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

Due date	Last edited	Edited by	Status
09/27/2024	09/27/2024	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.	09/27/2024

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	04/01/2023
A5b	**Reporting period end date** Auto-populated from report dashboard.	03/31/2024
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 438.71See 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 average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	2,107,574
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	1,649,377

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 Medicaid agency staff State actuaries EQRO

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. If no PI activities were performed, enter 'No PI activities were performed during the reporting period' as your response. 'N/A' is not an acceptable response.	The state implemented a beneficiary verification plan (BVP) with each Hoosier Care Connect MCE that launched on 7/1/24. The BVP is a state response to a CAP imposed on Indiana by CMS on October 6, 2023. With the implementation of the BVP, the MCEs will report on inaccurately invoiced claims submitted by IHCP providers.
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).	Section 7.4: Program Integrity Overpayment Recovery
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	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 require the MCE 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 the MCE 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 topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	The Hoosier Care Connect 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 Benefit Enrollment and Maintenance (834) file is sent to the health plans on a daily basis. Additionally, the state sends the health plans a weekly reconciliation file. The MCEs review the files to identify any discrepancies in enrollment. The MCEs are responsible for verifying member eligibility data and reconciling with capitation payments for each eligible member on a monthly basis. If the MCE discovers a discrepancy in eligibility or capitation information, the MCE 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 MCE must accept enrollment data in electronic format ,currently via secure file transfer protocol(“FTP”).
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, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter 'No such audits were conducted during the reporting year' as your response. 'N/A' is not an acceptable response.	In 2023, the independent EQRO completed CMS' Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plans using data from CY 2022. https://www.in.gov/fssa/ompp/files/OMPP_Technical_Report_2023.pdf (Pages 85-111)

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.	Indiana has a contract with each MCE: Anthem (Contract #51705), MHS (Contract #51706), United Healthcare (Contract #51704)
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	Each contract runs from April 1, 2021 through March 31, 2025.
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-service should not be listed here.	Behavioral health Dental Transportation
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 average number of individuals enrolled in this managed care program per	97,432

	month during the reporting year (i.e., average member months).	
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. If there were no major changes, please enter 'There were no major changes to the population or benefits during the reporting year' as your response. 'N/A' is not an acceptable response.	The COVID-19 PHE emergency ended during the reporting year. Eligibility redetermination actions began in April 2023, with a 12-month plan to return to normal operations. Individuals for whom all eligibility determination is known and verified and have remained eligible under normal rules during the public health emergency were subject to standard requirements starting in April 2023. Individuals who only remained eligible for Hoosier Care Connect due to the special rules effective since March 2020 were reevaluated when their annual redetermination came due and could not be disenrolled until after such time. As a result, HCC enrollment is no longer increasing. Additionally, the Pathways for Aging Program went live on 7/1/24. Although this is outside of the reporting year, enrollment numbers will decrease because of the program's implementation

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 section references, not page numbers.	8.6. Encounter data submission and exhibit 2D(7) Encounter Data Quality Report

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.	Exhibit 2D(7) 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 2D: Non-Financial Incentives FSSA may recognize managed care plan contractors that attain superior performance and/or improvement by publicizing their reports, including encounter data quality submissions. The State may reward high performing MCEs through the auto-assignment logic. For example, in developing the auto-assignment methodology, the State reserves the right to consider factors such as MCE performance on clinical quality outcomes as report, enrollee satisfaction, other outcome measures.
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 year. If there were no barriers, please enter 'The state did not experience any barriers to collecting or validating encounter data during the reporting year' as your response. 'N/A' is not an acceptable response.	The state did not experience any barriers to collecting or validation encounter data during the reporting year.

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
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 MCEs 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 MCO, PIHP or PAHP receives the appeal.	The MCEs shall resolve each expedited appeals within forty-eight (48) hours after the Contractor receives notice of 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 MCEs 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 access standards. If the state and MCPs did not encounter any challenges, please enter 'No challenges were encountered' as your response. 'N/A' is not an acceptable response.	UHC continued to have an open network into 2023 and will maintain it open until it can meet all standards.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	To assist with gaps in network adequacy, Indiana provides the MCEs access to the state's IHCP portal. The portal allows the MCEs to identify IHCP enrolled providers.

