Hoosier Healthwise
Health Care Program

HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind

External Quality Review of Indiana's Hoosier Healthwise Program and Healthy Indiana Plan for the Review Year Calendar 2012

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2013 External Quality Review of Indiana's Hoosier Healthwise Program and Healthy Indiana Plan

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EXECUTIVE SUMMARY

As the single state agency responsible for Indiana's Medicaid program, the Indiana Office of Medicaid Policy and Planning (OMPP) has implemented two managed care programs using Section 1115 waiver authority. The Hoosier Healthwise (HHW) program, which began in 1994, covers children, pregnant women, and low-income families. The Healthy Indiana Plan (HIP), which began in 2008, covers custodial parents, noncustodial parents and childless adults ages 19 through 64 with family income up to 200 percent of the Federal Poverty Level who are not otherwise eligible for Medicare or Medicaid.

At the end of Calendar Year (CY) 2012, enrollment in HHW was 696,611 and enrollment in HIP was 39,578. Enrollment was effectively unchanged in HHW for both the child and adult populations from the end of CY 2011 to the end of CY 2012. The HIP enrollment decreased 2.1 percent in CY 2012 from the previous year.

The OMPP contracts with managed care entities (MCEs) to provide most services available to HHW and HIP members. The OMPP pays the MCEs a capitation rate per member per month (PMPM) based on the member cohort and the member's home region. Providers choose to contract with one or more MCE.

Three MCEs are under contract to provide services to both the HHW and HIP under a single contract that requires each MCE to offer services statewide. The MCEs—Anthem, Managed Health Services, and MDwise—have all been working with the OMPP for a number of years. Anthem's contract with the OMPP began in 2007 while MHS and MDwise have both involved with the program since the inception of Medicaid managed care in Indiana in 1994.

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

EQRO Activities in CY 2013

In past EQRs, B&A has worked with the OMPP on the topics to cover in each annual review. A more general review of compliance with Medicaid managed care regulations occurred for HHW and for HIP in last year's review. This year, in cooperation with the OMPP, B&A developed focus studies in addition to the mandatory activities. This year's topics include the following:

- Validation of Performance Measures
- Validation of MCE Performance Improvement Projects (PIPs)
- Optional EQR Activity: Calculation of Performance Measures (Selected CMS Child Core Measures)
- Optional EQR Activity: Conduct a Focus Study on Access to Care
- Optional EQR Activity: Conduct a Focus Study on Mental Health Utilization and Care Coordination

Validation of Performance Measures

B&A used CMS's EQR Protocol #2, *Validation of Performance Measures*, as the basis for conducting the validation of six HEDIS®-like measures that the MCEs are required to report to the OMPP on a quarterly basis. These measures are "HEDIS®-like" because the OMPP requires that the MCE utilize most of the definitions of the actual HEDIS® measure but to change the anchor period with each quarterly submission so that the data is kept up on a rolling 12-month period throughout the year. The other difference from HEDIS® is that the data submitted to the OMPP throughout the year uses the administrative (claims-based) method only.

The measures included in this year's validation were:

1. Well Child Visits in the First 15 Months of Life (the basis of which is HEDIS® measure W15);
2. Well Child Visits in the 3rd through 6th Years of Life (the basis of which is HEDIS® measure W34);
3. Adolescent Well Care Visits (the basis of which is HEDIS® measure AWC);
4. Children and Adolescents' Access to Primary Care Practitioners (the basis of which is HEDIS® measure CAP);
5. Adults' Access to Preventive Ambulatory Services (the basis of which is HEDIS® measure AAP); and
6. Utilization of Imaging Studies for Low Back Pain (the basis of which is HEDIS® measure LBP).

The first four measures were validated in HHW only; the last two were validated in both HHW and HIP.

This validation exercise was intended to match B&A's results using the method for the quarterly submissions (administrative method only) against the results reported by the MCEs. To serve as another source for comparison, B&A also compared the final quarterly submission for CY 2012 with the results computed by each MCE's HEDIS® auditor for HEDIS® 2013 (using the administrative method only). Using this third party as a benchmark will help to understand if there are differences between the EQRO and the MCE what might be the source of the difference (e.g., the State's dataset versus the MCE's dataset).

B&A received an extract from the State's data warehouse that contained the encounters submitted by the MCEs along with enrollment information. We then computed the values for each measure on a quarterly basis to mimic what would have been completed by each MCE to submit its quarterly reports. The B&A results were then compared to the MCE's results on a measure-by-measure, quarter-by-quarter basis. Results were shared with MCE staff in onsite meetings held in June.

Ultimately, it was found that B&A computed values that were lower with some significance in three out of 10 measures with Anthem, three out of ten with MHS, and two out of ten with MDwise for HHW. For HIP, B&A was lower than Anthem on two out of three measures and for MDwise on one out of three.

Two measures in particular had the most differences in values—AAP 20-44 years and LBP. B&A also compared the results from the HEDIS® Auditor against the B&A and MCE results. For AAP 20-44 years, the HEDIS® Auditor was always closer to the MCE finding than B&A's finding. For LBP, the results were more mixed.

Ultimately, the reasons for the differences in the results between B&A and the MCEs were attributed to the data source (OMPP's data warehouse versus the MCE's own warehouse), the effects of retroactively eligibility, and the impact of inclusion of paid-only or paid and denied encounters by the MCEs but not by B&A.

Validation of Performance Improvement Projects

B&A chose to validate three PIPs from each MCE. The PIPs that were selected were among those that the MCEs selected from pre-set lists defined by the OMPP that are tied to the State's overall quality strategy. The PIPs selected by B&A for review were chosen by all three MCEs (with some minor differences noted). All of them are HEDIS® measures. They include:

1. Well Child Visits (0-15 Months, 3rd through 6th Years of Life, and Adolescent) were selected by all three MCEs. This PIP is for the HHW population only.

2. Diabetes Care (Anthem chose the Comprehensive Diabetes Care HEDIS® measure while MHS and MDwise selected LDL-C Screening component only). This PIP is for both HHW and HIP.

3. Follow-up Care After an Inpatient Mental Health Hospitalization (Anthem and MHS chose both the 7-day and 30-day follow-up; MDwise selected the 7-day follow-up only). This PIP is for both the HHW and HIP populations.

B&A followed the steps in Activity 1 of the CMS EQR Protocol #3, *Validating Performance Improvement Projects*, to complete this validation. MCEs were asked to submit to B&A information about their PIPs for B&A to conduct a desk review. The information reviewed included the methodology used, interventions chosen, and results from both the benchmark period and any remeasurement periods. Information was reported by each MCE using NCQA's Quality Improvement Activity Form. Two members from B&A's EQR Review Team each reviewed these materials and independently completed a draft of the EQR PIP Review Worksheet. After meeting to compare results, areas that could not be fully assessed on the PIP Review Worksheet were identified. The team members created customized interview protocols for each MCE/PIP for the onsite meeting in order to have a full assessment to complete the PIP Review Worksheets.

After the onsite meetings were completed in early August, the EQR team members re-reviewed their responses to each PIP Review Worksheet and supplied justifications to each of the components on the tool. This was done independently by each reviewer and then responses were shared to confirm concurrence between the reviewers so that each PIP Review Worksheet could be finalized.

Upon conclusion of this PIP validation exercise, B&A has high confidence in the results reported by the MCEs for each measure included in its PIPs since each were subject to audit by a certified HEDIS® auditor. What is less clear to B&A is the validity of any results reported on the effectiveness of interventions that the MCEs implemented to improve performance. This is primarily due to the lack of information provided by the MCEs to measure effectiveness.

B&A developed recommendations on the administration of performance improvement projects in HHW and HIP. Specifically, B&A recommends that the OMPP consider working with the MCEs to revise the PIP form so that it is most useful to the OMPP, the EQRO and the MCEs themselves. The new format should be more concise but should contain most all of the requirements included in NCQA's tool. B&A recommends that a revised tool could provide less information about methodology for HEDIS®-based PIPs and more information about the interventions. In turn, B&A recommends that the MCEs build more data analytics into each of their interventions to assess their effectiveness. This recommendation stems from the fact that each MCE has conducted numerous and varied types of interventions in these PIPs and in some cases have seen little improvement over multiple remeasurement periods.

B&A has additional recommendations to both the OMPP and to the MCEs which appear at the end of Section IV of the report.

Calculation of Performance Measures

The OMPP asked B&A to calculate the results of seven measures that will be required to be reported later this year as part of the Initial Core Set of children's health care quality measures included in the State's annual submission to CMS regarding its CHIP. These seven measures are the remaining ones that the OMPP has yet to submit as part of its annual report. The OMPP wanted to ensure that when the time comes to report these measures that there are no data integrity issues which would prevent the OMPP from reporting on them. The specific measures calculated by B&A include:

- Measure 3: Live Births Weighing Less than 2,500 Grams;
- Measure 4: Cesarean Rate for Nulliparous Singleton Vertex;
- Measure 7: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Body Mass Index Assessment for Children/Adolescents;
- Measure 8: Developmental Screening in the First Three Years of Life;
- Measure 18: Ambulatory Care- Emergency Department Visits;
- Measure 20: Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit; and
- Measure 22: Annual Pediatric Hemoglobin (HbA1c) Testing.

The activities in the CMS EQR Protocol #6, *Calculation of Performance Measures*, were used as the basis for completing these calculations in whole or in part.

Section V of this report details the methodology used to compute the results for each measure. In an effort to assess the integrity of the most recent year's results, B&A computed annual results for each measure from 2009 to 2012 to assess trends as well as to assist the OMPP in establishing benchmarks for future measurement.

The results reported for these measures, for the most part, appear to be consistent over the four-year period examined. Some further research is warranted for Measures 4, 18 and 22. Investigation for Measure 4 relates to the values used to identify single live births. For Measure 18, the rate of ED visits for all age groups studied increased significantly from 2009 to 2012 and deserves further review. For Measure 22, data from CY 2009 caused the results related to hemoglobin testing to be much higher in this year than in the subsequent three years.

Focus Study on Access to Care

In consultation with the OMPP, B&A constructed a focus study on access to care which included both a quantitative and qualitative component. In the quantitative component, B&A conducted a drill-down analysis on access to primary care among children and adults not only by MCE but also by age, race/ethnicity and region of the state. B&A also reviewed access by measuring the rate of enrollees within each MCE who had received an office-based primary care service among those ever enrolled in the MCE at some point during CY 2012. This analysis expanded the population studied beyond the limits as defined by the HEDIS® measures for access to primary care but limited the study just to primary care office visits conducted in a physician office, at a federally qualified health clinic (FQHC), or at a rural health clinic (RHC). Analyses using these parameters were also examined by age, race/ethnicity and region of the state.

The qualitative component to this focus study included interviews with the MCE Provider Services staff in June to learn more about their approach to outreach to providers. B&A then conducted 59 interviews with provider entities contracted with the MCEs over a ten week period from July to September. The

interviews included representation of all provider specialties in each region of the state. In total, interviews were conducted at 29 primary medical provider (PMP) offices, 10 FQHCs, 10 RHCs, and 10 community mental health centers (CMHCs).

When the data was stratified by age, race/ethnicity and region, the results for access to primary care for children and adolescents (the HEDIS® CAP measure) showed similarities across the MCEs when measured by age and race/ethnicity. There were differences between age groups and race/ethnicities, however, specifically lower access for children age seven to 19 than for younger children by ten percentage points and lower access for African-American members which were usually five percentage points below other race/ethnicities. There were differences in access to primary care for children by region and these variances differed for each MCE.

When examining adults' access to primary care, MHS had the greatest access among the three MCEs. The disparities by race/ethnicity for children were also observed in the adult populations, but for HHW only. Interestingly, access to primary care for African-American members in HIP was higher than other race/ethnicities. There were fewer differences in the rate of access to primary care for adults across the regions than was found for children. Further, the access rates were usually similar across the MCEs within a region. The access rate among HIP adults was higher for every MCE in every region than the corresponding age/region cohort in HHW. This is probably more an artifact of the population mix in each program more so than regional access.

All of the MCEs reported that it is their goal to have at least one face-to-face visit with each PMP office per year. High-volume providers (defined differently by each MCE) may be visited more often. The provider services staff at each MCE serves both HHW and HIP providers. Since all of the MCEs utilize provider services staff at a regional level for primary care, it is typical that the provider representative will coordinate provider meetings during a period that they are visiting that region of the state.

Most often, the MCE provider services staff meets with the office manager and/or billing staff when onsite with the provider. On occasion, the meeting will also include coders, front line staff, or the clinician(s) in the office. The MCE provider representatives each have a 'Provider Toolkit' of materials at their disposal to share with providers while in the field. B&A learned that about 20 of the component materials are similar across all three MCEs.

The results of the face-to-face interviews with providers were enlightening. Although B&A had a list of pre-set questions to cover in each meeting, numerous other topics were also voluntarily brought up by provider office staff. In all, 12 different topics comprised most of the conversations and much of the feedback was similar on each topic. Topics included the quality of the MCE provider staff, MCE customer service, PMP assignment, Gaps in Care (member utilization) reports, billing requirements, and access (or lack thereof) of specialists to name a few. The feedback on each of these topics is covered in detail in Section VI of the report.

Provider feedback pertaining to the HHW and HIP programs in general and with MCEs in particular ranged from satisfaction to frustration. B&A analyzed the key factors related to provider satisfaction which included the quality of the MCEs' provider field staff, the quality of assistance and training the office staff received from the MCEs, and the ease in getting paid by the MCE. The key factor related to frustration from providers related to consistency across MCEs and programs (i.e., prior authorization submission and adjudication, a single Medicaid manual rather than one for fee-for-service (FFS) Medicaid and separate manuals for each MCE, consistent and accurate claims processing, and consistent responses from customer service representatives). Among B&A's sample of providers interviewed that contract with more than one MCE, three quarters of them cited areas such as this.

It should be noted that among all of the items mentioned in the open-ended question on improving either HHW or HIP, the rate of reimbursement was mentioned infrequently. In fact, only four providers cited this as something they would like to see changed.

B&A has identified 15 specific recommendations to the OMPP covering many of the topics brought up by providers in the meeting on ways that the OMPP can improve the providers' experience with the program through MCE contract requirements. B&A has also developed 13 recommendations for all of the MCEs as well as some recommendations specific to each MCE. All of these are found at the end of Section VI of this report.

Focus Study on Mental Health Utilization and Care Coordination

In last year's EQR, B&A's clinical team reviewed 134 care plans for members enrolled in the OMPP's Right Choices Program (RCP), a program where members are restricted to one PMP, one hospital and one pharmacy in an effort to combat member abuse of services. Many of the individuals who are enrolled in the RCP were found to have mental health diagnoses. Therefore, one component of the care plan review was to gauge whether or not mental health diagnoses and medications were being tracked in the care plan. B&A offered the recommendation to the MCEs that tracking both of these elements could be improved in the documentation of the care plans for RCP members.

B&A developed a focus study for this year's EQR which is a continuation of the work conducted in last year's EQR. In this year's EQR, a review of mental health utilization was conducted more broadly for all members of HHW and HIP, not just the RCP members. Additionally, B&A reviewed the first submissions of the new complex and moderate case management reports for mental health conditions covering 1st Quarter 2013 that were implemented January 1, 2013.

Specific elements of this year's focus study included the following:

- A quantitative claims-based utilization analysis to assess who among HHW and HIP members have mental health diagnoses, how many members with these diagnoses are receiving mental health services, and from whom do they receive these services;

- A qualitative component that included interviews with the MCEs about the delivery of mental health services to members; and

- A clinical component included the review of case files for individuals enrolled in the MCE's case management program due to mental health diagnoses.

The quantitative analysis in many ways mirrored the analysis conducted on access to primary care; namely, utilization was measured for members in HHW and HIP by where they received mental health services which was stratified by age, race/ethnicity and region. Whereas the access to primary care focused on those providers who deliver primary care, the mental health utilization analysis focused on providers who most often deliver mental health services.

Among 906,669 members ever enrolled in HHW during CY 2012, there were 157,280 members (17.3%) who had a mental health diagnosis reported on an encounter in CY 2012. This is further divided between 106,048 child members (15.1% of ever enrolleds) and 51,232 adults (25.3% of ever enrolleds). Of the 52,886 members ever enrolled in HIP during CY 2012 (all adults), 15,281 (28.9%) had a mental health diagnosis reported on an encounter.

The percentage of HHW and HIP members with a mental health diagnosis is being driven mostly by Caucasian members. In HHW, 21.0 percent of Caucasians had a mental health diagnosis compared to 12.5 percent of African-American members and 8.7 percent of Hispanic members. A similar trend was found in HIP with 31.3 percent of Caucasian members with mental health diagnosis on an encounter compared to 20.2 percent for African-American and 16.6 percent for Hispanics.

Three categories of diagnoses comprised half of all of the mental health diagnoses cited on encounters for the HHW population—attention deficit disorder (24.9% of total), anxiety organic disorder (14.5%), and major depressive or bipolar disorder (12.9%). Among the HIP population, three diagnoses also comprised half of all mental health diagnoses—tobacco use disorder (19.6% of total), attention deficit disorder (15.5% of total), and major depressive or bipolar disorder (14.9% of total).

Outpatient mental health clinics and CMHCs play an important role in the delivery of these services since more than 80 percent of all services were billed by these two provider types in both HHW and HIP. Community mental health providers delivered less than 10 percent of the services (except in Anthem HIP). It is interesting to note that in MDwise HIP, primary care providers comprise a larger proportion of mental health services delivered than the other MCEs or in MDwise HHW.

