing to meet contract requirements

D3.VIII.3 Plan name
United Healthcare

D3.VIII.4 Reason for intervention

Contractor did not meet contractual requirements to notify a member's PMP within 72 hours of an inpatient stay or Emergency Department visit

specific to behavioral health needs. Contractor also failed to notify a member's PMP within 5-days of a non-behavioral health inpatient or emergency department visit and lack of care coordination for members.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/01/2022

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

Yes, remediated 11/03/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

3 / 16

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

Contractor did not meet quality metrics outlined in contract during quarterly reporting for informal dispute resolution within 30 days and provider helpline after hours return call within 1 business day.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$3,780

D3.VIII.7 Date assessed

09/02/2022

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

Yes, remediated 09/28/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

4 / 16

D3.VIII.2 Intervention topic

Excess charges

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

Contractor incorrectly billed and requested payment for drugs subject to the 340b pricing program rebate.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/06/2022

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

Yes, remediated 06/02/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

5 / 16

D3.VIII.2 Intervention topic

Timeliness

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

MHS was late when responding to one internet quorum (IQ) inquiry for the month of March.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$300

D3.VIII.7 Date assessed

04/03/2022

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

Yes, remediated 04/12/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

Contractor did not meet quality metrics for member appeals and informal disputes outlined in contract during Q1 reporting.

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$4,620

D3.VIII.7 Date assessed

06/02/2022

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

Yes, remediated 06/22/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

7 / 16

D3.VIII.2 Intervention topic

Timeliness

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

During the MHS July Readiness Review Onsite, it was identified that MHS was noncompliant with the independent review organization (IRO) timeline expectations.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

08/04/2022

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

Yes, remediated 11/18/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

8 / 16

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name

Reporting | Managed Health Services

D3.VIII.4 Reason for intervention

Contractor did not meet quality metrics for member appeals and informal disputes outlined in contract during Q2 reporting.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$2,310

D3.VIII.7 Date assessed

09/07/2022

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

Yes, remediated 10/06/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

9 / 16

D3.VIII.2 Intervention topic

Excess charges

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

MHS was incorrectly billing and requesting payment for drugs subject to the 340b pricing program rebate.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/06/2022

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

Yes, remediated 06/30/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

10 / 16

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

Contractor did not meet quality metrics for informal disputes outlined in contract during Q3 reporting.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$2,310

D3.VIII.7 Date assessed

12/12/2022

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

Yes, remediated 12/20/2022

D3.VIII.9 Corrective action plan

Yes

D3.VIII.1 Intervention type: Liquidated damages

11 / 16

Complete

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
Anthem

D3.VIII.4 Reason for intervention

MCE did not meet quality metrics for informal disputes during Q1 2022 reporting.

Sanction details

D3.VIII.5 Instances of non-compliance
3

D3.VIII.6 Sanction amount
$2,310

D3.VIII.7 Date assessed
05/23/2022

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 06/01/2022

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

12 / 16

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
Anthem

D3.VIII.4 Reason for intervention

MCE did not meet quality metrics for informal disputes or appeals for Q2 2022 reporting.

Sanction details

D3.VIII.5 Instances of non-compliance
3

D3.VIII.6 Sanction amount
$4,620

D3.VIII.7 Date assessed
09/07/2022

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 09/16/2022

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

13 / 16

D3.VIII.2 Intervention topic
Timeliness

D3.VIII.3 Plan name
Anthem

D3.VIII.4 Reason for intervention

MCE failed to respond to a formal inquiry within the specified timeframe.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$300

D3.VIII.7 Date assessed
09/08/2022

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 09/23/2022

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

14 / 16

D3.VIII.2 Intervention topic
Excess charges

D3.VIII.3 Plan name
Anthem

D3.VIII.4 Reason for intervention

Anthem was incorrectly billing and requesting payment for drugs subject to the 340b pricing program rebate.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
12/06/2022

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 06/07/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

15 / 16

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
Anthem

D3.VIII.4 Reason for intervention

MCE did not meet quality metrics for informal disputes or appeals for Q3 2022 reporting

Sanction details

D3.VIII.5 Instances of non-compliance
3

D3.VIII.6 Sanction amount
$4,620

D3.VIII.7 Date assessed

12/09/2022

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

Yes, remediated 12/20/2022

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

16 / 16

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

MCE did not meet quality metrics for appeals for Q4 2022 reporting

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$2,310

D3.VIII.7 Date assessed

03/17/2023

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

Yes, remediated 04/03/2023

D3.VIII.9 Corrective action plan

Yes

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Anthem** 8 **United Healthcare** 3 **Managed Health Services** 5
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**Anthem** 110 **United Healthcare** 14 **Managed Health Services** 92
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	**Anthem** 110:60,632 **United Healthcare** 14:5,928 **Managed Health Services** 92:34,392

D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations have been resolved by the plan in the past year?	**Anthem** 79 **United Healthcare** 7 **Managed Health Services** 79
D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**Anthem** 79:632 **United Healthcare** 7:5,928 **Managed Health Services** 79:34,392
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Anthem** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **United Healthcare** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Managed Health Services** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals	**Anthem** 11 **United Healthcare** 0 **Managed Health Services** 11
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.1) as the denominator.	**Anthem** 11:60,632 **United Healthcare** 0:5,928 **Managed Health Services** 11:34,392

D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2).	**Anthem** 1. 01/01/2022-12/31/2022 2. Overpayments recovered by the MCE: $659,073.53. Anthem is an MCE for HIP, HHW, and HCC. The state's PI team does not differentiate staff, overpayments, or investigations by program. 3. The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR: 0 **United Healthcare** 1. 01/01/2022-12/31/2022 2. Overpayments recovered by the MCE: $668,964.25. 3. The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR: 0 **Managed Health Services** 1. 01/01/2022-12/31/2022 2. Overpayments recovered by the MCE: $230,516.00. MHS is an MCE for HIP, HHW, and HCC. The state's PI team does not differentiate staff, overpayments, or investigations by program. 3. The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR: 0
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Anthem** Daily **United Healthcare** Daily **Managed Health Services**

Daily

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus Heath Services, Inc** Enrollment Broker
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus Heath Services, Inc** Enrollment Broker/Choice Counseling