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: 12

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 1 / 12

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 / 12

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

C2.V.2 Measure standard

The MCES 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

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

5 / 12

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

6 / 12

C2.V.2 Measure standard

Two (2) durable medical equipment providers must be available to provide services to the Contractor's members

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	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 7 / 12

C2.V.2 Measure standard

Two (2) home health providers must be available to provide services to the Contractor's members 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
home health	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 8 / 12

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

9 / 12

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

10 / 12

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

11 / 12

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	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

12 / 12

C2.V.2 Measure standard

The transport distance to an inpatient psychiatric facility 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
Behavioral health	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(es) 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.	To be accessible to all beneficiaries, member materials must be written at a fifth grade reading level. Alternative formats must be made available by Maximus; these formats must consider the requirements of the Americans with Disabilities Act and the special needs of those who, for example, may be visually limited or have limited English proficiency. If a member calls with their own TTY services, Maximus will accept those calls and handle those calls as they would any other calls. Also, if a member requests TTY services for hearing impaired members maximus will refer them to TTY services that are offered.
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 or critical incident data? Refer to 42 CFR 438.71(d)(4).	N/A LTSS does not apply to Hoosier Care Connect
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 OMPP 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** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Anthem** 57,988 **United Healthcare** 6,080 **Managed Health Services** 33,363
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** 2.8% **United Healthcare** 0.3% **Managed Health Services** 1.6%
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** 3.5% **United Healthcare** 0.4% **Managed Health Services** 2%

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. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Anthem** 94% **United Healthcare** 101% **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** Program-specific statewide **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 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.	**Anthem** N/A **United Healthcare** 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**

		Yes **Managed Health Services** Yes
N/A	Enter the start date.	**Anthem** 01/01/2021 **United Healthcare** 01/01/2021 **Managed Health Services** 01/01/2021
N/A	Enter the end date.	**Anthem** 12/31/2021 **United Healthcare** 12/31/2021 **Managed Health Services** 12/31/2021

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 via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before5 p.m. (Est) on Wednesday each week. **United Healthcare** The Contractor shall submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before5 p.m. (Est) on Wednesday each week. **Managed Health Services** The Contractor shall submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied institutional, pharmacy and professional claims and any claims not previously submitted before5 p.m. (Est) on Wednesday each week.
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 year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year 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 year.	**Anthem** N/A **United Healthcare** N/A **Managed Health Services** N/A
D1III.3	**Share of encounter data submissions that were HIPAA compliant**	**Anthem** N/A

What percent of the plan's encounter data submissions (submitted during the reporting year) 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 year.	**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 during 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** 978 **United Healthcare** 123 **Managed Health Services** 849
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**Anthem** 33 **United Healthcare** 2 **Managed Health Services** 58
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 whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	**Anthem** N/A **United Healthcare** N/A **Managed Health Services** N/A
D1IV.4	**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal**	**Anthem** N/A **United Healthcare**

	For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year 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 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.	N/A **Managed Health Services** N/A
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 within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Anthem** 934 **United Healthcare** 56 **Managed Health Services** 831
D1IV.5b	**Expedited appeals for which timely resolution was**	**Anthem**

	provided Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	42 **United Healthcare** 67 **Managed Health Services** 18
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 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).	**Anthem** 956 **United Healthcare** 123 **Managed Health Services** 757
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** 22 **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** 92

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** 0 **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** 23 **United Healthcare** 1 **Managed Health Services** 76
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** 36 **United Healthcare** 15 **Managed Health Services** 362
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan 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".	**Anthem** 131 **United Healthcare** 1 **Managed Health Services** 50
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan	**Anthem** 63 **United Healthcare**

	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".	5 **Managed Health Services** 154
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** 304 **United Healthcare** 77 **Managed Health Services** 184
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 not cover skilled nursing services, enter "N/A".	**Anthem** 2 **United Healthcare** 2 **Managed Health Services** 12
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** 1 **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	**Anthem** 46 **United Healthcare**

	were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	8 **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 paid primarily by Medicaid, enter "N/A".	**Anthem** 373 **United Healthcare** 12 **Managed Health Services** 0

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**Anthem** 12 **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** 4 **United Healthcare** 0 **Managed Health Services** 0
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** 10 **United Healthcare** 0 **Managed Health Services** 3
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) during the reporting year prior to reaching a decision.	**Anthem** 0 **United Healthcare** 0 **Managed Health Services** 0

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** 43 **United Healthcare** 1 **Managed Health Services** 14
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 medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Anthem** 99 **United Healthcare** 0 **Managed Health Services** 25

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** 911 **United Healthcare** 78 **Managed Health Services** 174
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Anthem** 37 **United Healthcare** 13 **Managed Health Services** 19
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 time that the grievance was filed). If this does not apply, enter N/A.	**Anthem** N/A **United Healthcare** N/A **Managed Health Services** 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	**Anthem** N/A **United Healthcare** N/A

	the reporting year 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 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.	**Managed Health Services** N/A
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 year.	**Anthem** 910 **United Healthcare** 76

See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.