The patterns of service delivery shown above carried through when reviewing within these demographic cohorts, with some exceptions. For example, mental health services are more likely to be delivered by community mental health providers to adults than to children in HHW. Also, African-American members were more likely to receive services from CMHCs than other HHW or HIP members and Hispanic members were more likely to receive services from outpatient mental health clinics than other race/ethnicities. This was true for all MCEs.

B&A obtained reports submitted by the MCEs to the OMPP about HHW and HIP members enrolled in complex case management during 1st Quarter 2013 from which to derive a sample of case files for review onsite. Ultimately, 297 cases (95 from Anthem, 98 from MDwise and 104 from MHS) were reviewed by the EQR Clinical Review Team of two MDs and three RNs. A case file review tool was developed specifically for this EQR for the clinicians to track evidence of diagnoses, medications, service utilization and communications with providers in the case file. Also, items were reviewed related to the care plans developed for the members—whether they contained measurable goals, if they incorporated patient diagnoses, and if the care plan was sent to either PMPs or mental health providers.

In addition to the care plan reviews onsite at each MCE in August, the doctors on the clinical team interviewed MCE staff responsible for implementing the MCE's behavioral health program on items required in the contract, the staffing of the behavioral health team, and policies and procedures around case management.

Overall, the reviewers noted that care plan goals are often not measureable, not specific to a particular need, nor do they address the main physical or mental health diagnosis of the member. Seldom did they address things such as substance abuse, medication compliance, steps to prevent future hospitalizations, ways to ensure and coordinate follow-up with PMP and/or mental health provider appointments, or ways to build toward a healthier lifestyle.

The care plans reviewed are not really care plans. They are a repository of chronologic events in a member's health care needs. This chronology is imperfect and generally without any real focus on impacting in a positive way the member's health and/or utilization of medical services. It is more focused on helping with appointments, assigning PMPs, etc. These are important tasks, but not really what a care plan is all about.

At all three MCEs, there was little documentation of coordination and integration of information between the PMPs and the mental health providers.

The absence of consistent and accurate utilization data available to the case manager is a significant deficiency at all three MCEs. Another issue is the accuracy of important information such as diagnoses, both physical and mental. These need to be readily available and accurate.

This is the third time in the past five years that the EQR Clinical Team has looked at the MCEs' care plan/case management efforts for various aspects of care. Although there has been some definite improvement, and despite significant efforts on the part of the MCEs through the purchasing of advanced computerized case management software products, overall there remains a huge gap between what is defined in the contract scope of work for the MCEs to do and the reality of what is being accomplished.

One aspect of this gap is, in the opinion of the clinical team, caused by a disconnect in the language of the contract and the reality of where case management as a discipline has evolved. B&A has made specific recommendations related to the case and care management functions as a result of this review to both the OMPP and to all of the MCEs. These are listed below. Other recommendations specific to each MCE appear at the end of Section VII of this report.

<u>Recommendations to the OMPP</u>

1. The OMPP should consider re-writing the contract requirements for case/care management to better reflect current methodologies of care plan development and case management.

2. If care plans continue to be a contract requirement, the OMPP should consider precisely defining what should be in them, how they should be measured and monitored, and how the documentation of communication and coordination should be accomplished.

3. The OMPP should consider financial incentives to the MCEs to reach certain goals in integrating the communication between the PMP and mental health providers.

4. OMPP should consider either revising or adding clarification language to the "180 day rule" for requiring case management to all members discharged from mental health inpatient stays.

5. In the case of all three MCEs, the completion of the new QR-CMBH1 report which was used for identifying HHW and HIP members enrolled in complex case management was problematic. Information submitted to B&A for this review did not tie out to the reports submitted to the OMPP. The OMPP should reconvene the OMPP/MCE workgroup created in CY 2012 to ensure common understanding of the requirements related to these report submissions.

<u>Recommendations to All MCEs</u>

1. All MCEs need to focus on developing measurable care plan goals that focus both on physical health needs as well as mental health needs.

2. All MCEs need to aggressively look at incentive programs for providers in order to have better cooperation and availability. Chronic pain management is one area in need of more providers.

3. All MCEs need to significantly improve sending and documenting that the care plan went to the member's mental health provider(s).

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

Introduction

As the single state agency responsible for Indiana's Medicaid program, the Indiana Office of Medicaid Policy and Planning (OMPP) has implemented two managed care programs using Section 1115 waiver authority. The Hoosier Healthwise (HHW) program began in 1994. By the end of 2005, all Medicaid members that had previously been enrolled in the HHW Primary Care Case Management (PCCM) system were transitioned into managed care entities (MCEs).[1] Effective January 1, 2008, the HHW program was subsumed under the state's Section 1115 waiver.

The HHW program covers the following populations:

- Caretakers and children less than 18 years receiving TANF (Temporary Assistance for Needy Families);
- Pregnant women who do not receive TANF. The full scope of benefits are available to women who meet strict income and resource criteria;
- Children whose families do not receive TANF but who are under age 21 and meet the eligibility requirements; and
- Children in families whose income exceeds TANF requirements, but who are at or below 150 percent of the Federal poverty level (CHIP I).

Additionally, HHW is offered to the following:

- Pregnancy-related coverage is provided to women whose income is below 200 percent of the federal poverty level (FPL) (Benefit Package B).
- SCHIP benefits (Benefit Package C) are available to children in families whose income is 151% - 250% (CHIP II & III) of the FPL. Package C requires premiums to be paid depending on income and family size factors.

Also part of the January 2008 Section 1115 approval was the creation of the Healthy Indiana Plan (HIP). The HIP covers two expansion populations:

- Uninsured custodial parents and caretaker relatives of children eligible for Medicaid or the Children's Health Insurance Program (CHIP) with family income up to 200 percent of the FPL but are not otherwise eligible for Medicaid or Medicare (the "Caretakers" category); and
- Uninsured noncustodial parents and childless adults ages 19 through 64 who are not otherwise eligible for Medicaid or Medicare with family income up to 200 percent of the FPL (the "Adults" category).

[1] In Indiana, the term MCE is synonymous with the term managed care organization and will be used as such throughout this report. It refers to those entities that the OMPP contracts with under a full-risk arrangement.

For both Caretakers and Adults, eligibles cannot have access to employer-sponsored health insurance and must be uninsured for at least six months prior to enrollment in the HIP.

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

Enrollment in HHW was 696,611 at the end of Calendar Year 2012 and enrollment in HIP was 39,578 members at this time. Enrollment grew among HHW children by 2.6 percent from the end of 2010 to the end of 2011 but was flat throughout CY 2012 (refer to Exhibit I.1). Enrollment among HHW adults was generally flat in both years. The HIP enrollment decreased 6.0 percent in CY 2011 and another 2.1 percent in CY 2012.

Exhibit I.1
Enrollment Trends in Hoosier Healthwise and HIP

	Hoosier Healthwise Children	Hoosier Healthwise Adults	HIP Members
December 2010	569,597	111,755	43,010
December 2011	584,574	111,555	40,437
December 2012	584,573	112,038	39,578
Pct Change 10-11	**2.6%**	**-0.2%**	**-6.0%**
Pct Change 11-12	**0.0%**	**0.4%**	**-2.1%**

Source: MedInsight, OMPP's Data Warehouse
B&A retrieved enrollment data May 1, 2013.

As seen in Exhibit I.2, as a percentage of all members, there are more minorities among HHW children than among the adults, but there are also a significantly higher proportion of minority adults in HHW than in HIP.

Exhibit I.2
Hoosier Healthwise and HIP Members by Race/Ethnicity
As of December 2012

	Hoosier Healthwise Children	Hoosier Healthwise Adults	Healthy Indiana Plan Members
By Race/Ethnicity			
Caucasian	61%	68%	83%
African-American	22%	25%	10%
Hispanic	13%	4%	3%
Other	3%	3%	4%

Source: MedInsight, OMPP's Data Warehouse
B&A retrieved enrollment data May 1, 2013.

At the regional level, the proportion of members is consistent between HHW and HIP, with the exception that the Southeast Region has higher representation and the Central Region has lower representation in HIP than in HHW.

Exhibit I.3
Hoosier Healthwise and HIP Members by Region
As of December 2012

	Hoosier Healthwise Children	Hoosier Healthwise Adults	Healthy Indiana Plan Members
By Region			
Northwest	13%	14%	12%
North Central	10%	9%	9%
Northeast	12%	10%	13%
West Central	7%	8%	7%
Central	31%	32%	25%
East Central	9%	10%	12%
Southeast	9%	9%	13%
Southwest	8%	8%	8%
Out-of-State	0%	0%	0%

Source: MedInsight, OMPP's Data Warehouse
B&A retrieved enrollment data May 1, 2013.

MCEs Contracted in the Hoosier Healthwise and Healthy Indiana Plan

The OMPP contracts with MCEs to provide most services available to HHW and HIP members. The OMPP pays the MCEs a capitation rate per member per month (PMPM) based on the member cohort and the member's home region. Individual providers have the option to contract with one or more MCEs.

OMPP entered into new contracts with the MCEs for the period effective January 1, 2011. Under this contract, the three MCEs that contact with the OMPP serve both HHW and HIP members under one combined contract. All three MCEs serve HHW and HIP members statewide.

Anthem

Anthem Blue Cross and Blue Shield is a licensed subsidiary of WellPoint which offers group and individual health benefits, life and disability products nationwide. In 2004, WellPoint Health Networks Inc. and Anthem, Inc. merged to create the largest commercial health benefits company in the United States. In 2012, WellPoint purchased Amerigroup to expand its coverage of Medicaid eligibles. WellPoint is headquartered in Indianapolis. In Indiana, Anthem has been under contract with OMPP for HHW since January 2007 and for HIP since the program's inception in January 2008.

MDwise

MDwise is a locally-owned, Indianapolis-based, non-profit MCE that has been participating in HHW since its inception. MDwise has contracted with OMPP to serve HIP members since the program's inception in January 2008. In January 2007, MDwise obtained its own HMO license with the State. MDwise subcontracts the management of services to eight delivery systems. One of these delivery

systems serves members statewide while the other seven are regionally-based. In addition to HHW and HIP, MDwise also is under contract with the OMPP to administer the Care Select program, a non risk-based program for the Aged, Blind and Disabled population.

Managed Health Services

MHS is a subsidiary of Centene Corporation, a St. Louis-based Medicaid managed care company founded in 1984. Centene created MHS in 1994 when it began serving the HHW population. MHS's headquarters is located in Indianapolis. MHS utilizes another Centene subsidiary, Cenpatico, for the management of behavioral health services. It also leverages other Centene-owned subsidiaries such as Nurse Response (nurse hotline), Nurtur (disease management), U.S. Script (pharmacy) and OptiCare Managed Vision (vision).

Exhibit I.4 shows the distribution of the HHW and HIP enrollment as of December 2012 by MCE. MDwise has a higher proportion among the MCEs in the HHW child population while Anthem has 62 percent of the HIP members to MDwise's 25 percent. MHS began enrolling HIP members effective January 1, 2011. There is also a small component of the HIP population (the Enhanced Services Plan, or ESP) that is excluded from managed care[2].

Exhibit I.4
Hoosier Healthwise and HIP Members by MCE
As of December 2012

	Hoosier Healthwise Children	Hoosier Healthwise Adults	Healthy Indiana Plan Members
By MCE			
Anthem	30%	37%	62%
MDwise	40%	38%	25%
MHS	30%	25%	9%
Other (HIP ESP)	0%	0%	4%

Source: MedInsight, OMPP's Data Warehouse
B&A retrieved enrollment data May 1, 2013.

Benefit Package

The benefit package for the HIP is more limited in amount, duration and scope than the Package A HHW program. Exhibit I.5 (appearing on the next page) outlines the benefits in both programs and limitations in the HIP.

Dental services and pharmacy coverage are also available to HHW members, but these are not managed by the MCEs. Additionally, HHW members are eligible for Individualized Education Plans (IEPs) and early intervention services (First Steps), but these are also carved out of the MCE capitation payment.

[2] The ESP was not reviewed in this EQR.

Exhibit I.5
Benefit Package for Members in the Hoosier Healthwise Program and Healthy Indiana Plan

Benefit	HHW	HIP	Notes on Benefit for HHW and HIP or Limits if Covered in the HIP
Inpatient Medical/Surgical	X	X	
Emergency room services	X	X	Self-referral Co-pay for services for HIP members when the service is determined to be non-emergent
Urgent care	X	X	
Outpatient hospital	X	X	
Outpatient Mental Health and Substance Abuse	X	X	Medicaid Rehabilitation Option (MRO) and Psychiatric Residential Treatment Facility (PRTF) services are not the responsibility of the MCEs; Psychiatry is a self-referred service
Primary care physician services	X	X	
Preventive care services	X	X	
Immunizations	X	X	Self-referral
EPSDT services	X	X	In HIP, EPSDT screening for members age 19 and 20 only
Specialist physician services	X	X	
Radiology and pathology	X	X	
Physical, occupational and speech therapy	X	X	In HIP, 25-visit annual maximum for each type of therapy
Chiropractic services	X		Self-referral
Podiatry services	X		Self-referral
Eye care services	X		Self-referral; excludes surgical services
Prescription Drug (carved out of the MCE contract)	X	X	Brand name drugs are not covered where a generic substitute is available.
Home health/Home IV therapy	X	X	Excludes custodial care but includes case management
Skilled Nursing Facility	X	X	
Ambulance	X	X	Emergency ambulance transportation only
Durable Medical Equipment	X	X	
Family Planning Services	X	X	Self-referral; excludes abortions, abortifacients
Hearing Aids	X	X	In HIP, ages 19 and 20 only
FQHC and Rural Health Center Services	X	X	In HIP, subject to the benefit coverage limits
Disease Management Services	X	X	
Diabetes self-management	X		
Transportation	X		

HIP POWER Account

The Personal Wellness and Responsibility (POWER) Account is the feature of the HIP that makes it unique among programs developed nationally for the low-income uninsured. The POWER Account is modeled on the concept of a Health Savings Account (HSA). A $1,100 allocation is contributed for each HIP member's POWER Account annually. These dollars are funded through contributions from the member, the State (with federal matching dollars) and, in some cases, the member's employer. The member's annual household income is calculated at eligibility determination. The member's contribution to the $1,100 balance is calculated based upon household income. The member is allowed to pay for his/her POWER account contribution in 12 monthly installments throughout the year.

A member's POWER Account contribution amount may be changed during the year due to extenuating circumstances causing a change in income or family size. At a minimum, the POWER Account

contribution is reviewed annually at redetermination when household income or other eligibility criteria are also reviewed.

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

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

If a member utilizes services in excess of the $1,100 in the POWER Account, she/he is not at risk. These costs are covered by the State.

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

Background

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

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

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

For the first activity, B&A completed a full review of compliance with all federal Medicaid managed care regulations as well as additional contractual requirements mandated by the OMPP in its contract with the managed care entities (MCEs) in the EQR conducted in 2012 covering Calendar Year (CY 2011). B&A utilized the CMS Protocol *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al."* published in February 2003 to complete this review. This periodic review was completed last year because the OMPP entered into new contracts with the MCEs effective January 1, 2011 in which the requirements for administering the Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) programs were subsumed under one contract.

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

For the mandatory activity related to the validation of performance measures, B&A has selected a sample of reports that the MCEs are required to submit to OMPP on a regular basis in order to validate the performance measures reported. In last year's EQR, an exception was made so that the full compendium of reports that the MCEs are required to submit to the OMPP (usually on a quarterly basis) were reviewed. After completing a desk review of the data reported for each measure on the reports (which comprised over 85 in total), B&A convened a workgroup with all of the MCEs as well as OMPP representatives to identify the measures/reports where the greatest differences were found in the results reported across the MCEs. The outcome of these meetings was the streamlining of the MCE Reporting Manual which included the removal of some reports, the addition of new reports, and the clarification of instructions on other reports. The new MCE Reporting Manual took effect January 1, 2013.

In CY 2010, B&A began the validation of MCE performance improvement projects (PIPs) for the Review Year 2009 (prior to this they were not required by the OMPP). In CY 2011, an update on the prior year's PIP validation activities was conducted rather than a full validation since the actual PIPs remained the same in all but one case at the MCEs. In CY 2012, the validation of PIPs was once again excluded from the review since PIPs were not required by the OMPP.

Exhibit II.1
EQR Focus Studies Conducted of MCE Operations in HHW and HIP, 2009 - 2012

Year Review Conducted	Review Year	Program	Functional Area	Review Topic
CY 2009	CY 2008	HHW	Utilization Management	Authorization Processes
CY 2009	CY 2008	HHW	Provider Network Management	Survey of HHW Primary Medical Providers
CY 2009	CY 2008	HHW	Information Systems	Claims Processing and Pricing
CY 2010	CY 2009	HHW, HIP	Member Services	Initiatives to Address Cultural Competency
CY 2010	CY 2009	HHW, HIP	Program Integrity	Program Integrity Functions
CY 2010	CY 2009	HHW, HIP	Provider Network	Availability and Accessibility of Providers to Members
CY 2010	CY 2009	HHW, HIP	Utilization Management	Retrospective Authorization and Claim Denial Review
CY 2011	CY 2010, Q1 2011	HHW, HIP	Disease Management	Review of Disease, Case and Care Management Practices
CY 2011	CY 2010	HHW, HIP	Clinical Practices	Clinical Review of Complicated C-sections and Hospital Readmissions
CY 2011	CY 2010	HHW, HIP	Emergency Services	ER Utilization and Payment Practices
CY 2012	CY 2011	HHW, HIP	Utilization Mgmt, Behavioral Health	Review of Inpatient Psychiatric Stays
CY 2012	CY 2011	HHW, HIP	Utilization Mgmt	Review of the Right Choices Program

EQRO Activities in CY 2013

B&A met with the OMPP in early 2013 and developed the following topics for this year's EQR:

- Validation of Performance Measures
- Validation of MCE Performance Improvement Projects (PIPs)
- Optional EQR Activity: Calculation of Performance Measures (Selected CMS Child Core Measures)
- Optional EQR Activity: Conduct a Focus Study on Access to Care
- Optional EQR Activity: Conduct a Focus Study on Mental Health Utilization and Care Coordination

For the validation of performance measures and PIPs, B&A utilized the CMS Protocols EQR Protocol #2: *Validation of Performance Measures* and EQR Protocol #3: *Validating Performance Improvement Projects* for guidance in completing these mandatory activities. Additionally, B&A referenced EQR Protocol #6: *Calculation of Performance Measures* to complete this optional activity. For the two focus studies, B&A worked with the OMPP Quality Lead to develop the elements of each study.

The details pertaining to each aspect of this year's EQR were released to the MCEs in an EQR Guide on May 10, 2013. The EQR Guide appears in Appendix A of this report. It contains information about the focus of each review topic in the EQR, the expectations of MCEs in the review, a document request, and a

schedule of events. For four of the five topics, a desk review, onsite reviews and post-onsite follow-up occurred. The fifth topic (Optional EQR Activity: Calculation of Performance Measures) was conducted as a desk review only. All of this year's EQR tasks were conducted during the period of April to September, 2013.

The EQR Review Team

This year's review team included the following staff:

- Mark Podrazik, Project Manager, Burns & Associates, Inc. Participated in all aspects of the review and primary report author. He has worked with the OMPP in various capacities since 2000. Previously, Mr. Podrazik has led the EQRs of HHW in CYs 2007-2012 as well as the EQRs for the HIP in CYs 2009-2012.

- Brian Kehoe, Senior Consultant, Burns & Associates, Inc. Participated in all face-to-face provider interviews conducted throughout the state. He also developed the sampling methodology for these interviews as well as the interview protocol. Mr. Kehoe has eight years of experience working with Medicaid managed care programs.

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

- Carol Weller, SAS Programmer, Burns & Associates, Inc. Conducted all SAS analytical support related to measuring access to primary care and behavioral health services. She also developed the utilization profiles used by the clinical team in the review of care plans. Ms. Weller previously participated in the operational EQR review conducted in CY 2008 and has provided analytical support to the EQRs conducted in CYs 2009-2012.

- Barry Smith, Analyst, Burns & Associates, Inc. Assisted in the tabulation of information related to the care plan reviews and the provider interviews. Mr. Smith has worked on the Data Analysis Team for the EQRs conducted in CYs 2009-2012.

- Dr. Linda Gunn, AGS Consulting, Inc. Participated as a team member in the face-to-face interviews with providers and associated meetings on provider relations with MCE staff. Dr. Gunn also participated in B&A's EQRs for Indiana programs in CYs 2009-2012.

- Kristy Lawrance, Cindy Collier Consulting, LLC. Participated as a team member in the validation of performance improvement projects and as a team member in the face-to-face interviews with providers and associated meetings on provider relations with MCE staff. Ms. Lawrance joins the B&A EQR for the first time this year. She has previous experience with these programs having previously worked for the OMPP and for one of the contractors in the OMPP's Care Select program.

- Dr. CJ Hindman, Kachina Medical Consultants. Dr. Hindman served as the Clinical Lead for the clinical aspects of the focus study on mental health utilization and care coordination, including the review of care plans. He was previously the Chief Medical Officer for Arizona's Medicaid program and also served as the Corporate Medical Director of a Medicaid managed care program.

Dr. Hindman also served on B&A's EQR Clinical Review Team in the EQRs conducted in CYs 2009-2012.

- Dr. Dan Asimus, subcontractor to Kachina Medical Consultants, is board certified in psychiatry, neurology, child psychiatry as well as holistic medicine. Dr. Asimus participated in interviews with the MCEs and oversaw the review of case files for the focus study related to mental health utilization and care coordination.

- Phyllis Click, RN and Kelly Johnson, RN, Kachina Medical Consultants. Assisted Dr. Hindman in the review of care plans.

- Melinda McKusky, RN, Brightstar Healthcare. Assisted Dr. Hindman in the review of care plans. She also served on B&A's EQR Clinical Review Team in 2011 and 2012.

- Helena Perez, Administrative Lead, Kachina Medical Consultants. Assisted the Clinical Review Team in various capacities related to the review of care plans onsite at the MCEs.

SECTION III: VALIDATION OF PERFORMANCE MEASURES

Introduction

In previous External Quality Reviews (EQRs), Burns & Associates, Inc. (B&A) has selected performance measures to validate from among the various reports that the Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) managed care entities (MCEs) submit to the Office of Medicaid Policy and Planning (OMPP) on a regular basis in the MCE Reporting Manual. In last year's EQR, a different approach was taken. All of the measures submitted on reports in the MCE Reporting Manual were reviewed first as a desk review by B&A and later presented as findings to a workgroup comprised of B&A, OMPP and MCE staff. This workgroup was assembled to determine reasons for why results on some reports varied considerably by MCE. Discussions also occurred related to clarifying report definitions and instructions.

In this year's EQR, B&A returns to its usual format for validating performance measures. We have selected six performance measures from among the many in the MCE Reporting Manual for review. B&A has followed the steps in the Centers for Medicare and Medicaid's (CMS's) EQR Protocol #2, *Validation of Performance Measures*, with some slight adjustments discussed with the OMPP. The sections below describe our validation activities in this protocol. At the end of this section, the results of our validation are shown by MCE for its HHW and HIP measures.

Activity 1: Pre-Onsite Visit Activities

Activity 1 in the CMS Protocol is comprised of the following steps:

- Step 1: Define the scope of the validation
- Step 2: Assess the integrity of the MCO's information system
- Step 3: Select measures for detailed review
- Step 4: Initiate review of medical record data collection
- Step 5: Prepare for the MCO onsite visit

In cooperation with the OMPP, B&A selected six measures from the MCE Reporting Manual that are linked to HEDIS® measures. The OMPP requires the MCEs to contract with a certified HEDIS® auditor to validate the annual results of HEDIS® measures that are submitted to the National Committee for Quality Assurance (NCQA). These measures include tabulations using the administrative (claims-based) and the hybrid (claims and medical records) methods.

Within the year, the OMPP requires the MCEs to report on many of these HEDIS® measures on a quarterly basis using the administrative method only and "HEDIS®-like" specifications. That is, instead of using a single anchor date for the measure (many HEDIS® measures have an anchor date of December 31), these "HEDIS®-like" measures have a moving anchor date covering a 12-month period. For example, for a report that the MCE must submit covering the period ending March 31, 2012, the anchor date is March 31 and the service period is April 1 – March 31. Usually, all other specifications of the HEDIS® measure still apply.

The OMPP asked B&A to review some of the measures where these "HEDIS®-like" definitions apply which must be submitted to the OMPP quarterly. B&A conducted the validation test by creating a dataset of encounters reported to the OMPP by the MCEs and stored in the OMPP data warehouse, MedInsight. The data extract was completed on May 1, 2013 for dates of service covering a five-year period ending December 31, 2012.

This validation exercise is intended to match B&A's results using the method for the quarterly submissions (administrative method only) against the results reported by the MCEs. To serve as another source for comparison, B&A also compared the final quarterly submission for CY 2012 with the results computed by each MCE's HEDIS® auditor for HEDIS® 2013 (using the administrative method only). Using this third party as a benchmark will help to understand if there are differences between the EQRO and the MCE what might be the source of the difference (e.g., the State's dataset versus the MCE's dataset).

Because HEDIS® measures were selected and the MCEs are already subject to an information systems review by its HEDIS® auditor, B&A did not conduct a full assessment of the integrity of the MCE's information system. Rather, we reviewed the Information Systems Capabilities Assessments (ISCA) completed by the HEDIS® auditors in CY 2013 just prior to B&A going onsite. A report of the findings of the ISCA is required by the OMPP in its contract with the MCEs. The ISCA reports were delivered to each MCE in July 2013. The results reported by the HEDIS® auditors are as follows:

- Anthem- All standards were met.
- MDwise- All standards were met.
- MHS- All standards were met except one standard which was partially met (The organization continually assesses data completeness and takes steps to improve performance.) because MHS was unable to generate information on one measure. This information had no applicability to the measures that B&A was validating.

The measures shown below were selected for validation in this year's EQR. An indication is shown whether the measure is applicable to HHW, HIP or both. The reference to the report in the MCE Reporting Manual is also provided.

1. Well Child Visits in the First 15 Months of Life (the basis of which is HEDIS® measure W15); HHW only; OMPP Report QR-CA4.

2. Well Child Visits in the 3rd through 6th Years of Life (the basis of which is HEDIS® measure W34); HHW only; QR-CA5.

3. Adolescent Well Care Visits (the basis of which is HEDIS® measure AWC); HHW only; OMPP Report QR-CA6.

4. Children and Adolescents' Access to Primary Care Practitioners (the basis of which is HEDIS® measure CAP); HHW only; OMPP Report QR-CA3.

5. Adults' Access to Preventive Ambulatory Services (the basis of which is HEDIS® measure AAP); HHW and HIP; OMPP Report QR-PCC1.

6. Utilization of Imaging Studies for Low Back Pain (the basis of which is HEDIS® measure LBP); HHW and HIP; OMPP Report QR-PCC10.

Since all of the analysis in this year's validation is based on the administrative method, there was no need to initiate the review of any medical record data collection.

In preparation for the onsite meetings with each MCE, B&A conducted the following steps.

1. B&A collected the reports submitted to the OMPP by the MCEs that contained the values submitted quarterly in CY 2012 for each measure that is being validated.

2. B&A tabulated the results from these reports into a data sheet for comparison to B&A's independent calculations.
3. Validation tests were completed on the data extract received from the OMPP data warehouse. For example, B&A examined the following:
    a. Frequency counts of claims by month date of service by claim type (institutional, professional and pharmacy)
    b. Frequency counts of member months by program (HHW and HIP) and eligibility aid category within program
    c. The demographic information in 3(b) was attached to each claim. Then, frequency counts of claims by eligibility aid category were run.
4. B&A's programmer, Jesse Eng, programmed the HEDIS® specifications into a SAS program to tabulate the results for each measure. Because information was reported on a quarterly basis, B&A built the programs to generate results so that each calendar quarter served as the anchor date of a 12-month service period.
5. To further ensure the validity of the results using 12-month service dates ending in CY 2012, B&A also ran the same calculations for the anchor date ending each year in CY 2008, 2009, 2010 and 2011. These annual results were compared to the quarterly results computed for CY 2012.
6. The CY 2012 quarterly results were entered in a datasheet and compared to the MCE submitted values for each quarter.

Datasheets were prepared for each MCE showing the measures that were evaluated with the comparative data submitted by the MCE and the results computed by B&A. Separate results were compiled for HHW and HIP, where applicable.

Activity 2: Onsite Visit Activities

Activity 2 in the CMS Protocol is comprised of the following steps:

- Step 1: Review information systems underlying performance measurement
- Step 2: Assess data integration and control for performance measure calculation
- Step 3: Review performance measure production
- Step 4: Conduct detailed review of selected measures
- Step 5: Assess the sampling process (if applicable)
- Step 6: Preliminary findings and outstanding items

The focus of Activity 2 in this year's review was Steps 4 and 6. Steps 1 through 3 were not completed since B&A had reviewed each MCE's ISCA as stated previously.

On June 18-19, 2013 B&A's Project Lead Mark Podrazik walked through the results of each performance measure with the appropriate staff at each MCE who were responsible for the tabulation and submission of the measures to OMPP on the quarterly reports. Questions were asked that were specific to each MCE/measure in an effort to understand the potential root cause of differences between the MCE and B&A. To help facilitate this discussion, B&A provided supporting documentation for each measure including the counts of the potential population that were excluded due to HEDIS® specifications (e.g., non-continuous enrollment for all measures, contraindicators for the LBP measure). This information was shown for each of the four quarter reporting periods studied so that MCEs could examine both the numerator and denominator used in each measure. Additionally, annual results were shown for each measure over the previous five year period.

The MCEs shared the results from their HEDIS® auditor that were recently completed for HEDIS® 2013 to serve as a benchmark to compare against both of the data sources (B&A and the MCEs).

During the onsite meeting, the preliminary findings were reviewed which were the differences between how the MCE reported the measure and how B&A reported the measure. The MCEs were asked to identify potential items that could be reviewed on their end to help assist in identifying if adjustments needed to be made to either parties' figures.

Because all administrative data was used for the study period, there was no need to assess any sampling process.

Activity 3: Post-Onsite Visit Activities

Activity 3 in the CMS Protocol is comprised of the following steps:

- Step 1: Determine preliminary validation findings for each measure
- Step 2: Assess accuracy of MCO's performance measure reports to the State
- Step 3: Submission of validation report to the State

This report serves as the report submission to the State. It incorporates all adjustments made by either B&A or the MCEs to complete the validation process.

The findings for each MCE appear in the exhibits at the end of this section. Each exhibit is laid out the same and shows three parts. Part I is the information as tabulated by B&A using the OMPP's claims and enrollment files as the data source. Part II is the information as tabulated by the MCE. Part III is the difference between the two parties. At the bottom of each exhibit, a quick summary shows the comparisons for the anchor date of 12/31/12 between B&A, the MCE and the HEDIS® Auditor (using the administrative method).

Exhibits III.1, III.3 and III.5 are measures specific to HHW. Exhibits III.2, III.4 and III.6 are specific to HIP.

Findings

Exhibit III.1 on the next page summarizes the differences between B&A and the MCEs on the measures reviewed. A notation is made in any cell where the difference is considered significant. Whenever there is a difference, B&A's value is lower than the MCE's. For HHW, B&A was lower on three out of 10 measures with Anthem, three out of ten with MHS, and two out of ten with MDwise. For HIP, B&A was lower than Anthem on two out of three measures and for MDwise on one out of three.

Two measures in particular had the most differences in values—AAP 20-44 years and LBP. B&A also compared the results from the HEDIS® Auditor against the B&A and MCE results. For AAP 20-44 years, the HEDIS® Auditor was always closer to the MCE finding than B&A's finding. For LBP, the results were more mixed. The HEDIS® Auditor result was between B&A and the MCE in the case of Anthem (HHW and HIP) and MDwise HIP. For MHS HHW, the HEDIS® Auditor and MHS were exactly the same. For MDwise HHW, the HEDIS® Auditor was closer to B&A's result and both entities were significantly lower than the value reported by MDwise.

Exhibit III.1
Summary of Validation of Performance Measures Reviewed
Notable Differences Between B&A and the MCEs

Measure	B&A and Anthem	B&A and MHS	B&A and MDwise
HHW			
W15	B&A lower		
W34			
AWC			
CAP 12-24 mo			
CAP 24 mo-6 yrs			
CAP 7-11 yrs		B&A lower	
CAP 12-19 yrs		B&A lower	
AAP 20-44 yrs	B&A lower		B&A lower
AAP 45-64 yrs			
LBP	B&A lower	B&A lower	B&A lower
HIP			
AAP 20-44 yrs	B&A lower		
AAP 45-64 yrs			
LBP	B&A lower		B&A lower

Probable Limitations in the Data that Prevent Closer Alignment of Results

B&A discussed the differences shown above with the OMPP and each MCE. Ultimately, the reasons for the differences in the results were attributed to the following:

1. The data source. B&A used information from the OMPP data warehouse. These encounters are submitted by the MCEs to the OMPP. They are then put through a scrubbing process before being promoted to the data warehouse. If either (a) the MCE did not submit all of their encounters or (b) some encounters were removed in the data scrubbing process, then B&A's results will be understated compared to the MCE's. This would also hold true when comparing B&A's results to the HEDIS® auditor.

2. Retroactive eligibility. B&A was able to compute all of the measures at the same time in June 2013. Any retroactive eligibility of members was accounted for in this tabulation. The MCEs are submitted their results on a quarterly basis on a 30-day lag after the end of the reporting period. To the extent that eligibility changes occurred more than 30 days after the end of the reporting period, these would be captured by B&A but not by the MCEs.

3. Paid versus Denied encounters. B&A only included encounters with a paid status. In some cases, MCEs included denied claims in their HEDIS® computations as per the HEDIS® specifications.