Managed Health Services

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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** 22 **United Healthcare** 3 **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** 286 **United Healthcare** 54 **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 substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 4 **United Healthcare** 0 **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	**Anthem** 10 **United Healthcare**

	mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	1 **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** 59 **United Healthcare** 3 **Managed Health Services** 2
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** 0 **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	**Anthem** 95 **United Healthcare** 5

	not cover this type of service, enter "N/A".	**Managed Health Services** 15
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** 117 **United Healthcare** 11 **Managed Health Services** 44
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 paid primarily by Medicaid, enter "N/A".	**Anthem** 316 **United Healthcare** 1 **Managed Health Services** 113

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** 91 **United Healthcare** 4 **Managed Health Services** 11
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** 44 **United Healthcare** 0 **Managed Health Services** 2

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** 208 **United Healthcare** 7 **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** 40 **Managed Health Services** 5
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 enrollee's access to or the accessibility of enrollee materials or plan communications.	**Anthem** 18 **United Healthcare** 13 **Managed Health Services** 0

D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**Anthem** 150 **United Healthcare** 10 **Managed Health Services** 4
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan 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** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Anthem** 0 **United Healthcare** 0 **Managed Health Services** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal**	**Anthem** 18 **United Healthcare**

	(including requests to expedite or extend appeals) Enter the total number of grievances resolved by the plan 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).	0 **Managed Health Services** 5
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan 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 request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Anthem** 0 **United Healthcare** 0 **Managed Health Services** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Anthem** 225 **United Healthcare** 4 **Managed Health Services** 145

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: 57

Complete

D2.VII.1 Measure Name: Cervical Cancer Screening (CCS)

1 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0032

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

44.08

United Healthcare

33.09

Managed Health Services

48.42

Complete

D2.VII.1 Measure Name: Colorectal Cancer Screening (COL)

2 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0034

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

Age 46-50: 31.92; Age 51-75: 47.05

United Healthcare

Age 46-50: 17.44; Age 51-75: 23.45

Managed Health Services

Age 46-50: 27.79; Age 51-75: 42.28

Complete

D2.VII.1 Measure Name: Chlamydia Screening in Women (CHL)

3 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0033

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

Age 16-20: 52.27; Age 21-24: 54.39

United Healthcare

Age 16-20: 47.83; Age 21-24: 52.38

Managed Health Services

Age 16-20: 49.73; Age 21-24: 59.93

Complete

D2.VII.1 Measure Name: Breast Cancer Screening (BCS-E)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

2372

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

47.58

United Healthcare

50.43

Managed Health Services

47.87

Complete

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

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

NA-using HEDIS

Measure results

Anthem

Timeliness Prenatal Care: 82.44; Postpartum Care: 77.10

United Healthcare

Timeliness Prenatal Care: 85.71; Postpartum Care: 42.86

Managed Health Services

Timeliness Prenatal Care: 80.26; Postpartum Care: 75.00

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life (W30)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

N/A

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

Age 15 months: 55.74; Age 15 to 30 months: 81.09

United Healthcare

Age 15 months: 50.00; Age 15 to 30 months: 68.15

Managed Health Services

Age 15 months: 56.52; Age 15 to 30 months: 78.43

Complete

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

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

Age 3-11: 67.14; Age 12-17: 55.89; Age 18-21: 29.39

United Healthcare

Age 3-11: 66.13; Age 12-17: 47.62; Age 18-21: 17.90

Managed Health Services

Age 3-11: 66.81; Age 12-17: 56.80; Age 18-21: 28.99

Complete

D2.VII.1 Measure Name: Prenatal Immunization Status (PRS-E)

D2.VII.2 Measure Domain

Maternal and perinatal health

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

3438

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

Influenza: 26.14; Tdap: 59.75; Combination: 24.07

United Healthcare

Influenza: 31.25; Tdap: 50.00; Combination: 31.25

Managed Health Services

Influenza: 16.78; Tdap: 50.34; Combination: 15.44

Complete

D2.VII.1 Measure Name: Prenatal Depression Screening and Follow-Up (PND-E)

9 / 57

D2.VII.2 Measure Domain

Maternal and perinatal health

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

N/A

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

Screening: 9.54 Follow up: 85.71

United Healthcare

N/A

Managed Health Services

Screening: 12.75; Follow up: 40.00

Complete

D2.VII.1 Measure Name: Asthma Medication Ratio (AMR)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