Exhibit III.2
Summary of Validation of Performance Measures Reviewed
Anthem: Hoosier Healthwise

PART 1: Computed by Burns & Associates (Encounters and Enrollment from OMPP Data Warehouse)

Anchor End Date	Well Child Visits in the First 15 Months of Life (6 visits)	Well Child Visits in the 3rd through 6th Years of Life	Adolescent Well Care Visits	Children and Adolescents' Access to Primary Care Practitioners				Adults' Access to Preventive Ambulatory Services		Utilization of Imaging Studies for Low Back Pain
				12-20 mo	24 mo-6 yrs	7-11 yrs	12-19 yrs	20-44 yrs	45-64 yrs	
03/31/12	48.9%	64.8%	42.4%	95.0%	84.6%	73.5%	74.3%	80.9%	86.1%	70.2%
06/30/12	48.6%	62.4%	41.7%	94.9%	84.4%	73.5%	74.3%	81.4%	86.5%	71.0%
09/30/12	48.5%	62.4%	40.2%	94.9%	85.1%	74.6%	73.8%	81.7%	86.5%	70.2%
12/31/12	48.9%	63.7%	43.3%	94.9%	85.8%	74.6%	74.9%	81.4%	85.6%	70.6%
PART 2: Reported by the MCE on Quarterly Reports (from Internal MCE Sources)										
03/31/12	51.0%	62.9%	42.8%	95.9%	86.0%	74.1%	75.0%	84.0%	86.4%	74.3%
06/30/12	53.0%	61.8%	42.7%	95.8%	85.6%	74.1%	75.0%	84.6%	87.4%	74.7%
09/30/12	54.8%	62.3%	40.9%	95.8%	86.4%	75.3%	74.2%	85.1%	87.7%	74.5%
12/31/12	56.5%	65.7%	45.2%	95.7%	87.1%	75.3%	75.7%	85.3%	87.2%	74.1%
PART 3: Difference										
03/31/12	-2.1%	2.0%	-0.3%	-0.9%	-1.4%	-0.6%	-0.7%	-3.1%	-0.3%	-4.1%
06/30/12	-4.4%	0.6%	-1.0%	-0.9%	-1.2%	-0.6%	-0.7%	-3.1%	-0.9%	-3.6%
09/30/12	-6.3%	0.1%	-0.6%	-0.9%	-1.2%	-0.7%	-0.4%	-3.4%	-1.2%	-4.3%
12/31/12	-7.6%	-2.0%	-1.9%	-0.8%	-1.3%	-0.8%	-0.8%	-3.9%	-1.5%	-3.5%
Comparison of Administrative Data for 12 Month Period Ending 12/31/12 from Three Data Sources										
B&A	48.9%	63.7%	43.3%	94.9%	85.8%	74.6%	74.9%	81.4%	85.6%	70.6%
MCE	56.5%	65.7%	45.2%	95.7%	87.1%	75.3%	75.7%	85.3%	87.2%	74.1%
HEDIS Auditor	56.7%	66.7%	46.7%	96.2%	87.4%	90.0%	89.2%	85.3%	86.4%	72.3%

Exhibit III.3
Summary of Validation of Performance Measures Reviewed
Anthem: Healthy Indiana Plan

PART 1: Computed by Burns & Associates
(Encounters and Enrollment from OMPP Data Warehouse)

Anchor End Date	Adults' Access to Preventive Ambulatory Services		Utilization of Imaging Studies for Low Back Pain
	20-44 yrs	45-64 yrs	
03/31/12	87.6%	90.7%	66.4%
06/30/12	88.4%	90.9%	67.2%
09/30/12	87.4%	89.8%	68.6%
12/31/12	86.6%	89.3%	69.4%

PART 2: Reported by the MCE on Quarterly Reports
(from Internal MCE Sources)

03/31/12	90.6%	93.0%	76.6%
06/30/12	91.3%	93.1%	75.7%
09/30/12	91.4%	93.0%	76.7%
12/31/12	91.2%	93.0%	75.2%

PART 3: Difference

03/31/12	-3.1%	-2.3%	-10.3%
06/30/12	-2.9%	-2.2%	-8.5%
09/30/12	-4.0%	-3.3%	-8.0%
12/31/12	-4.5%	-3.6%	-5.8%

Comparison of Administrative Data for 12 Month Period Ending 12/31/12 from Three Data Sources

B&A	86.6%	89.3%	69.4%
MCE	91.2%	93.0%	75.2%
HEDIS Auditor	91.2%	92.9%	72.5%

Exhibit III.4
Summary of Validation of Performance Measures Reviewed
MHS: Hoosier Healthwise

PART 1: Computed by Burns & Associates (Encounters and Enrollment from OMPP Data Warehouse)

Anchor End Date	Well Child Visits in the First 15 Months of Life (6 visits)	Well Child Visits in the 3rd through 6th Years of Life	Adolescent Well Care Visits	Children and Adolescents' Access to Primary Care Practitioners				Adults' Access to Preventive Ambulatory Services		Utilization of Imaging Studies for Low Back Pain
				12-20 mo	24 mo-6 yrs	7-11 yrs	12-19 yrs	20-44 yrs	45-64 yrs	
03/31/12	53.2%	68.1%	49.5%	96.4%	87.3%	76.5%	78.7%	82.2%	88.1%	67.5%
06/30/12	53.8%	65.8%	49.0%	96.0%	86.8%	76.1%	78.7%	82.4%	87.7%	67.3%
09/30/12	53.1%	64.8%	47.9%	96.1%	86.7%	76.9%	78.0%	82.2%	88.0%	68.8%
12/31/12	53.0%	65.6%	49.7%	96.0%	87.8%	77.4%	78.7%	82.4%	89.5%	68.0%
PART 2: Reported by the MCE on Quarterly Reports (from Internal MCE Sources)										
03/31/12	55.3%	65.0%	48.2%	96.2%	87.3%	90.7%	90.4%	84.8%	89.0%	71.7%
06/30/12	53.8%	63.4%	47.9%	95.9%	86.7%	90.6%	92.0%	84.7%	88.4%	70.3%
09/30/12	54.0%	63.1%	46.3%	96.0%	86.8%	90.4%	91.1%	84.4%	88.3%	71.9%
12/31/12	54.9%	66.9%	49.9%	96.0%	87.9%	90.5%	91.0%	84.5%	90.4%	72.1%
PART 3: Difference										
03/31/12	-2.1%	3.1%	1.3%	0.2%	0.0%	-14.2%	-11.7%	-2.6%	-0.9%	-4.2%
06/30/12	0.0%	2.4%	1.1%	0.1%	0.1%	-14.5%	-13.3%	-2.3%	-0.7%	-3.0%
09/30/12	-0.9%	1.7%	1.6%	0.1%	-0.1%	-13.5%	-13.1%	-2.2%	-0.3%	-3.2%
12/31/12	-1.9%	-1.3%	-0.2%	0.0%	-0.1%	-13.1%	-12.3%	-2.1%	-0.9%	-4.1%
Comparison of Administrative Data for 12 Month Period Ending 12/31/12 from Three Data Sources										
B&A	53.0%	65.6%	49.7%	96.0%	87.8%	77.4%	78.7%	82.4%	89.5%	68.0%
MCE	54.9%	66.9%	49.9%	96.0%	87.9%	90.5%	91.0%	84.5%	90.4%	72.1%
HEDIS Auditor	53.6%	65.5%	48.5%	96.1%	88.0%	90.6%	91.0%	84.5%	90.4%	72.1%

Exhibit III.5
Summary of Validation of Performance Measures Reviewed
MHS: Healthy Indiana Plan

PART 1: Computed by Burns & Associates
(Encounters and Enrollment from OMPP Data Warehouse)

Anchor End Date	Adults' Access to Preventive Ambulatory Services		Utilization of Imaging Studies for Low Back Pain
	20-44 yrs	45-64 yrs	
03/31/12	81.6%	87.5%	71.8%
06/30/12	82.8%	88.4%	75.5%
09/30/12	85.9%	89.3%	73.6%
12/31/12	87.3%	92.1%	72.8%

PART 2: Reported by the MCE on Quarterly Reports
(from Internal MCE Sources)

03/31/12	84.8%	89.0%	71.7%
06/30/12	84.7%	88.4%	70.3%
09/30/12	84.4%	88.3%	71.9%
12/31/12	84.5%	90.4%	72.1%

PART 3: Difference

03/31/12	-3.2%	-1.5%	0.1%
06/30/12	-1.9%	0.0%	5.2%
09/30/12	1.5%	1.0%	1.7%
12/31/12	2.8%	1.7%	0.7%

Comparison of Administrative Data for 12 Month Period Ending 12/31/12 from Three Data Sources

B&A	87.3%	92.1%	72.8%
MCE	84.5%	90.4%	72.1%
HEDIS Auditor	92.5%	95.2%	75.0%

Exhibit III.6
Summary of Validation of Performance Measures Reviewed
MDwise: Hoosier Healthwise

PART 1: Computed by Burns & Associates (Encounters and Enrollment from OMPP Data Warehouse)

Anchor End Date	Well Child Visits in the First 15 Months of Life (6 visits)	Well Child Visits in the 3rd through 6th Years of Life	Adolescent Well Care Visits	Children and Adolescents' Access to Primary Care Practitioners				Adults' Access to Preventive Ambulatory Services		Utilization of Imaging Studies for Low Back Pain
				12-20 mo	24 mo-6 yrs	7-11 yrs	12-19 yrs	20-44 yrs	45-64 yrs	
03/31/12	54.3%	68.5%	46.8%	95.6%	86.1%	74.6%	77.0%	80.5%	86.6%	69.3%
06/30/12	54.0%	66.3%	46.1%	95.6%	85.6%	74.3%	76.5%	80.5%	85.3%	68.8%
09/30/12	53.3%	65.7%	44.6%	95.9%	85.8%	75.2%	75.6%	80.7%	85.6%	69.2%
12/31/12	53.0%	66.9%	47.2%	95.8%	86.6%	75.6%	76.4%	80.8%	85.7%	70.3%
PART 2: Reported by the MCE on Quarterly Reports (from Internal MCE Sources)										
03/31/12	53.1%	64.3%	46.9%	96.1%	86.0%	74.2%	77.0%	84.4%	88.0%	87.5%
06/30/12	53.5%	64.1%	46.7%	96.0%	85.9%	74.3%	77.0%	85.0%	87.8%	87.6%
09/30/12	53.1%	64.2%	44.9%	96.2%	86.3%	75.4%	76.3%	85.3%	87.8%	86.7%
12/31/12	53.1%	67.8%	48.7%	96.4%	87.4%	76.3%	77.5%	85.6%	87.8%	87.6%
PART 3: Difference										
03/31/12	1.2%	4.3%	-0.1%	-0.5%	0.1%	0.4%	0.0%	-3.9%	-1.4%	-18.2%
06/30/12	0.5%	2.2%	-0.6%	-0.5%	-0.3%	0.0%	-0.5%	-4.5%	-2.5%	-18.8%
09/30/12	0.2%	1.6%	-0.3%	-0.3%	-0.5%	-0.3%	-0.7%	-4.6%	-2.2%	-17.5%
12/31/12	-0.1%	-0.9%	-1.5%	-0.6%	-0.8%	-0.7%	-1.1%	-4.8%	-2.1%	-17.3%
Comparison of Administrative Data for 12 Month Period Ending 12/31/12 from Three Data Sources										
B&A	53.0%	66.9%	47.2%	95.8%	86.6%	75.6%	76.4%	80.8%	85.7%	70.3%
MCE	53.1%	67.8%	48.7%	96.4%	87.4%	76.3%	77.5%	85.6%	87.8%	87.6%
HEDIS Auditor	52.4%	68.0%	48.6%	96.2%	87.3%	90.3%	90.9%	84.5%	87.2%	74.6%

Exhibit III.7
Summary of Validation of Performance Measures Reviewed
MDwise: Healthy Indiana Plan

PART 1: Computed by Burns & Associates
(Encounters and Enrollment from OMPP Data Warehouse)

Anchor End Date	Adults' Access to Preventive Ambulatory Services		Utilization of Imaging Studies for Low Back Pain
	20-44 yrs	45-64 yrs	
03/31/12	83.9%	88.3%	69.2%
06/30/12	84.9%	88.3%	68.5%
09/30/12	85.2%	88.4%	65.7%
12/31/12	84.9%	88.7%	66.3%

PART 2: Reported by the MCE on Quarterly Reports
(from Internal MCE Sources)

03/31/12	84.0%	89.3%	75.1%
06/30/12	84.6%	88.6%	73.5%
09/30/12	84.7%	88.7%	69.7%
12/31/12	89.5%	91.7%	72.4%

PART 3: Difference

03/31/12	-0.1%	-1.0%	-5.9%
06/30/12	0.3%	-0.3%	-5.1%
09/30/12	0.5%	-0.3%	-3.9%
12/31/12	-4.6%	-3.0%	-6.1%

Comparison of Administrative Data for 12 Month Period Ending 12/31/12 from Three Data Sources

B&A	84.9%	88.7%	66.3%
MCE	89.5%	91.7%	72.4%
HEDIS Auditor	89.6%	91.8%	71.8%

SECTION IV: VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

Introduction

The Office of Medicaid Policy and Planning (OMPP) gave each managed care entity (MCE) the choice from which to select mandatory Performance Improvement Projects (PIPs). The choices were the same to all MCEs. Part of the OMPP's rationale in doing this was to ensure that the Hoosier Healthwise (HHW) program and Healthy Indiana Plan (HIP) have program-wide initiatives that correspond to the State's Quality Strategy. Each MCE can (and does) also have other PIPs in addition to the minimum required by the OMPP.

Burns & Associates (B&A) chose to validate three PIPs from each MCE. The PIPs that were selected were among those that the MCEs selected from the OMPP lists and were PIPs selected by all three MCEs (with some minor differences noted). All of them are HEDIS® measures. They include:

1. Well Child Visits (0-15 Months, 3rd through 6th Years of Life, and Adolescent) were selected by all three MCEs. This PIP is for the HHW population only.

2. Diabetes Care (Anthem chose the Comprehensive Diabetes Care HEDIS® measure while MHS and MDwise selected the LDL-C Screening component only). This PIP is for both the HHW and HIP populations.

3. Follow-up Care After an Inpatient Mental Health Hospitalization (Anthem and MHS chose both the 7-day and 30-day follow-up; MDwise selected the 7-day follow-up only). This PIP is for both the HHW and HIP populations. However, Anthem chose to create a PIP for the HIP population only since their results on this measure for HHW are already above the 90th percentile among Medicaid MCOs nationally.

Methodology

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

Activity 1: Assess the Study Methodology

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

Activity 2, Verify Study Findings, is an optional activity and was not completed as part of this year's external quality review (EQR). Activity 3, Evaluate and Report Overall Validity and Reliability of PIP Results, is presented in this section of the EQR report.

B&A completed the Centers for Medicare and Medicaid's (CMS's) *EQR Protocol 3, Attachment A, PIP Review Worksheet* for each PIP reviewed as part of the validation. These worksheets appear in Appendix B. It should be noted that B&A did adjust some of the components in the PIP Review Worksheet.

A subset of components, but not all of them, was selected for review in Steps 1 through 6 of Protocol 3. The reason for this is because each PIP that was validated is a HEDIS® measure. Since the MCEs selected HEDIS® measures as PIPs,

- The results reported for the baseline and each subsequent year are HEDIS® results which are calculated by a certified HEDIS® auditor. Thus, B&A referred to the HEDIS® auditor reports to ensure that the results reported in the PIP were reportable under NCQA guidelines and that there were no deficiencies in the data collection methods used by the MCE.

- Since the parameters of each HEDIS® measure are defined by NCQA, B&A did not focus as much on the components related to identifying the study population or reviewing the sampling methods.

- Likewise, since the OMPP mandated that PIPs be selected from a pre-defined list, the OMPP already assured that the study topics were consistent with the demographics and epidemiology of the enrolled populations.

More of the focus of this year's PIP validation centered on Step 7 of Protocol 3- Assess the MCE's Improvement Strategies. In particular, interventions were reviewed in depth for each PIP to determine if distinct interventions were developed to change behavior at the provider level, the beneficiary level, and the MCE level.

Desk Review

MCEs were asked to submit descriptions of their PIP which included the study question, the methodology used, interventions chosen, and results from both the benchmark period and any remeasurement periods. Information was reported by each MCE using NCQA's Quality Improvement Activity Form. Two members from B&A's EQR Review Team, Mark Podrazik and Kristy Lawrance, each reviewed these materials and independently completed a draft of the EQR PIP Review Worksheet. After meeting to compare results, areas that could not be fully assessed on the PIP Review Worksheet were identified. The team members created customized interview protocols for each MCE/PIP for the onsite meeting in order to have a full assessment to complete the PIP Review Worksheets.

Onsite Meeting

The MCEs were instructed to have representatives from their team who were the leads for each PIP and those that could speak to the specific PIP interventions available for the onsite interviews. The EQR team members jointly met with MCE representatives to go over the questions in the customized interview protocols for each PIP. Items from the NCQA Quality Improvement Activity Form were also clarified as needed. In some instances, the MCEs brought supplemental information to the meeting to either explain more fully analytics completed on PIP measure results or to share collateral materials on interventions.

Post-Onsite Evaluation

The EQR team members re-reviewed their responses to each PIP Review Worksheet and supplied justifications to each of components on the tool. This was done independently by each reviewer and then

responses were shared to confirm concurrence between the reviewers so that each PIP Review Worksheet could be finalized.

Anthem PIP Findings

Comprehensive Diabetes Care (HEDIS® CDC)

Anthem began its PIP for Comprehensive Diabetes Care in HEDIS® Rate Year (RY) 2008 (service dates in CY 2007). B&A examined results through Remeasurement Year (RM) 5 (HEDIS® RY 2013).

LDL-C screening is one of the current pay-for-performance (P4P) measures that the OMPP has in its contract with the MCEs. Anthem reports that it had 1,354 HHW adult members and 1,909 HIP members diagnosed with diabetes at the end of calendar year (CY) 2012.

For this PIP, Anthem elected to include three measures to determine the efficacy of its PIP activities:

1. HbA1c screening: The percentage of eligible members who received an HbA1c test performed during the measurement year, as identified by claim/ encounter or automated laboratory data.
2. Diabetes retinal exam (DRE): The percentage of eligible members who received a diabetic retinal eye exam during the measurement year.
3. LDL-C screening: The percentage of eligible members who received an LDL-C test during the measurement year.

In each case, Anthem uses the current HEDIS® definition for the measure and updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year. Results are separately tabulated and measured for the eligible HHW and HIP populations. Results are tabulated using the hybrid method (administrative claims and medical records).

Interventions

Anthem has implemented a number of interventions to try to improve scores on these HEDIS® measures. Some of the more noteworthy interventions include:

1. A Lab in Envelope program was initiated in 4th Quarter 2011 to all non-compliant HHW members for LDL-C and HbA1c (n=455 members combined). This is a home testing kit where Anthem offered rewards for member completion. Unfortunately, there was little take up by members and even less follow through.
2. Diabetes health fairs were held in Marion and Lake Counties in 4th Quarter 2011. Despite invitations to all eligible members, few members accepted the invitation and there were numerous no shows.
3. Education was given to 25 primary care providers across Indiana in 4th Quarter 2012 that was focused to those providers who had non-compliant records received during the prior year HEDIS® audit.
4. Gaps in Care reports are delivered to primary care providers and the diabetes-related measures are included in these reports. There were 71 provider offices visited to review the reports in face-to-face meetings in the 2nd Quarter of 2012.
5. Outbound calls began in June 2012 to members that were non-compliant with one or more diabetes tests.

Results

Exhibit IV.1 shows that, other than in RM1for diabetes retinal exam, there has not been any statistically significant improvement in any of the three measures for diabetes care among HHW members. The benchmark for HbA1c is HEDIS® 50th percentile; for DRE, HEDIS® 50th percentile; and for LDL-C, the benchmark was lowered back to HEDIS® 25th percentile.

Exhibit IV.1
Results Reported for Anthem Performance Improvement Project
Comprehensive Diabetes Care
Hoosier Healthwise

Measure #1: HbA1c Screening								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2008	Baseline	249	320	77.8%	85.6%	2008, 75th	N/A	N/A
HEDIS RY2009	RM1	321	425	75.5%	84.2%	2008, 75th	79.8%	NO
HEDIS RY2010	RM2	416	549	75.8%	80.6%	2009, 50th	76.2%	NO
HEDIS RY2011	RM3	422	548	77.0%	81.1%	2010, 50th	76.6%	NO
HEDIS RY2012	RM4	420	548	76.6%	81.1%	2011, 50th	78.4%	NO
HEDIS RY2013	RM5	434	548	79.2%	82.4%	2012, 50th	unknown	NO

Measure #2: Diabetes Retinal Exam								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2008	Baseline	80	320	25.0%	39.4%	2008, 25th	N/A	N/A
HEDIS RY2009	RM1	219	425	51.5%	53.4%	2008, 50th	28.0%	YES
HEDIS RY2010	RM2	254	549	46.3%	55.2%	2009, 50th	52.5%	NO
HEDIS RY2011	RM3	270	548	49.3%	54.0%	2010, 50th	47.3%	NO
HEDIS RY2012	RM4	281	548	51.3%	54.0%	2011, 50th	52.7%	NO
HEDIS RY2013	RM5	310	548	56.6%	52.9%	2012, 50th	unknown	unknown

Measure #3: LDL-C Screening								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2008	Baseline	189	320	59.1%	66.2%	2008, 25th	N/A	N/A
HEDIS RY2009	RM1	251	425	59.1%	66.7%	2008, 25th	62.1%	NO
HEDIS RY2010	RM2	325	549	59.2%	76.2%	2009, 50th	60.1%	NO
HEDIS RY2011	RM3	340	548	62.0%	75.4%	2010, 50th	60.2%	NO
HEDIS RY2012	RM4	347	548	63.3%	69.3%	2011, 25th	63.7%	NO
HEDIS RY2013	RM5	364	548	66.4%	70.3%	2012, 25th	unknown	unknown

For the HIP, Anthem has seen some more improvement than what was found in the HHW population. There was statistically significant improvement in RM1 for HbA1c as well as in RM3 for DRE. The benchmark for HbA1c is HEDIS® 75th percentile; for DRE, HEDIS® 25th percentile; and for LDL-C, the benchmark was increased to HEDIS® 75th percentile.

Exhibit IV.2
Results Reported for Anthem Performance Improvement Project
Comprehensive Diabetes Care
Healthy Indiana Plan

Measure #1: HbA1c Screening								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2010	Baseline	448	548	81.8%	86.2%	2009, 75th	N/A	N/A
HEDIS RY2011	RM1	472	548	86.1%	90.2%	2010, 90th	82.4%	YES
HEDIS RY2012	RM2	463	548	84.5%	86.4%	2011, 75th	86.5%	NO
HEDIS RY2013	RM3	479	548	87.4%	91.1%	2012, 75th	unknown	NO

Measure #2: Diabetes Retinal Exam								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2010	Baseline	151	548	27.6%	55.2%	2009, 50th	N/A	N/A
HEDIS RY2011	RM1	135	548	24.6%	54.0%	2010, 50th	28.6%	NO
HEDIS RY2012	RM2	171	548	31.2%	32.1%	2011, 10th	32.6%	NO
HEDIS RY2013	RM3	218	548	39.8%	45.0%	2012, 25th	unknown	YES

Measure #3: LDL-C Screening								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2010	Baseline	386	548	70.4%	76.2%	2009, 50th	N/A	N/A
HEDIS RY2011	RM1	431	548	78.6%	80.1%	2010, 75th	71.3%	YES
HEDIS RY2012	RM2	419	548	76.5%	75.4%	2011, 50th	77.9%	NO
HEDIS RY2013	RM3	438	548	79.9%	80.9%	2012, 75th	unknown	NO

Anthem reported a number of barriers it has seen that are limiting improvement in these measures:

1. The low sample size of the population included in the measures overall;
2. Errors in practice office coding;
3. False positives with diagnoses of diabetes recorded on emergency room claims; and
4. Outside labs versus physician in-house labs (which have access to medical records to improve numerator counts).

Follow-up Care after Hospitalization for Mental Illness (HEDIS® FUH)

Anthem has seen significant improvement in its results for FUH in HHW. Results among HIP members have been lagging, however, which was the impetus for this PIP. Anthem's results in HIP for 7-day follow-up were below the HEDIS® 25th percentile. The results for 30-day follow-up were between the 25th and 50th percentile. Anthem began its PIP for FUH in HEDIS® RY 2010 (service dates in CY 2009). B&A examined results through RM 3 (HEDIS® RY 2013).

For this PIP, Anthem elected to include two measures to determine the efficacy of its PIP activities:

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

In each case, Anthem uses the current HEDIS® definition for the measure and updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year. Results are tabulated using the administrative (claims-based) method.

Interventions

Anthem has implemented a number of interventions to try to improve scores on these HEDIS® measures. Some of the interventions that occurred in CY 2012 include:

1. Live member outreach calls as reminders to meet appointments and ongoing education post-discharge.
2. Implementing a "Bridge Appointment" program with high-volume inpatient psychiatric hospitals. The bridge appointment itself requires prior authorization from Anthem so that Anthem can ensure exactly what was completed during the appointment (e.g., emergency plan after patient goes home, medications filled, ongoing interaction).
3. Development of facility-specific report cards that measure patient length of stay, readmission rate, and adherence to follow-up appointments. Many reports are drilled down to the diagnosis level.
4. Meetings with underperforming hospitals to review their report cards.

Results

Exhibit IV.3 on the following page shows that there was considerable improvement (which was statistically significant) in both the 7-day and 30-day measures between RM1 and RM2. As a result, Anthem increased its benchmark for both measures to the HEDIS® 75th percentile.

Exhibit IV.3
Results Rported for Anthem Performance Improvement Project
7-Day / 30-Day Follow-up Appointment After Mental Health Hospitalization
Healthy Indiana Plan

Measure #1: 7-Day Follow-up								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2010	Baseline	100	338	29.6%	44.5%	2009, 50th	N/A	N/A
HEDIS RY2011	RM1	83	243	34.2%	43.5%	2010, 50th	32.6%	NO
HEDIS RY2012	RM2	142	260	54.6%	45.1%	2011, 50th	45.1%	YES
HEDIS RY2013	RM3	122	225	54.2%	57.7%	2012, 75th	unknown	NO

Measure #2: 30-Day Follow-up								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2010	Baseline	192	338	56.8%	64.3%	2009, 50th	N/A	N/A
HEDIS RY2011	RM1	143	243	58.8%	62.6%	2010, 50th	59.8%	NO
HEDIS RY2012	RM2	196	260	75.4%	74.3%	2011, 75th	unknown	YES
HEDIS RY2013	RM3	164	225	72.9%	77.5%	2012, 75th	unknown	NO

Well Care for Children and Adolescents (HEDIS® W15, W34 and AWC)

Anthem began its PIP for Well Child/Adolescent Care in HEDIS® RY 2011 (service dates in CY 2010). B&A examined results through RM 2 (HEDIS® RY 2013). These measures are part of the OMPP's P4P with the MCEs.

For this PIP, Anthem elected to include three measures to determine the efficacy of its PIP activities:

1. HEDIS® W15: The percentage of eligible members who turn 15 months old during the measurement year who received six or more well child visits with a provider during their first 15 months of life.
2. HEDIS® W34: The percentage of eligible members who turned ages three, four, five or six years old during the measurement year who had one or more well child visit during the measurement year.
3. HEDIS® AWC: The percentage of eligible members, ages 12-21 years, who receive one comprehensive well care visit with a PMP or OB/GYN practitioner during the measurement year.

Anthem identified significant opportunities for improvement on these measures. At the start of this PIP, Anthem's rate for W15 was at the HEDIS® 25th percentile; for W34, it was at the 10th percentile; for AWC, it was at the 50th percentile.

In each case, Anthem uses the current HEDIS® definition for the measure and updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year. Results are tabulated using the hybrid method.

Interventions

Anthem has implemented a number of interventions to try to improve scores on these HEDIS® measures. Some of the interventions that occurred in CYs 2011 and 2012 include:

1. Automated calls to all eligible members who have not yet had an annual visit reminding them to make appointments.
2. Live member outreach calls to parents of infants who have had five visits, but not yet the sixth visit, in the first 15 months of life.
3. Live calls to mothers post-delivery focusing education on post-partum care for themselves and wellness appointments for babies.
4. Enrolled 22 doctor offices in the Bright Futures program (funded by Anthem).

Results

Exhibit IV.4 shows that there was statistically significant improvement in W15 from the baseline to RM1 and also from RM1 to RM2. Anthem has increased the comparison benchmark to the HEDIS® 75th percentile. To date, there has been modest, but not been statistically significant, improvement in W34 or AWC since the base period.

Exhibit IV.4
Results Reported for Anthem Performance Improvement Project
Well Child Visits
Hoosier Healthwise

Measure #1: Six Well Child Visits in the First 15 Months of Life								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2011	Baseline	224	411	54.5%	61.3%	2011, 50th	N/A	N/A
HEDIS RY2012	RM1	259	411	63.0%	61.3%	2011, 50th	56.4%	YES
HEDIS RY2013	RM2	270	384	70.3%	68.9%	2011, 75th	64.0%	YES

Measure #2: Well Child Visits in the Third through Sixth Year of Life								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2011	Baseline	248	376	66.0%	72.3%	2011, 50th	N/A	N/A
HEDIS RY2012	RM1	259	376	68.9%	65.9%	2011, 25th	67.6%	NO
HEDIS RY2013	RM2	264	360	73.3%	72.3%	2012, 50th	69.2%	NO

Measure #3: Adolescent Well Care Visits								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2011	Baseline	233	411	56.7%	57.2%	2010, 75th	N/A	N/A
HEDIS RY2012	RM1	238	411	57.9%	56.0%	2011, 75th	58.7%	NO
HEDIS RY2013	RM2	222	403	55.1%	63.2%	2012, 90th	60.0%	NO

MDwise PIP Findings

LDL-C Screening for Diabetes Care

MDwise began its PIP for LDL-C in HEDIS® RY 2010 (service dates in CY 2009). B&A examined results through RM 3 (HEDIS® RY 2013). LDL-C screening is one of the current P4P measures that the OMPP has in its contract with the MCEs. MDwise uses the HEDIS® definition for LDL-C screening in its PIP: The percentage of eligible members who received an LDL-C test during the measurement year.

MDwise updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year. Results are separately tabulated and measured for the eligible HHW and HIP populations. Results are tabulated using the hybrid method (administrative claims and medical records).

Interventions

MDwise has implemented a number of interventions to try to improve its LDL-C scores. Some of the interventions conducted in CY 2012 include:

1. Development of a Diabetes Toolkit for primary care physicians.
2. Gaps in Care reports are delivered to primary care providers and the diabetes-related measures are included in these reports.
3. Supplemental reports to the Gaps in Care reports were distributed by MDwise's Network Improvement Team that included information specific to diabetes measures. Among the information was member's last visit with a PMP, number of ER visits in 2012, and members with only one ER code of diagnosis 250 (diabetes).
4. Home testing kits were distributed by Hoosier Alliance, MDwise's largest delivery system, to eligible members.
5. A fax back pilot program was initiated in December 2012 enabling providers to submit LDL values or shadow claims which are then stored in a data repository for later matching to claims or medical records.

Results

Unfortunately, MDwise has actually seen a reduction in its results for LDL-C screening since the baseline period for both HHW and HIP (refer to Exhibit IV.5 on the next page). The comparison benchmark remains to be the HEDIS® 90th percentile.

Exhibit IV.5
Results Reported for MDwise Performance Improvement Project
LDL-C Testing
Hoosier Healthwise & Healthy Indiana Plan

Measure #1: LDL-C Testing for HHW Population								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2010	Baseline	376	548	68.6%	84.0%	2010, 90th	71.6%	N/A
HEDIS RY2011	RM1	350	548	63.9%	84.0%	2010, 90th	71.6%	unknown
HEDIS RY2012	RM2	367	548	67.0%	84.2%	2011, 90th	71.6%	NO
HEDIS RY2013	RM3	363	548	66.2%	83.4%	2012, 90th	71.6%	unknown

Measure #1: LDL-C Testing for HIP Population								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2010	Baseline	444	548	81.0%	84.0%	2010, 90th	84.2%	N/A
HEDIS RY2011	RM1	444	548	81.0%	84.0%	2010, 90th	84.2%	no change
HEDIS RY2012	RM2	423	548	77.2%	84.2%	2011, 90th	84.2%	NO
HEDIS RY2013	RM3	443	548	80.8%	83.4%	2012, 90th	84.2%	unknown

MDwise reported barriers it has seen that are limiting improvement on this measure:

1. False positives with diagnoses of diabetes recorded on emergency room claims;
2. Providers' perceptions that members must fast before a LDL-C screening (this is required for other diabetes tests but not the LDL-C test specifically); and
3. Adherence by its delivery systems to enhanced education with its provider network on diabetes.

Follow-up Care after Hospitalization for Mental Illness (HEDIS® FUH)

MDwise created this PIP due to the OMPP's requirements around adherence to 7-day follow-up appointments after hospitalizations from an inpatient psychiatric facility as well as the recognition that the MCE has considerable room for improvement on this measure. MDwise was below the HEDIS® 50th percentile for both HHW and HIP. MDwise began its PIP for FUH in the first quarter of 2009. The MCE identified RM1 as the 4th Quarter of 2009 for HHW and has tracked results quarterly since that time. For HIP, RM1 began in the 1st Quarter of 2011 and results have been tracked quarterly since then. B&A examined results through the 4th Quarter of 2012 for both programs.

For this PIP, MDwise uses the 7-day HEDIS® measure to determine the efficacy of its PIP activities:

> The percentage of members age six and greater that have attended a FUH appointment within seven days of discharge from an acute psychiatric setting with a mental health diagnosis.

MDwise uses the current HEDIS® definition for the measure and updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year. Results are tabulated using the administrative (claims-based) method.

Interventions

MDwise has implemented a number of interventions to try to improve scores on these HEDIS® measures. Some of the interventions that occurred in CY 2012 include:

1. Implementing a "Bridge Appointment" program with high-volume inpatient psychiatric hospitals.
2. All delivery systems have now implemented an intensive case management (ICM) program that tracks discharges until the member attends a follow-up appointment.
3. FUH report cards went out to all inpatient psychiatric hospitals in the behavioral health network in December 2012.

Results

Exhibit IV.6 below shows that the results for this measure have increased over 20 percentage points from the baseline period but are still significantly below the benchmark value of the HEDIS® 90th percentile as well as the comparison goal. The data in Exhibit IV.7 on the next page shows that results have been much more volatile in HIP; however, this is due to the low sample that is eligible for measurement.