1800

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

Age 5-11: 73.91; Age 12-18: 59.86; Age 19-50: 62.04; Age 51-64: 49.57

United Healthcare

Age 5-11: 87.50; Age 12-18: 100.00; Age 19-50: 45.83; Age 51-64: 35.00

Managed Health Services

Age 5-11: 69.57; Age 12-18: 72.22; Age 19-50: 55.45; Age 51-64: 49.55

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

0018

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

73.24

United Healthcare

63.50

Managed Health Services

66.18

Complete

D2.VII.1 Measure Name: Hemoglobin A1c Control for Patients With Diabetes (HBD)

12 / 57

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

59/575

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

Adequate HbA1c Control: 63.75; Poor HbA1c Control: 27.25

United Healthcare

Adequate HbA1c Control: 52.49; Poor HbA1c Control: 38.81

Managed Health Services

Adequate HbA1c Control: 54.50; Poor HbA1c Control: 37.23

Complete

D2.VII.1 Measure Name: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0058

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

Age 3m-17: 61.11; Age 18-64: 37.60; Age 65+: 29.27

United Healthcare

Age 3m-17: 85.71; Age 18-64: 17.39; Age 65+: 50.00

Managed Health Services

Age 3m-17: 68.48; Age 18-64: 33.86; Age 65+: 46.15

Complete

D2.VII.1 Measure Name: Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0071

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

42.86

United Healthcare

66.67

Managed Health Services

70.00

Complete

D2.VII.1 Measure Name: Blood Pressure Control for Patients With Diabetes (BPD)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0061

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

73.97

United Healthcare

62.19

Managed Health Services

72.26

Complete

D2.VII.1 Measure Name: Eye Exam for Patients With Diabetes (EED)

16 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0055

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

61.31

United Healthcare

45.27

Managed Health Services

60.83

Complete

D2.VII.1 Measure Name: Kidney Health Evaluation for Patients With Diabetes (KED)

17 / 57

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0062

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

Age 18-64: 35.27; Age 65-74: 42.64; Age 75-85: 40.63

United Healthcare

Age 18-64: 28.65; Age 65-74: 34.69; Age 75-85: 46.67

Managed Health Services

Age 18-64: 36.17; Age 65-74: 41.41; Age 75-85: 37.30

Complete

D2.VII.1 Measure Name: Statin Therapy for Patients With Diabetes (SPD)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0545

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

Received therapy: 71.19 Adherence: 74.60

United Healthcare

Received therapy: 65.29; Adherence: 65.77

Managed Health Services

Received therapy: 73.55; Adherence: 73.72

Complete

D2.VII.1 Measure Name: Statin Therapy for Patients With Cardiovascular Disease (SPC)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0543

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

Received therapy total: 82.89 Adherence total: 76.12

United Healthcare

Received therapy total: 87.30 Adherence total: 58.18

Managed Health Services

Received therapy total: 81.16 Adherence total: 76.43

Complete

D2.VII.1 Measure Name: Cardiac Rehabilitation (CRE)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0642/0643

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

Initiation total: 8.94; Engagement 1 total: 8.61; Engagement 2 total: 5.63; Achievement total: 1.32

United Healthcare

Initiation total: 3.70; Engagement 1 total: 7.41; Engagement 2 total: 7.41; Achievement total: 0.0

Managed Health Services

Initiation total: 8.76; Engagement 1 total: 8.03; Engagement 2 total: 5.84; Achievement total: 3.65

Complete

D2.VII.1 Measure Name: Plan All-Cause Readmissions (PCR)

D2.VII.2 Measure Domain

Readmissions

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

1768

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

Ages 18-64: 11.54

United Healthcare

Ages 18-64: 13.08

Managed Health Services

Ages 18-64: 11.65

Complete

D2.VII.1 Measure Name: Diagnosed Mental Health Disorders (DMH)

22 / 57

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Age 1-17: 59.83; Age 18-64: 53.72; Age 65+: 27.76

United Healthcare

Age 1-17: 56.19; Age 18-64: 50.60; Age 65+: 19.10

Managed Health Services

Age 1-17: 60.23; Age 18-64: 51.20; Age 65+: 23.81

Complete

D2.VII.1 Measure Name: Antidepressant Medication Management (AMM)

23 / 57

D2.VII.2 Measure Domain

Behavioral health care

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

0105

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

Acute: 65.11; Continuation: 47.35

United Healthcare

Acute: 64.08; Continuation: 48.54

Managed Health Services

Acute: 66.04; Continuation: 48.27

Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed ADHD Medication (ADD)

D2.VII.2 Measure Domain

Behavioral health care

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

0108

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

Initiation: 46.15 Continuation: 44.23

United Healthcare

Initiation: 48.84; Continuation: 44.44

Managed Health Services

Initiation: 45.91; Continuation: 55.13

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness (FUH)

25 / 57

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

30-day follow up total: 61.74; 7-day follow up total: 40.53

United Healthcare

30-day follow up total: 55.91; 7-day follow up total: 39.78

Managed Health Services

30-day follow up total: 54.49; 7-day follow up total: 29.65

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness (FUM)

26 / 57

D2.VII.2 Measure Domain

Behavioral health care

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

3489

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

30-day follow up total: 57.70; 7-day follow up total: 43.31

United Healthcare

30-day follow up total: 50.88; 7-day follow up total: 38.60

Managed Health Services

30-day follow up total: 58.96; 7-day follow up total: 43.78

Complete

D2.VII.1 Measure Name: Diagnosed Substance Use Disorders (DSU)

27 / 57

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Total: 13.12

United Healthcare

Total: 13.38

Managed Health Services

Total: 11.52

Complete

D2.VII.1 Measure Name: Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

28 / 57

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Total 30-day follow-up: 64.42; Total 7-day follow-up: 46.03

United Healthcare

Total 30-day follow-up: 51.85; Total 7-day follow-up: 32.10

Managed Health Services

Total 30-day follow-up: 48.81; Total 7-day follow-up: 23.54

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use (FUA)

29 / 57

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Total 30-day follow-up: 46.33; Total 7-day follow-up: 32.37

United Healthcare

Total 30-day follow-up: 40.48; Total 7-day follow-up: 28.57

Managed Health Services

Total 30-day follow-up: 32.12; Total 7-day follow-up: 21.17

Complete

D2.VII.1 Measure Name: Pharmacotherapy for Opioid Use Disorder (POD)

30 / 57

D2.VII.2 Measure Domain

Behavioral health care

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

3400

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

Total: 31.40

United Healthcare

Total: 18.18

Managed Health Services

Total: 28.63

Complete

D2.VII.1 Measure Name: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

D2.VII.2 Measure Domain

Behavioral health care

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

1932

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

84.99

United Healthcare

84.21

Managed Health Services

82.28

Complete

D2.VII.1 Measure Name: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

D2.VII.2 Measure Domain

Behavioral health care

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

1933

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

74.63

United Healthcare

100.00

Managed Health Services

80.00

Complete

D2.VII.1 Measure Name: Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)

D2.VII.2 Measure Domain

Behavioral health care

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

1879

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

65.87

United Healthcare

58.82

Managed Health Services

65.25

Complete

D2.VII.1 Measure Name: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

D2.VII.2 Measure Domain

Behavioral health care

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

2800

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

Blood Glucose Testing total: 54.68; Cholesterol Testing total: 38.35; Blood Glucose Cholesterol Testing total: 37.45

United Healthcare

Blood Glucose Testing total: 54.46; Cholesterol Testing total: 43.56; Blood Glucose Cholesterol Testing total: 42.57

Managed Health Services

Blood Glucose Testing total: 52.58; Cholesterol Testing total: 37.88 ;Blood Glucose Cholesterol Testing total: 36.48

Complete

D2.VII.1 Measure Name: Use of Opioids at High Dosage (HDO)

35 / 57

D2.VII.2 Measure Domain

Behavioral health care

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

2940

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

4.56

United Healthcare

4.35

Managed Health Services

3.65

Complete

D2.VII.1 Measure Name: Use of Opioids From Multiple Providers (UOP)

36 / 57

D2.VII.2 Measure Domain

Behavioral health care

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

2950

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

Multiple Prescribers: 18.30; Multiple Pharmacies: 4.70; Multiple Prescribers and Multiple Pharmacies: 1.97

United Healthcare

Multiple Prescribers: 18.06; Multiple Pharmacies: 0.88; Multiple Prescribers and Multiple Pharmacies: 0.44;

Managed Health Services

Multiple Prescribers: 16.04; Multiple Pharmacies: 3.77; Multiple Prescribers and Multiple Pharmacies: 1.42

Complete

D2.VII.1 Measure Name: Risk of Continued Opioid Use (COU)

37 / 57

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Covered 15 or More Days: 8.89; Covered 31 or More Days: 6.47

United Healthcare

Covered 15 or More Days: 8.79; Covered 31 or More Days: 9.16

Managed Health Services

Covered 15 or More Days: 7.97; Covered 31 or More Days: 4.47

Complete

D2.VII.1 Measure Name: Adults' Access to Preventive/Ambulatory Health Services (AAP)