Exhibit IV.6
Results Reported for MDwise Performance Improvement Project
7-Day Follow-up Appointment After Mental Health Hospitalization
Hoosier Healthwise

Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
1st Qtr 2009	Baseline	108	412	26.2%	N/A	N/A	N/A	N/A
4th Qtr 2009	RM1	207	638	32.4%	65.4%	2008, 90th	57.4%	not completed
1st Qtr 2010	RM2	202	559	36.1%	64.2%	2009, 90th	56.6%	not completed
2nd Qtr 2010	RM3	244	625	39.0%	64.2%	2009, 90th	56.6%	not completed
3rd Qtr 2010	RM4	270	648	41.7%	64.2%	2009, 90th	56.6%	not completed
4th Qtr 2010	RM5	312	686	45.5%	64.2%	2009, 90th	56.6%	not completed
1st Qtr 2011	RM6	273	549	49.7%	64.3%	2010, 90th	59.1%	not completed
2nd Qtr 2011	RM7	272	568	47.9%	64.3%	2010, 90th	59.1%	not completed
3rd Qtr 2011	RM8	260	564	46.1%	64.3%	2010, 90th	59.1%	not completed
4th Qtr 2011	RM9	276	631	43.7%	64.3%	2010, 90th	59.1%	not completed
1st Qtr 2012	RM10	250	519	48.2%	68.3%	2011, 90th	53.9%	not completed
2nd Qtr 2012	RM11	287	629	45.6%	68.3%	2011, 90th	53.9%	not completed
3rd Qtr 2012	RM12	265	595	44.5%	68.3%	2011, 90th	53.9%	not completed
4th Qtr 2012	RM13	290	609	47.6%	68.3%	2011, 90th	53.9%	not completed

Exhibit IV.7
Results Reported for MDwise Performance Improvement Project
7-Day Follow-up Appointment After Mental Health Hospitalization
Healthy Indiana Plan

Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
1st Qtr 2009	Baseline	58	170	34.1%	N/A	N/A	N/A	N/A
1st Qtr 2011	RM1	14	41	34.1%	64.3%	2010, 90th	59.1%	cannot be completed with any accuracy since the sample is so low
2nd Qtr 2011	RM2	15	46	32.6%	64.3%	2010, 90th	59.1%	
3rd Qtr 2011	RM3	19	43	44.2%	64.3%	2010, 90th	59.1%	
4th Qtr 2011	RM4	21	42	50.0%	64.3%	2010, 90th	59.1%	
1st Qtr 2012	RM5	12	40	30.0%	68.3%	2011, 90th	53.9%	
2nd Qtr 2012	RM6	16	43	37.2%	68.3%	2011, 90th	53.9%	
3rd Qtr 2012	RM7	10	26	38.5%	68.3%	2011, 90th	53.9%	
4th Qtr 2012	RM8	10	27	37.0%	68.3%	2011, 90th	53.9%	

Well Care for Children and Adolescents (HEDIS® W15, W34, AWC and CAP)

MDwise began its PIP for Adolescent Care in HEDIS® RY 2010 (service dates in CY 2009), which includes the HEDIS® measures AWC and CAP for children age 12-19. It added Well Child Care (HEDIS® measures W15 and W34) in HEDIS® RY 2011. B&A examined results through HEDIS® RY 2013 for all four measures. These measures are part of the OMPP's P4P with the MCEs.

For this PIP, MDwise elected to include four measures to determine the efficacy of its PIP activities:

1. HEDIS® W15: The percentage of eligible members who turn 15 months old during the measurement year who received six or more well child visits with a provider during their first 15 months of life.
2. HEDIS® W34: The percentage of eligible members who turned ages three, four, five or six years old during the measurement year who had one or more well child visit during the measurement year.
3. HEDIS® AWC: The percentage of eligible members, ages 12-21 years, who receive one comprehensive well care visit with a PMP or OB/GYN practitioner during the measurement year.
4. HEDIS® CAP: The percentage of eligible members, ages 12-19 years, who receive a visit with a primary care provider during the measurement year.

MDwise identified significant opportunities for improvement on these measures. At the start of this PIP, MDwise's rates for adolescent care were at the HEDIS® 25th percentile; for W15 and W34, they were at the 50th percentile.

In each case, MDwise uses the current HEDIS® definition for the measure and updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year. Results for W15, W34 and AWC are tabulated using the hybrid method; for CAP, the administrative method is used.

Interventions

The following are some of the interventions that MDwise enacted in CYs 2011 and 2012 to try to improve scores on these HEDIS® measures:

1. Financial recognition of high volume providers hitting 90th and 75th HEDIS® percentiles ($5,000 and $2,500, respectively) and mid volume 90th and 75th percentiles ($1,500 and $1,000, respectively). A bonus of $5,000 was given to any provider that hit the 90th percentile on W15, W34 and AWC.
2. In June 2012, a new monthly report was developed to include denominator lists for providers that added information about member's last PMP visit and any ER visits.
3. Conducted targeted provider outreach sessions beginning in September 2012 with a focus on W34 and AWC.
4. Initiated the "Star Performer" program which introduces scheduling techniques, promotion of a quality culture and naming a quality champion at provider offices.

Results

Exhibit IV.8 on the following page shows that there has been moderate improvement on the W15 measure since the baseline and a reduction in the W34 measure since the baseline. For AWC, the results have been mixed—first there was a statistically significant improvement from the baseline to RM1, then a statistically significant decrease from RM1 to RM2. Ultimately, there has been a net decrease since the baseline period. Results for the CAP measure have also been up and down since the baseline period, but not as drastic as what was found for AWC.

Exhibit IV.8
Results Reported for MDwise Performance Improvement Project
Well Child Visits
Hoosier Healthwise

Measure #1: Six Well Child Visits in the First 15 Months of Life								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2011	Baseline	254	411	61.8%	76.3%	2010, 90th	63.8%	N/A
HEDIS RY2012	RM1	258	411	62.8%	77.1%	2011, 90th	63.8%	NO
HEDIS RY2013	RM2	268	411	65.2%	77.3%	2012, 90th	63.8%	unknown

Measure #2: Well Child Visits in the Third through Sixth Year of Life								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2011	Baseline	296	411	72.0%	82.5%	2010, 90th	74.0%	N/A
HEDIS RY2012	RM1	284	411	69.1%	82.9%	2011, 90th	74.0%	NO
HEDIS RY2013	RM2	285	411	69.3%	83.0%	2012, 90th	74.0%	unknown

Measure #3: Adolescent Well Care Visits								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2010	Baseline	219	411	53.3%	63.2%	2010, 90th	56.3%	N/A
HEDIS RY2011	RM1	269	411	65.5%	63.2%	2001, 90th	56.3%	YES
HEDIS RY2012	RM2	242	411	58.9%	64.1%	2011, 90th	64.1%	YES
HEDIS RY2013	RM3	209	411	50.9%	64.7%	2012, 90th	64.1%	unknown

Measure #4: Children's Access to Primary Care Ages 12-19								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2010	Baseline	26,890	29,785	90.3%	92.2%	2010, 90th	92.2%	N/A
HEDIS RY2011	RM1	33,042	35,613	92.8%	92.2%	2001, 90th	92.2%	YES
HEDIS RY2012	RM2	34,810	37,719	92.3%	93.4%	2011, 90th	93.4%	NO
HEDIS RY2013	RM3	39,754	43,733	90.9%	93.0%	2012, 90th	93.4%	unknown

Note that MDwise also reports administrative rates internally for Measures #1, #2 and #3 which are not shown. MDwise also examined AWC rates for the HIP population, but the sample size was too small (<30) to report.

MHS PIP Findings

LDL-C Screening for Diabetes Care

MHS began its PIP for LDL-C in HEDIS® RY 2010 (service dates in CY 2009) as a result of the OMPP's implementation of a P4P on this measure. B&A examined results through RM 2 (HEDIS® RY 2012). Date for RM 3 (HEDIS® RY 2013) was not available at the time of the review.

MHS uses the HEDIS® definition for LDL-C screening in its PIP: The percentage of eligible members who received an LDL-C test during the measurement year. MHS updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year. Results are not separately tabulated and measured for the eligible HHW and HIP populations because the overall HIP population enrolled with MHS is small and the sample for this measure would be extremely small. Results are tabulated using the hybrid method (administrative claims and medical records).

Interventions

MDwise has implemented a number of interventions to try to improve its LDL-C scores. Some of the interventions conducted in CYs 2011 and 2012 include:

1. A fax back pilot program was initiated in January 2011 enabling providers to submit LDL values outside of claims. MHS reported that this has been less successful than anticipated since about 98 percent of the data that they are receiving in the fax back program ultimately appears on claims.
2. Development of a Diabetes Call Series (5-step process) was initiated in October 2011. It was implemented in English and Spanish.
3. Implemented rigorous training of case managers in 2011 and more focused case management "rounds" in 2012. Also standardized the assessment tool used to audit case managers.
4. Gaps in Care reports are delivered to primary care providers and the diabetes-related measures are included in these reports.
5. The MHS Medical Director began face-to-face meetings with low performing practitioners in the 4th Quarter of 2012.

Results

Unfortunately, MHS has seen no improvement in its LDL-C screening rate since the baseline period (refer to Exhibit IV.9 on the next page). The comparison benchmark remains to be the HEDIS® 75th percentile.

Exhibit IV.9
Results Reported for MHS Performance Improvement Project
LDL-C Testing
Hoosier Healthwise & Healthy Indiana Plan Combined

Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2010	Baseline	383	631	60.7%	80.2%	2011, 75th	75.4%	N/A
HEDIS RY2011	RM1	357	631	56.6%	80.2%	2011, 75th	75.4%	NO
HEDIS RY2012	RM2	385	631	61.0%	80.2%	2011, 75th	75.4%	NO
HEDIS RY2013	RM3	not available at the time of the review						

Note that MHS did not start serving the HIP population until Jan. 1, 2011. Current membership is low so any HIP members are incorporated into these figures. NCQA considers HHW and HIP the same line of business.

Follow-up Care after Hospitalization for Mental Illness (HEDIS® FUH)

MHS began its PIP for FUH in HEDIS® RY 2008 (service dates in CY 2007). For this PIP, MHS elected to include two measures to determine the efficacy of its PIP activities:

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

In each case, MHS uses the current HEDIS® definition for the measure and updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year. Results are tabulated using the administrative (claims-based) method.

MHS has seen consistent improvement in both the 7-day and 30-day measures over time. Since MHS began its PIP, the OMPP has implemented a P4P on these HEDIS® measures. Thus, MHS increased its comparison benchmark to the HEDIS® 90th percentile.

B&A examined results through RM 4 (HEDIS® RY 2012). Information was not available at the time of this review for RM 5 (HEDIS® RY 2013).

Interventions

Interventions that MHS has implemented to try to improve scores on these HEDIS® measures include:

1. Face-to-face outreach with high volume facilities with a focus on data sharing and developing plans for coordination of outpatient services.
2. Implementing a "Bridge Appointment" program with high-volume inpatient psychiatric hospitals. This originally occurred in CY 2010. MHS had been requiring prior authorization before this appointment could be billed in order to ensure that the appointment was meaningful. In June 2012, the PA requirement was lifted.
3. Retrained all Cenpatico clinicians responsible for discharge planning in June 2012.

4. Worked with inpatient and outpatient "preferred providers" by incorporating the 7-day/30-day measures into their agreements. If there is improvement in 7-day/30-day, then MHS removes other administrative burdens from these providers.

Results

Exhibit IV.10 shows that MHS saw statistically significant improvement in the 7-day measure between the baseline and RM 1 and then from RM 1 to RM 2. There was then a statistically significant decline in RM 3 which was followed by a statistically significant improvement in RM 4. The result was steady as of RM 5.

After enjoying a statistically significant improvement from the baseline period to RM 1, the results for the 30-day measure have remained more steady in the last four years compared to the 7-day measure.

Exhibit IV.10
Results Rported for MHS Performance Improvement Project
7-Day / 30-Day Follow-up Appointment After Mental Health Hospitalization
Hoosier Healthwise & Healthy Indiana Plan Combined

Measure #1: 7-Day Follow-up								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2008	Baseline	410	897	45.7%	43.0%	2007, 75th	43.0%	N/A
HEDIS RY2009	RM1	576	1,048	55.0%	43.8%	2008, 75th	56.6%	YES
HEDIS RY2010	RM2	734	1,221	60.1%	56.6%	2009, 75th	56.6%	YES
HEDIS RY2011	RM3	669	1,292	51.8%	56.6%	2010, 75th	56.6%	YES
HEDIS RY2012	RM4	693	1,164	59.5%	68.3%	2011, 90th	56.6%	YES
HEDIS RY2013	RM5	729	1,194	61.1%	not available at time of review			

Measure #2: 30-Day Follow-up								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2008	Baseline	548	897	61.1%	64.3%	2007, 50th	64.3%	N/A
HEDIS RY2009	RM1	811	1,048	77.4%	64.0%	2008, 50th	81.5%	YES
HEDIS RY2010	RM2	969	1,221	79.4%	81.5%	2009, 90th	81.5%	NO
HEDIS RY2011	RM3	962	1,292	74.5%	81.5%	2009, 90th	81.5%	NO
HEDIS RY2012	RM4	911	1,164	78.3%	82.6%		74.3%	YES
HEDIS RY2013	RM5	935	1,194	78.3%	not available at time of review			

Well Care for Children and Adolescents (HEDIS® W15, W34 and AWC)

MHS began its PIP for Well Child/Adolescent Care in HEDIS® RY 2011 (service dates in CY 2010). B&A examined results through RM 2 (HEDIS® RY 2013). These measures are part of the OMPP's P4P with the MCEs.

For this PIP, MHS elected to include three measures to determine the efficacy of its PIP activities:

1. HEDIS® W15: The percentage of eligible members who turn 15 months old during the measurement year who received six or more well child visits with a provider during their first 15 months of life.
2. HEDIS® W34: The percentage of eligible members who turned ages three, four, five or six years old during the measurement year who had one or more well child visit during the measurement year.
3. HEDIS® AWC: The percentage of eligible members, ages 12-21 years, who receive one comprehensive well care visit with a PMP or OB/GYN practitioner during the measurement year.

MHS identified significant opportunities for improvement on these measures. At the start of this PIP, the MCE's rate for all three measures was below the HEDIS® 50th percentile.

In each case, MHS uses the current HEDIS® definition for the measure and updates the logic for computing results with any changes from NCQA, as required, in each remeasurement year. Results are tabulated using the hybrid method.

Interventions

MHS has implemented a number of interventions to try to improve scores on these HEDIS® measures. Some of the interventions that occurred in CYs 2011 and 2012 include:

1. Live member outreach calls to families of adolescents in May 2012 to obtain school physicals and immunizations prior to the start of school.
2. Provider education in October 2011 regarding opportunistic visits as a means to enhance well child visit scores.
3. Developed a P4P with providers who participate in Bright Futures. This is no cost to providers upfront (costs to administer are withdrawn from a provider's future administrative bonus).

Results

Unfortunately, to date MHS has not seen improvement in its well child scores since the baseline period (refer to Exhibit IV.11 on the next page). In fact, the rate for AWC has seen a statistically significant decline. MHS uses the HEDIS® 90th percentile as the comparison benchmark since this is what is stated in the OMPP P4P program.

Exhibit IV.11
Results Reported for MHS Performance Improvement Project
Well Child Visits
Hoosier Healthwise

Measure #1: Six Well Child Visits in the First 15 Months of Life								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2011	Baseline	241	426	56.6%	76.5%	2011, 90th	60.0%	N/A
HEDIS RY2012	RM1	260	425	61.2%	76.5%	2011, 90th	60.0%	NO
HEDIS RY2013	RM2	252	453	55.6%	76.5%	2011, 90th	60.0%	NO

Measure #2: Well Child Visits in the Third through Sixth Year of Life								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2011	Baseline	279	399	69.9%	82.5%	2011, 90th	71.7%	N/A
HEDIS RY2012	RM1	242	372	65.1%	82.5%	2011, 90th	71.7%	NO
HEDIS RY2013	RM2	306	453	67.5%	82.5%	2011, 90th	71.7%	NO

Measure #3: Adolescent Well Care Visits								
Time Period Measurement Covers	Measure-ment Period	Num-erator	Denom-inator	Rate	Comparison Benchmark Value	Comparison HEDIS Year, Percentile	Comparison Goal	Statistically Significant Change?
HEDIS RY2011	Baseline	265	432	61.3%	63.2%	2011, 90th	46.7%	N/A
HEDIS RY2012	RM1	227	412	55.1%	63.2%	2011, 90th	46.7%	YES
HEDIS RY2013	RM2	246	453	54.3%	63.2%	2011, 90th	46.7%	NO

Recommendations

Upon conclusion of this PIP validation exercise, B&A has high confidence in the results reported by the MCEs for each measure included in its PIPs since each were subject to audit by a certified HEDIS® auditor. What is less clear to B&A is the validity of any results reported on the effectiveness of interventions that the MCEs implemented to improve performance. This is primarily due to the lack of information provided by the MCEs to measure effectiveness.

Based on the findings presented in each MCE's NCQA Quality Improvement Activity Form, their responses to onsite interview questions, and the review team's completion of *EQR Protocol 3, Attachment A, PIP Review Worksheet*, B&A has developed recommendations on the administration of performance improvement projects in HHW and HIP. Our recommendations are divided into the following categories described more fully below.

- Recommendations to the OMPP
- Recommendations to the MCEs

Recommendations to the OMPP

1. The OMPP should consider working with the MCEs to revise the PIP form so that it is most useful to the OMPP, the EQRO and the MCEs themselves. The new format should be more concise but should contain most all of the requirements included in NCQA's tool. B&A recommends that a revised tool could provide less information about methodology for HEDIS®-based PIPs and more information about the interventions. For example:
    a. Categorize interventions by who they are directed to (beneficiaries, providers, the MCE)
    b. Record quantitative information, where appropriate, when describing interventions to help assess the effectiveness of the intervention going forward. For example, if calls are being made prior to an adolescent's birthday to remind them about a well care visit, how many are made? Is it to the entire eligible population or to a subset? Are other analytics completed to determine the target population for the intervention, e.g. members who have not already had a claim for a well care visit in the prior six months?
    c. Where possible, for PIPs related to HEDIS® measures, crosswalk those members in the numerator to determine if they received a specific intervention. Alternatively, crosswalk those members in the denominator only for the HEDIS® measure to determine if they did or did not receive an intervention. These analyses will also assist the MCE in measuring the effectiveness of the intervention.