38 / 57

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Age 20-44: 75.10; Age 45-64: 87.94; Age 65+: 75.35

United Healthcare

Age 20-44: 69.57; Age 45-64: 82.08; Age 65+: 58.92

Managed Health Services

Age 20-44: 71.26; Age 45-64: 86.83; Age 65+: 69.51

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Substance Use Disorder Treatment (IET)

39 / 57

D2.VII.2 Measure Domain

Behavioral health care

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

0004

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

Initiation total: 40.21; Engagement total: 18.13

United Healthcare

Initiation total: 46.86; Engagement total: 12.92

Managed Health Services

Initiation total: 38.27; Engagement total: 13.11

Complete

D2.VII.1 Measure Name: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

40 / 57

D2.VII.2 Measure Domain

Behavioral health care

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

2801

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

Age 1-11: 57.24; Age 12-17: 54.66

United Healthcare

Age 1-11: 68.42; Age 12-17: 50.00

Managed Health Services

Age 1-11: 50.60; Age 12-17: 45.71

Complete

D2.VII.1 Measure Name: Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

N/A

United Healthcare

Screening total : 0.59; Follow up total: 100.00

Managed Health Services

Screening total : 0.72; Follow up total: 47.22

Complete

D2.VII.1 Measure Name: Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

D2.VII.2 Measure Domain

Behavioral health care

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

1934

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

75.92

United Healthcare

59.09

Managed Health Services

72.41

Complete

D2.VII.1 Measure Name: Oral Evaluation, Dental Services (OED)

D2.VII.2 Measure Domain

Dental and oral health services

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

2517

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

Age 0-2: 25.78; Age 3-5: 51.93; Age 6-14: 56.18; Age 15-20: 36.39

United Healthcare

Age 0-2: 26.21; Age 3-5: 48.58; Age 6-14: 52.73; Age 15-20: 34.19

Managed Health Services

Age 0-2: 31.45; Age 3-5: 54.08; Age 6-14: 58.01; Age 15-20: 37.54

Complete

D2.VII.1 Measure Name: Topical Fluoride for Children (TFC)

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Age 1-2: 7.37; Age 3-4: 15.24

United Healthcare

Age 1-2: 10.66; Age 3-4: 15.79

Managed Health Services

Age 1-2: 10.12; Age 3-4: 15.89

Complete

D2.VII.1 Measure Name: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0024

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

(BMI Percentile: Age 3-11: 85.43; Age 12-17: 80.89) (Nutrition Counseling: Age 3-11: 76.77; Age 12-17: 61.15) (Physical Activity Counseling: Age 3-11: 64.57; Age 12-17: 59.87)

United Healthcare

(BMI Percentile: Age 3-11: 68.58; Age 12-17: 68.75) (Nutrition Counseling: Age 3-11: 46.22; Age 12-17: 38.75) (Physical Activity Counseling: Age 3-11: 38.37; Age 12-17: 31.25)

Managed Health Services

(BMI Percentile: Age 3-11: 74.70; Age 12-17: 64.56) (Nutrition Counseling: Age 3-11: 79.45; Age 12-17: 64.56) (Physical Activity Counseling: Age 3-11: 67.98; Age 12-17: 60.76)

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (CIS)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Dtap: 73.88 IPV: 92.70 MMR: 88.76 HiB: 89.04 Hepatitis B: 91.57 VZV: 89.61 Pneumococcal Conjugate: 70.79 Hepatitis A: 90.45 Rotavirus: 55.34 Influenza: 42.13 Combo 3: 65.17 Combo 7: 46.35 Combo 10: 24.44

United Healthcare

Dtap: 65.35 IPV: 79.21 MMR: 81.19 HiB: 76.24 Hepatitis B: 83.17 VZV: 81.19 Pneumococcal Conjugate: 63.37 Hepatitis A: 77.23 Rotavirus: 44.55 Influenza: 43.56 Combo 3: 59.41 Combo 7: 35.64 Combo 10: 22.77

Managed Health Services

Dtap: 65.66 IPV: 85.54 MMR: 86.14 HiB: 80.12 Hepatitis B: 87.35 VZV: 84.34 Pneumococcal Conjugate: 63.86 Hepatitis A: 84.94 Rotavirus: 51.81 Influenza: 32.53 Combo 3: 56.63 Combo 7: 40.96 Combo 10: 16.87

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents (IMA)

47 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1407

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

Meningococcal: 85.95;Tdap: 87.98; HPV: 33.71; Combo 1: 85.23; Combo 2: 32.48

United Healthcare

Meningococcal: 81.25; Tdap: 81.25; HPV: 35.42; Combo 1: 79.17; Combo 2: 35.42

Managed Health Services

Meningococcal: 84.43; Tdap: 87.35; HPV: 28.71; Combo 1: 83.94; Combo 2: 26.76

Complete

D2.VII.1 Measure Name: Lead Screening in Children (LSC)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

N/A

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

68.54

United Healthcare

47.06

Managed Health Services

60.24

Complete

D2.VII.1 Measure Name: Appropriate Testing for Pharyngitis (CWP)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0002

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

Age 3-17: 87.26; Age 18-64: 71.90; Age 65+: 40.91

United Healthcare

Age 3-17: 85.53; Age 18-64: 58.06, Age 65+: N/A

Managed Health Services

Age 3-17: 86.87; Age 18-64: 72.52; Age 65+: 77.78

Complete

D2.VII.1 Measure Name: Pharmacotherapy Management of COPD Exacerbation (PCE)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0549

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

Systemic Corticosteroid: 73.03; Bronchodilator: 85.13

United Healthcare

Systemic Corticosteroid: 81.63; Bronchodilator: 91.84

Managed Health Services

Systemic Corticosteroid: 76.04; Bronchodilator: 88.17

Complete

D2.VII.1 Measure Name: Appropriate Treatment for Upper Respiratory Infection (URI)

51 / 57

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0069

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

Age 3m-17: 88.36; Age 18-64: 74.52; Age 65+: 63.89

United Healthcare

Age 3m-17: 91.62; Age 18-64: 70.59; Age 65+: 100.00

Managed Health Services

Age 3m-17: 90.86; Age 18-64: 75.43; Age 65+: 78.95

Complete

D2.VII.1 Measure Name: Use of Imaging Studies for Low Back Pain (LBP)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0052

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

Total: 65.16

United Healthcare

Total: 78.87

Managed Health Services

Total: 70.73

Complete

D2.VII.1 Measure Name: Antibiotic Utilization for Respiratory Conditions (AXR)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

N/A

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

Age 3m-17: 31.61; Age 18-64: 22.38; Age 65+: 16.09

United Healthcare

Age 3m-17: 30.32; Age 18-64: 20.72; Age 65+: 6.06

Managed Health Services

Age 3m-17: 30.92; Age 18-64: 22.66; Age 65+: 17.15

Complete

D2.VII.1 Measure Name: Adult Immunization Status (AIS-E)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

3620

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

Influenza total: 18.90; TdTap total: 38.47; Zoster total: 8.83; Pneumococcal: 43.20

United Healthcare

Influenza total: 22.27; TdTap total: 39.89; Zoster total: 12.73; Pneumococcal: 39.86

Managed Health Services

Influenza total: 13.71; TdTap total: 26.83; Zoster total: 4.41; Pneumococcal: 29.72

Complete

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

55 / 57

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Yes

D2.VII.8 Measure Description

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

Measure results

Anthem

72.00%

United Healthcare

70.70%

Managed Health Services

69.80%

Complete

D2.VII.1 Measure Name: Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

56 / 57

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

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

0577

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

23.80

United Healthcare

0.00

Managed Health Services

17.73

Complete

D2.VII.1 Measure Name: Ambulatory Care (AMB)

57 / 57

D2.VII.2 Measure Domain

Primary care access and preventative care

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

N/A

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

Outpatient Total: 5990.70; ED Total: 988.93

United Healthcare

Outpatient Total: 4615.08; ED Total: 942.07

Managed Health Services

Outpatient Total: 4820.95; ED Total: 973.15

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: 20

Complete

D3.VIII.1 Intervention type: Liquidated damages

1 / 20

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Did not meet metric requirements in the Q4 2022 priority reporting

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$6,710

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

Complete

D3.VIII.1 Intervention type: Liquidated damages

2 / 20

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Did not meet metric requirements in the Q1 2023 priority report

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$14,700

D3.VIII.7 Date assessed

06/21/2023

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

Yes, remediated 07/05/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

3 / 20

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Did not meet metric requirements in the Q2 2023 priority report