2. For some HEDIS® measures, a lookback period is required which for some MCE members includes time that they were enrolled in the OMPP's fee-for-service program. It is possible that the OMPP could elevate the State's (MCE's) HEDIS® rates by passing fee-for-service claims data to the MCEs. This can be done in the same manner that pharmacy claims are currently passed.

3. Regarding the FUH HEDIS® measure, the MCEs reported some potential problems with a new report that the OMPP is requiring related to readmissions and follow-up appointments. The MCEs believe that the metrics are important but have expressed concern with the mathematical calculations. The OMPP should work with the MCEs to resolve this potential issue.

4. Another issue related to the FUH measure involves the OMPP's requirement that MCEs enroll any member discharged from an inpatient psychiatric hospitalization for a minimum of 180 days. The MCEs believe that this is not always appropriate and there is often little follow-up by case managers with some of these members (more information on this is found in findings reported in Section VII of this report). One way to assess the need for the 180-day requirement is to have the OMPP collect information from each MCE to determine if these members are continually in the numerator of the 7-day and 30-day FUH measures.

5. With respect to the AWC HEDIS® measure, some of the MCEs have been working with the Indiana High School Athletic Association (IHSAA) to determine how to modify school sports physicals to qualify HHW members in the numerator for this measure. The key piece that is not included to make the adolescent 'countable' is anticipatory guidance. B&A encourages the OMPP to work with the IHSAA and the MCEs to develop guidelines to ensure that anticipatory guidance is included in these sports physicals and to develop methods to transfer information to the MCEs to track sports physicals for the AWC measure.

6. The OMPP may want to evaluate its P4P program related to the LDL-C HEDIS® measure. Based on the counts of potential members defined in this measure, the MCEs may be expending a disproportionate amount of effort in HHW on this measure since the members who are 'countable' in the measure are spread over many PMPs. Because each PMP only has a small

number of diabetic HHW members, they are each less likely to want to participate in intervention activities.

Recommendations to the MCEs

1. Although all MCEs usually were clear as to the source of their comparison benchmark value in their PIP template, they were not always clear as to the source of their comparison goal. A baseline goal was provided in Section I, Part B of the tool but when the MCE met this comparison goal it was not clear how a new goal was derived. For example, if the benchmark was the HEDIS® 90th percentile, was the new goal the 75th percentile or some other goal defined internally within the MCE?

2. Also, when measuring performance, all MCEs should provide context with respect to HEDIS® percentiles in their writeup (e.g., "In Remeasurement Year 2, the MCE's result of x% exceeded the HEDIS® 50th percentile but did not reach the 75th percentile.").

3. Related to the recommendation on reporting more information on PIP interventions, all MCEs are strongly encouraged to make data analysis part of each intervention. For example, before implementing a new intervention, the MCE should determine how it will be measured, what defines success, and what criteria will be used to decide if the intervention should be continued. It should be noted that Anthem has done this for many of its interventions in the PIPs reviewed already and is encouraged to expand this with other interventions.

4. When measuring statistical significance in its report on year-to-year change, all MCEs should also consider reporting if the PIP has had statistically significant change since the baseline in addition to the year-over-year change.

5. MCEs are encouraged to seek out best practices from other Medicaid health plans on best practices related to the interventions that were used in their states to seek improvement in the HEDIS® measures that are a part of their existing PIPs.

6. A recommendation to MHS in particular is to stratify some of their HEDIS® measure results by demographic cohorts other than age which is already embedded in many HEDIS® measures (e.g., race/ethnicity, region, gender) to determine if certain results may yield specific opportunities for interventions.

7. A recommendation to MDwise in particular is to ensure that whatever interventions are adopted for these PIPs are adhered to, implemented, and reported on by each of its delivery systems.

SECTION V: CALCULATION OF PERFORMANCE MEASURES

Introduction

Section 2108(a) and Section 2108(e) of the Social Security Act provides that the States must assess the operation of their Children's Health Insurance Program (CHIP) in each Federal Fiscal Year (FFY) and report to the Centers for Medicare and Medicaid (CMS) by January 1 following the end of the FFY on the results of the assessment. One component of this annual submission is to provide results on the Initial Core Set of children's health care quality measures (as authorized by CHIPRA 2009). Since the release of this core set, the State of Indiana has reported on most of the measures, predominantly HEDIS® measures as reported by the managed care entities (MCEs).

An optional activity that may be completed by EQROs is to calculate performance measures. The OMPP asked B&A to calculate the results of the measures that have not been reported by the OMPP in its annual CHIP report to CMS as part of this year's external quality review (EQR). This was done to ensure that when the time comes to report these measures in this year's CHIP report that there are no data integrity issues which would prevent the OMPP from reporting on these measures. For this review, the measures were calculated for the entire eligible Hoosier Healthwise population, not just CHIP members, and were computed for all MCEs and the fee-for-service portion of Medicaid/CHIP combined. Seven Child Core measures were calculated by B&A including:

- Measure 3: Live Births Weighing Less than 2,500 Grams;
- Measure 4: Cesarean Rate for Nulliparous Singleton Vertex;
- Measure 7: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Body Mass Index Assessment for Children/Adolescents;
- Measure 8: Developmental Screening in the First Three Years of Life;
- Measure 18: Ambulatory Care- Emergency Department Visits;
- Measure 20: Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit; and
- Measure 22: Annual Pediatric Hemoglobin (HbA1c) Testing.

The activities in the CMS EQR Protocol #6, *Calculation of Performance Measures*, were used as the basis for completing these calculations in whole or in part. Each activity is discussed further below.

Activity 1: Prepare for Measurement

Activity 1 in the CMS Protocol is comprised of the following steps:

1. Review state performance measure requirements
2. Prepare for data collection
3. Review MCO's Information System Capacity Assessment

B&A utilized the CMS guidance provided to states to calculate the Child Core Measures as the basis for building SAS programs to compute each of measures requested by the State.[3] Based on our review of

[3] *Initial Core Set of Children's Health Care Quality Measures: Technical Specifications and Resource Manual for Federal Fiscal Year 2012 Reporting* (updated November 2012). http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Qualityof-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html

these requirements, B&A determined that all information that was required for calculating the measures resides in the OMPP's data warehouse, MedInsight, with one exception. Measures 3 and 4 state that vital records are required to complete the calculations. These were not available to B&A for this review. For Measure 3, the vital records are required to capture the birth weight. B&A has a workaround for this by using either diagnosis codes or condition codes that are present on the claims and encounters. Measure 4 requires that only a woman's first birth should be captured in the numerator in this calculation. B&A used a workaround for this by excluding any cases that contained the following ICD-9 diagnosis codes: 654.20 Previous C-section, unspecified; 654.21 Previous C-section, with or without antepartum condition; and 654.23 Previous C-section delivery with antepartum condition.

It should be noted that for Measures 7 and 22 a hybrid option was available for calculating the measures. It was determined with the OMPP that the hybrid method was outside the scope of this year's EQR.

Since B&A had already reviewed the Information Systems Capabilities Assessments (ISCA) completed by the HEDIS® auditors in CY 2013 as part of the validation of performance measures, this step was not required in this process. The findings from our review of the ISCAs appear in Section III of this report.

Activity 2: Calculate Measures

1. Collect performance measure data
2. Clean data
3. Integrate data into repository
4. Conduct preliminary analysis
5. Calculation of the denominators, numerators and performance measure rates

Also mentioned in Section III was the process for collecting data used for multiple aspect of this EQR. B&A extracted a five-year dataset of institutional, professional and pharmacy paid claims and encounters reported to the OMPP with dates of service from January 1, 2008 to December 31, 2012 that were paid as of May 1, 2013 directly from MedInsight, OMPP's data warehouse. A corresponding enrollment file was also extracted. Indiana's data warehouse stores information on enrollees at the monthly level. Unlike previous analyses discussed in this report, B&A included any time that a person was enrolled in Indiana's CHIP in our analysis, including any portion while in the fee-for-service program. The enrollee's fee-for-service claims were also included in the analysis.

B&A had already run some validation tests on the dataset that were required for all aspects of the EQR this year when validating the performance measures. These are referenced in Section III of the report. Additionally, B&A ran validation tests on the dataset to ensure a "clean" dataset for the calculation of these performance measures. For example, B&A examined the following:

- Ensured that there were valid values in all variables used in these calculations
- The frequency of diagnosis codes appeared reasonable (e.g., although up to four diagnosis codes were available on each claim, the primary diagnosis field should always be present, then less so for diagnosis field 2, diagnosis field, 3, etc.)
- The diagnosis fields were "picking up" values based on the number of required positions (e.g. leading and trailing zeroes were not lost)

After this second round of validation, B&A built datasets for each of the measures to be calculated. Claims and enrollment information was stored for the four year period covering 2009 through 2012. In some cases, the measure explicitly states December 31 as the anchor date. In other measures, it is not implied. For the calculations completed for the OMPP, B&A assumed December 31 as the anchor date for each measure when explicitly stated in the instructions. For the remainder, the federal fiscal year

(FFY) was used since this is what is required in the annual CHIP report to CMS. By creating a multi-year dataset, we could compute a value for each measure in each year to build a baseline trend for the OMPP. It also allowed for another verification to ensure that there was not anomalous data in the most recent year studied.

When completing this longitudinal analysis, B&A discovered that we could not report results for all four years for Measure 8 due to the parameters outlined in the measure. Measure 8 requires us to check for continuous enrollment in a 12-month lookback period prior to the child's 1st, 2nd or 3rd birthday. Therefore, for this measure alone, results are only reported for CY 2011 and CY 2012.

Once the datasets were prepared, B&A conducted preliminary analysis on the dataset by examining potential denominator values. Specifically, we reviewed to see if the denominators made sense compared to the overall enrollment in the population (e.g., the number of one year olds in CHIP as a percentage of all CHIP enrollees). We also examined the values in the denominators across years to confirm that the total values were following the enrollment trends in Indiana's CHIP overall in the four-year period.

Next, B&A created logic for each year in the enrollment file to flag each member based on the anchor date in the measurement year, the lookback period (where applicable) for each member, and the member's age on the anchor date. For the claims and encounters, a flag was created for each claims-based exclusion that needed to be applied in any of the measures that were being calculated. The criteria used in the calculation of each performance measure appear in worksheets in Appendix C.

Lastly, the results for each numerator, denominator and exclusion were produced in order to calculate the ultimate rate for each measure.

Activity 3: Report Results

1. Report preliminary performance measure rates to MCOs
2. Analyze data using prescribed benchmarks and performance standards
3. Submit a final report to the State

This section summarizes the results of our calculations and is considered the final report to the OMPP. Each measure is reported below with the trends shown across the four-year study period so that the OMPP can best assess appropriate benchmarks for each measure on a go forward basis.

Measure 3: Live Births Weighing Less than 2,500 Grams

When controlling for enrollment increases in the program, the trend of low birthweight babies in Medicaid/CHIP has increased from 4.85 percent in FFY 2009 to 6.61 percent in FFY 2012.

Exhibit V.1
Live Births Weighing Less Than 2,500 Grams

		FFY 2009	FFY 2010	FFY 2011	FFY 2012
1	All Inpatient Cases	1,214,275	1,443,712	1,472,729	1,491,487
2	Cases in Non Live Birth DRGs	1,182,841	1,406,089	1,436,718	1,457,503
3	Total Live Births (row 1 minus 2)	31,434	37,623	36,011	33,984
4	Live Births w/o Low Birthweight	29,910	35,435	33,619	31,738
5	Live Births w/ Low Birthweight	1,524	2,188	2,392	2,246
6	**Percent Live Births with Less Than 2,500 Grams (row 5 divided by 3)**	**4.85%**	**5.82%**	**6.64%**	**6.61%**

Measure 4: Cesarean Rate for Nulliparous Singleton Vertex

Exhibit V.2 shows a consistent trend for this measure of 10 to 11 percent in each year studied. The OMPP should verify, however, the magnitude of cases excluded in row 5 (diagnosis code for single live newborn) since these represent 23 to 33 percent of all total live births on row 3. This appears to be much too high. By excluding too many of these cases, this could influence the final result in row 10 depending upon how many of these cases were vaginal or C-section deliveries.

Exhibit V.2
Cesarean Rate for Nulliparous Singleton Vertex

		FFY 2009	FFY 2010	FFY 2011	FFY 2012
1	All Inpatient Cases	1,214,275	1,443,712	1,472,729	1,491,487
2	Cases in Non Live Birth DRGs	1,175,436	1,394,202	1,430,406	1,452,618
3	Total Live Births (row 1 minus 2)	38,839	49,510	42,323	38,869
4	Exclude Cases Based on ICD-9-CM Codes*	5,725	7,091	6,578	5,543
5	Exclude Cases with no V27.0 Diagnosis	12,944	14,738	9,922	8,770
6	Exclude Cases where previous birth designated	6,400	8,894	7,785	7,435
7	Total Eligible Births (row 3 minus 4, 5, 6)	13,770	18,787	18,038	17,121
8	C-section Births from Row 7	1,391	1,964	1,876	1,893
9	Vaginal Delivery Births from Row 7	12,379	16,823	16,162	15,228
10	**Percent C-section of all Eligible Births (row 8 divided by row 7)**	**10.10%**	**10.45%**	**10.40%**	**11.06%**

* Includes abnormal presentation, preterm delivery, fetal death, multiple gestation diagnosis codes, breech procedure codes, or a previous C-section delivery diagnosis.

Measure 7: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Body Mass Index Assessment for Children/Adolescents

The percentage of children with a body mass index percentile reported is extremely low for both the three to 11 age group and the 12 to 17 age group, although there has been slight improvement from the CY 2009 to CY 2012 results. The values reported for each exclusion item appear to be credible by age group.

Exhibit V.3
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Body Mass Index Assessment for Children/Adolescents

		CY 2009	CY 2010	CY 2011	CY 2012
1	All eligible children age 3 to 11 years	323,365	341,998	351,681	355,744
2	Exclude non-continuous enrolled	138,251	125,801	118,291	121,100
3	Exclude members with no outpatient visit	41,785	52,384	58,789	58,619
4	Exclude diagnosis of pregnancy	24	25	33	32
5	Net eligible children age 3 to 11 years (denominator) (row 1 minus 2,3,4)	143,305	163,788	174,568	175,993
6	Members with V85.5 present (numerator)	119	246	454	868
7	**Percent of children age 3 to 11 with BMI percentile present (row 6 divided by row 5)**	**0.08%**	**0.15%**	**0.26%**	**0.49%**

1	All eligible children age 12 to 17 years	157,313	167,764	173,744	178,470
2	Exclude non-continuous enrolled	68,010	62,974	59,364	61,041
3	Exclude members with no outpatient visit	21,920	23,744	30,417	31,386
4	Exclude diagnosis of pregnancy	1,176	1,241	1,285	1,155
5	Net eligible children age 12 to 17 years (denominator) (row 1 minus 2,3,4)	66,207	79,805	82,678	84,888
6	Members with V85.5 present (numerator)	112	218	291	566
7	**Percent of children age 12 to 17 with BMI percentile present (row 6 divided by row 5)**	**0.17%**	**0.27%**	**0.35%**	**0.67%**

1	All eligible children both age groups	480,678	509,762	525,425	534,214
2	Exclude non-continuous enrolled	206,261	188,775	177,655	182,141
3	Exclude members with no outpatient visit	63,705	76,128	89,206	90,005
4	Exclude diagnosis of pregnancy	1,200	1,266	1,318	1,187
5	Net eligible children both age groups (denominator) (row 1 minus 2,3,4)	209,512	243,593	257,246	260,881
6	Members with V85.5 present (numerator)	231	464	745	1,434
7	**Percent of children both age groups with BMI percentile present (row 6 divided by row 5)**	**0.11%**	**0.19%**	**0.29%**	**0.55%**

Measure 8: Developmental Screening in the First Three Years of Life

The rate of developmental screening was consistent across the two years studied within each age cohort. The rate was highest for eligible children age 2. The low rate for all ages is most likely attributable to incomplete coding by the professionals.

Exhibit V.4
Developmental Screening in the First Three Years of Life

		CY 2011	CY 2012
1	All eligible children age 1	49,460	49,402
2	Exclude non-continuous enrolled	11,465	9,948
3	Net eligible children (denominator) (row 1 minus row 2)	37,995	39,454
4	Members with CPT 96110 (numerator)	2,764	3,139
5	**Percent of children age 1 with a developmental screening (row 4 divided by row 3)**	**7.27%**	**7.96%**

		CY 2011	CY 2012
1	All eligible children age 2	46,627	44,577
2	Exclude non-continuous enrolled	16,754	15,130
3	Net eligible children (denominator) (row 1 minus row 2)	29,873	29,447
4	Members with CPT 96110 (numerator)	2,935	3,085
5	**Percent of children age 2 with a developmental screening (row 4 divided by row 3)**	**9.82%**	**10.48%**

		CY 2011	CY 2012
1	All eligible children age 3	45,235	44,263
2	Exclude non-continuous enrolled	16,431	15,509
3	Net eligible children (denominator) (row 1 minus row 2)	28,804	28,754
4	Members with CPT 96110 (numerator)	1,832	2,228
5	**Percent of children age 3 with a developmental screening (row 4 divided by row 3)**	**6.36%**	**7.75%**

		CY 2011	CY 2012
1	All eligible children age 1, 2 or 3	141,322	138,242
2	Exclude non-continuous enrolled	44,650	40,587
3	Net eligible children (denominator) (row 1 minus row 2)	96,672	97,655
4	Members with CPT 96110 (numerator)	7,531	8,452
5	**Percent of children age 1, 2 or 3 with a developmental screening (row 4 divided by row 3)**	**7.79%**	**8.65%**

Measure 18: Ambulatory Care- Emergency Department Visits

The rate of ED visits per 1,000 is increasing in each of the last four years for all three age cohorts examined. The rate increased dramatically from FFY 2009 to FFY 2010 and again from FFY 2010 to FFY 2011. A policy change occurred during this time whereby the MCEs were required to start paying a triage fee for ED services that had previously been denied. Since B&A included only paid claims, not denied claims, in this analysis, we attribute the increase in utilization to this policy change. It should be noted that, although it is not shown in the exhibit, B&A did exclude for services related to mental health and chemical dependency.