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$9,240

D3.VIII.7 Date assessed

09/12/2023

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

Yes, remediated 09/26/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

4 / 20

D3.VIII.2 Plan performance issue

noncompliance

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

Noncompliance for IQ inquiries, March 2023

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$400

D3.VIII.7 Date assessed

04/04/2023

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

Yes, remediated 04/19/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

5 / 20

D3.VIII.2 Plan performance issue

Noncompliance

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

MCE was not utilizing the new PA hierarchy that went into effect on 4/1/2023

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

05/24/2023

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

Yes, remediated 08/22/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

6 / 20

D3.VIII.2 Plan performance issue

Noncompliance

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

Noncompliance for IQ inquiries, June 2023

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$400

D3.VIII.7 Date assessed

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

07/13/2023

Yes, remediated 07/27/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

7 / 20

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

Did not meet metric requirements in the Q4 2022 priority report

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$4,510

D3.VIII.7 Date assessed

04/04/2023

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

Yes, remediated 04/19/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

8 / 20

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

Did not meet metric requirements in the Q1 2023 priority report

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$6,930

D3.VIII.7 Date assessed

06/28/2023

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

Yes, remediated 07/13/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

9 / 20

D3.VIII.2 Plan performance issue

Noncompliance

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

Noncompliance for IQ inquiries (Nov 2023)

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$400

D3.VIII.7 Date assessed

12/12/2023

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

Yes, remediated 12/26/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

10 / 20

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

Did not meet metric requirements in the Q1 2023 priority report

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

1

$2,310

D3.VIII.7 Date assessed

06/16/2023

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

11 / 20

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

Did not meet metric requirements in the Q3 2023 priority report

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$3,150

D3.VIII.7 Date assessed

12/04/2023

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

Yes, remediated 12/15/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

12 / 20

D3.VIII.2 Plan performance issue

Noncompliance

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

MCE had an incomplete online provider directory (missing provider office hours, website, email, accessibility indicators, access to public transportation, and cultural competency fields)

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

11/28/2023

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

Yes, remediated 03/02/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Warning

13 / 20

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Audited financial reports

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

01/09/2024

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

Yes, remediated 05/31/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

14 / 20

D3.VIII.2 Plan performance issue

Noncompliance

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

340B Drug Pricing Program Billing Practices noncompliance

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

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: Warning

15 / 20

D3.VIII.2 Plan performance issue

Noncompliance

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

Adherence to Emergency AutoPay List Noncompliance

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

01/09/2024

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

Yes, remediated 05/31/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Warning

16 / 20

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Managed Health Services

D3.VIII.4 Reason for intervention

Audited financial reports

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

01/09/2024

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

Yes, remediated 05/31/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

17 / 20

D3.VIII.2 Plan performance issue

Noncompliance

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

340B drug pricing program billing noncompliant practices

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

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: Corrective action plan

18 / 20

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

Audited Financial Reports

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

01/09/2024

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

Yes, remediated 05/31/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

19 / 20

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

Priority Reports Results for Q4 2023

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$1,470

D3.VIII.7 Date assessed

03/15/2024

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

Yes, remediated 03/29/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

20 / 20

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name

Managed Health Services

Noncompliance

D3.VIII.4 Reason for intervention

340B drug pricing billing noncompliance

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

12/06/2022

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

Yes, remediated 06/27/2023

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** 10 **United Healthcare** 3 **Managed Health Services** 4
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Anthem** 153 **United Healthcare** 40 **Managed Health Services** 137
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 to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Anthem** 2.64:1,000 **United Healthcare** 6.58:1,000 **Managed Health Services** 4.11:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Anthem** 145 **United Healthcare** 25 **Managed Health Services** 133

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 to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Anthem** 2.5:1,000 **United Healthcare** 4.11:1,000 **Managed Health Services** 3.99:1,000
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 SMA and MFCU concurrently **United Healthcare** Makes referrals to the SMA and MFCU concurrently **Managed Health Services** Makes referrals to the 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** 9 **United Healthcare** 2 **Managed Health Services** 3
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1).	**Anthem** 0.16:1,000 **United Healthcare** 0.33:1,000 **Managed Health Services** 0.09:1,000

	Express this as a ratio per 1,000 beneficiaries.	
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, at minimum, 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 42 CFR 438.8(f)(2).	**Anthem** Date: 04/01/2023-03/31/2024 Amount: $1,466,789.07 Ratio: N/A **United Healthcare** Quarterly Reporting from 7/1/2023 - 6/30/2024 The dollar amount of Overpayments recovered: $267,781.33 Includes: Investigations recoveries, Waste & Error recoveries, DRG Audit recoveries The ratio of the dollar amount of overpayments recovered as a percent of premium revenue: N/A **Managed Health Services** Date: 04/01/2023-03/31/2024 Amount: $1,132,375.32 Ratio: N/A
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 performed 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