Exhibit V.5
Ambulatory Care - Emergency Department Visits

FFY 2009

Age	ED Visits	Member Months	Visits per 1,000 Member Months
< 1	9,129	279,077	32.71
1 - 9	67,513	3,352,596	20.14
10 - 19	35,122	2,405,652	14.60
Total	**111,764**	**6,037,325**	**18.51**

FFY 2010

Age	ED Visits	Member Months	Visits per 1,000 Member Months
< 1	12,074	287,082	42.06
1 - 9	96,618	3,675,101	26.29
10 - 19	53,320	2,710,019	19.68
Total	**162,012**	**6,672,202**	**24.28**

FFY 2011

Age	ED Visits	Member Months	Visits per 1,000 Member Months
< 1	15,335	287,488	53.34
1 - 9	129,275	3,785,001	34.15
10 - 19	72,954	2,848,676	25.61
Total	**217,564**	**6,921,165**	**31.43**

FFY 2012

Age	ED Visits	Member Months	Visits per 1,000 Member Months
< 1	15,532	285,440	54.41
1 - 9	133,043	3,835,613	34.69
10 - 19	76,961	2,923,404	26.33
Total	**225,536**	**7,044,457**	**32.02**

Measure 20: Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit

The rate of asthma-related ER visits for children age two to 20 has been steady in each of the last four years reported around 12 percent of the total eligible population.

Exhibit V.6
Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit

		CY 2009	CY 2010	CY 2011	CY 2012
1	All eligible children age 2 to 20	571,935	612,270	637,633	640,454
2	Exclude children with no ER claim	531,494	561,761	587,016	588,481
3	Exclude diagnoses 493.20, .21, .22	12	25	12	26
4	Net eligible children (denominator) (row 1 minus row 2,3)	40,429	50,484	50,605	51,947
5	Members with ED visit and asthma indicator (numerator)	4,936	5,603	5,643	6,062
6	**Percent of Patients with 1 or more ER Visit (row 5 divided by 4)**	**12.21%**	**11.10%**	**11.15%**	**11.67%**

Measure 22: Annual Pediatric Hemoglobin (HbA1c) Testing

The results for this measure were consistent for CYs 2010 through 2012, but the result is much higher for CY 2009. This appears to be driven by the value in row 2 which is much lower than the other years even though the total eligible children age 5 to 17 remained relatively constant across the four years.

Exhibit V.7
Annual Pediatric Hemoglobin (HbA1c) Testing

		CY 2009	CY 2010	CY 2011	CY 2012
1	All eligible children age 5 to 17	398,312	421,545	435,549	445,449
2	Children diagnosed with diabetes	8,649	13,083	14,048	13,617
3	Exclude non-continuous enrollment	5,199	6,707	7,531	7,478
4	Exclude polycystic ovaries	64	73	96	94
5	Exclude steroid-induced diabetes	424	527	584	551
6	Net eligible (denominator) (row 2 minus 3, 4,5)	2,962	5,776	5,837	5,494
7	Hemoglobin test code present (numerator)	2,014	2,253	2,445	2,409
8	**Percent of Members with Hemoglobin Test (row 7 divided by 6)**	**67.99%**	**39.01%**	**41.89%**	**43.85%**

Conclusion

The results reported for these measures, for the most part, appear to be consistent over the four-year period examined. Some further research is warranted for Measures 4, 18 and 22 as noted above. The OMPP can now establish a baseline for future year comparisons. Also, if the MCEs are required to report

on these Child Core Measures in the future like they are for the remaining Child Core Measures, there is now a baseline in place using administrative data only for comparison to the results that they compute.

SECTION VI: FOCUS STUDY ON ACCESS TO CARE

Introduction

In consultation with the OMPP, Burns & Associates (B&A) constructed a focus study on access to care as part of this year's EQR. Section III of this report showed B&A's results of its validation of performance measures in this year's external quality review (EQR). Among those examined were HEDIS® -like measures related to children's, adolescents' and adults' access to primary care practitioners. One component of the focus study on access to care was to conduct a drill-down analysis on these measures to compare results among children and adults on access to care not only across managed care entities (MCEs) but also by age, race/ethnicity and region of the state.

Another way to review access was completed by measuring the rate of enrollees within each MCE who had received an office-based primary care service among those ever enrolled in the MCE at some point during Calendar Year (CY) 2012. This analysis expanded the population studied beyond the limits as defined by the HEDIS® measures but limited the study just to primary care office visits conducted in a physician office, at a federally qualified health clinic (FQHC), or at a rural health clinic (RHC). Analyses using these parameters were also examined by age, race/ethnicity and region of the state.

For both sets of measures, B&A analyzed data for both the Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) membership enrolled in CY 2012.

B&A also included a qualitative component to this focus study. Specifically, we interviewed MCE Provider Services staff at each MCE to learn more about their approach to outreach to providers. B&A also conducted 59 interviews with provider entities contracted with the MCEs including 29 primary medical provider (PMP) offices, 10 FQHCs, 10 RHCs, and 10 community mental health centers (CMHCs).

Each component of the focus study is discussed in the sections below.

Methodology for Measuring Access to Care

B&A utilized the same dataset that was used for the validation of performance measures in Section III of this report to measure access to care across key demographic domains. Encounters reported to the OMPP and stored in the OMPP data warehouse, MedInsight, as of May 1, 2013 were the source data for this analysis. Only encounters with a status of paid were included in the study.

B&A also utilized an OMPP enrollment file stored in MedInsight to assign attributes to every encounter, e.g. the member's, race/ethnicity, and region of the state where they live. This enabled us to report utilization across these domains at the encounter level.

B&A also used a provider file stored in MedInsight to assign the provider specialty who delivered the service on every encounter. The provider specialties considered in this analysis include:

- Primary Care Services: Provider specialties include Family Practitioner (code 315), General Practitioner (code 318), obstetrician/gynecologist (code 328), General Internist (code 345) and General Pediatrician (code 345). These are the specialty codes that the OMPP uses to define a PMP.
- FQHC: Provider specialty FQHC (code 80)

- Rural Health Clinic: Provider specialty RHC (code 81)

B&A used two methods for measuring access to primary care:

- The first method replicated the HEDIS® 2012 definitions using administrative data only for the Children and Adolescents' Access to Primary Care Practitioners (CAP) measure for HHW members and the Adults' Access to Preventive /Ambulatory Health Services (AAP) measure for HHW and HIP members. Results were stratified at the age, race/ethnicity and region level within each MCE.

- The second method limited the scope of study to primary care services billed on professional claims (CMS-1500) using only CPT codes related to office-based visits and consultation (99201-99215 and 99241-99245) and billed by three provider specialties (PMPs, FQHCs and RHCs). The potential population examined differs from the first method in that all HHW and HIP members ever enrolled in the programs in CY 2012 were considered. This differs from the first method since HEDIS® limits the potential population in its measures to those with continuous enrollment in the measurement year.

Findings Related to Measuring Access to Care

The results of B&A's analysis using the first method described above appear in Exhibits VI.1 through VI.6; the results using the second method appear in Exhibits VI.7 through VI.11.

Exhibit VI.1 compares the results of the CAP HEDIS® measure across MCEs by age group. The results within each age group are quite similar across the MCEs, although for each age group MHS had the best results followed by MDwise and then Anthem. Across age groups, the trend was also consistent for each MCE in that access was greatest for children ages 12-24 months. The results for children age 25 months to six years were usually ten percentage points below the 12-24 month age group. Results for children in the two older age groups were consistently about 10 percentage points below the 25 months to six years age group for all MCEs.

Exhibit VI.1
Children's and Adolescents' Access to Primary Care Practitioners
Analyzing Utilization with Dates of Service in CY 2012
Comparison of MCEs by Age - HHW Children

MCE	12 - 24 Months	25 months to 6 yrs	7 - 11 years old	12 - 19 years old	All Ages
Anthem	94.9%	85.8%	74.6%	74.9%	80.1%
MHS	96.0%	87.8%	77.4%	78.7%	82.4%
MDwise	95.8%	86.6%	75.6%	76.4%	80.9%
All MCEs	95.6%	86.7%	75.9%	76.7%	81.2%

When access was examined by race/ethnicity, the trends were consistent across the MCEs, although the results for Anthem were once again slightly lower than those reported for MHS or MDwise (refer to Exhibit VI.2 on the next page). African-American children consistently had the lowest access to primary care practitioners in CY 2012 in HHW at 74.5 to 76.7 percent whereas the children in the other race/ethnicities studied accessed this service 81.1 to 84.3 percent of the time.

Exhibit VI.2
Children's and Adolescents' Access to Primary Care Practitioners
Analyzing Utilization with Dates of Service in CY 2012
Comparison of MCEs by Race/Ethnicity - HHW Children

MCE	Black	Hispanic	White	Other	All Races
Anthem	74.5%	81.1%	81.7%	81.6%	80.1%
MHS	76.1%	83.8%	84.3%	82.9%	82.4%
MDwise	76.7%	83.0%	82.2%	81.9%	80.9%
All MCEs	76.0%	82.8%	82.7%	82.0%	81.2%

Access to primary care by region varied across the eight regions of the state studied. There were also some differences in the rate of access reported by the MCEs within regions. For example, MDwise reported the greatest access in Regions 1, 3 and 4 while MHS reported the greatest access in Regions 2, 5, 6 and 7. Results were the same in Region 8 for MHS and MDwise. The greatest access to primary care for children was reported in Regions 7 and 8 in the southern portion of the state and, for MHS only, in the North Central region.

Exhibit VI.3
Children's and Adolescents' Access to Primary Care Practitioners
Analyzing Utilization with Dates of Service in CY 2012
Comparison of MCEs by Region - HHW Children

MCE	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast	All Regions
Anthem	73.3%	76.1%	81.7%	77.7%	79.9%	74.8%	86.1%	82.7%	80.1%
MHS	76.9%	84.8%	80.2%	80.8%	82.2%	82.7%	86.5%	84.4%	82.4%
MDwise	79.8%	82.1%	82.8%	81.7%	78.8%	82.0%	82.5%	84.4%	80.9%
All MCEs	77.4%	82.9%	81.9%	80.9%	80.0%	81.3%	85.7%	83.9%	81.2%

Exhibits VI.4 through VI.6 on the following pages show similar comparisons for access to primary care for the adult population. Separate comparisons are shown in each exhibit for the adults in HHW and HIP. In Exhibit VI.4, the data shows that MHS had the greatest access for adults followed by Anthem and then MDwise. The rate of access was higher for the 45-64 age group in both HHW and HIP and the incremental rate of access for this age group compared to the age 20-44 group was consistent for all three MCEs in both HHW and HIP.

When examined by race/ethnicity (Exhibit V.5 on the next page), the disparities found among African-Americans among children was also true for adults, but only in the HHW population. Interestingly, the access to primary care for African-American HIP members was higher than Whites overall and this held true for Anthem and MHS members in particular. Access to primary care for Hispanic HHW adults was slightly lower than that found for Whites as was found among HHW children, but Hispanic HIP adults had slightly greater access than White adults.

Exhibit VI.4
Adults' Access to Preventive Services
Analyzing Utilization with Dates of Service in CY 2012
Comparison of MCEs by Age - HHW Adults

MCE	20 - 44	45 - 64	All Ages
Anthem	81.4%	85.6%	81.7%
MHS	82.4%	89.5%	83.0%
MDwise	80.8%	85.7%	81.2%
All MCEs	81.4%	86.6%	81.8%

Comparison of MCEs by Age - HIP Adults

MCE	20 - 44	45 - 64	All Ages
Anthem	86.6%	89.3%	87.9%
MHS	87.3%	92.1%	89.3%
MDwise	84.9%	88.7%	86.8%
All MCEs	86.2%	89.3%	87.7%

Exhibit VI.5
Adults' Access to Preventive Services
Analyzing Utilization with Dates of Service in CY 2012
Comparison of MCEs by Race/Ethnicity - HHW Adults

MCE	Black	Hispanic	White	Other	All Races
Anthem	77.8%	79.6%	83.4%	80.3%	81.7%
MHS	78.2%	81.4%	84.8%	76.3%	83.0%
MDwise	76.3%	80.8%	83.8%	72.6%	81.2%
All MCEs	77.2%	80.5%	83.9%	76.8%	81.8%

Comparison of MCEs by Race/Ethnicity - HIP Adults

MCE	Black	Hispanic	White	Other	All Races
Anthem	90.2%	89.9%	87.9%	81.7%	87.9%
MHS	90.1%	88.4%	89.7%	82.0%	89.3%
MDwise	86.8%	88.3%	87.3%	74.3%	86.8%
All MCEs	89.0%	89.3%	87.9%	79.9%	87.7%

There were fewer differences in the rate of access to primary care for adults across the regions than was found for children (refer to Exhibit VI.6 on the next page). Further, the access rates were usually similar across the MCEs within a region. The greatest difference found was in the Central Region (Region 5) where the access rate among MHS adults was 82.3 percent and for MDwise adults it was 76.1 percent.

The access rate among HIP adults was higher for every MCE in every region than the corresponding age/region cohort in HHW. This is probably more an artifact of the population mix in each program more so than regional access. As was found in Exhibit VI.4, the adults in the 45-64 age range were more likely to access primary care services than the 20-44 age range. In HIP, the distribution of members between these two age groups is close to 50/50. In HHW, the 20-44 age group is represented more than ten times as much as the 45-64 age group.

Exhibit VI.6
Adults' Access to Preventive Services
Analyzing Utilization with Dates of Service in CY 2012
Comparison of MCEs by Region - HHW Adults

MCE	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast	All Regions
Anthem	77.4%	81.3%	83.6%	80.2%	81.7%	82.5%	85.5%	83.6%	81.7%
MHS	79.3%	84.2%	86.5%	84.3%	82.3%	80.5%	87.0%	82.6%	83.0%
MDwise	78.6%	81.8%	84.8%	84.4%	76.1%	85.5%	83.5%	86.6%	81.2%
All MCEs	78.3%	83.0%	84.9%	83.5%	79.8%	83.4%	85.5%	84.5%	81.8%

Comparison of MCEs by Region - HIP Adults

MCE	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast	All Regions
Anthem	88.1%	86.7%	88.3%	86.4%	88.1%	88.6%	88.0%	87.7%	87.9%
MHS	86.9%	91.6%	80.4%	93.4%	88.7%	94.4%	89.9%	89.9%	89.3%
MDwise	83.7%	83.1%	85.8%	91.7%	86.1%	88.9%	87.6%	87.7%	86.8%
All MCEs	86.8%	86.6%	87.3%	88.6%	87.5%	89.1%	88.0%	87.8%	87.7%

The series of reports on the following pages report results using B&A's second method to measure access, that is, the percentage of members ever enrolled in CY 2012 that accessed a primary care service in either a PMP office, an FQHC or an RHC. A consistent trend in these exhibits is that the access rates are significantly lower than those found in the preceding section. This is to be expected since Exhibits VI.1 through VI.6 limited the study to members continuously enrolled in CY 2012 whereas the members included in the findings in Exhibits VI.7 through VI.11 could be enrolled with an MCE for as little as one month during CY 2012. What is important to examine in these exhibits is the relative differences among the MCEs and the demographic cohorts studied (age, race/ethnicity and region). What is also interesting to note is the source (provider specialty) of where the primary care service was delivered.

Exhibit VI.7, which appears on the next page, shows the percentage of members ever enrolled in HHW and HIP that received a primary care service in CY 2012 by MCE and provider specialty. Approximately one third of all Anthem and MHS HHW members enrolled received a service from a PMP in their office where closer to one quarter of MDwise members had done so. Primary care was delivered to just under 10 percent of HHW members at FQHCs for all three MCEs. Although just a few HHW members received primary care services at RHCs, this percentage was greatest at MDwise.

The trends found in HHW also held true for HIP, however, the overall number of HIP members receiving a primary care service as a percentage of ever enrolled was higher across-the-board for HIP than for HHW.

There are two items that should be noted when examining the reports under this second method used by B&A. First, the percentages are not additive down a row for an MCE because individual members could have received a primary care service from any one of the three provider specialties. Second, the percentage of members shown to have received primary care services at FQHCs and RHCs may be understated due to data reporting by these providers. Since B&A used the presence of CPT codes as the indicator to count a primary care visit, if the FQHCs or RHCs submitted an encounter to an MCE without one of the required CPT codes in this study, the visit would not be counted even if a primary care visit was a part of that FQHC or RHC encounter.

Exhibit VI.7
Members Receiving a Primary Care Service in CY 2012
as a Percent of Ever Enrolled

Hoosier Healthwise Members

Provider Specialty	Anthem	MHS	MDwise
Primary Care Office	31.2%	35.7%	26.8%
FQHC	9.0%	8.7%	7.4%
RHC	1.7%	2.6%	4.2%

Healthy Indiana Plan Members

Provider Specialty	Anthem	MHS	MDwise
Primary Care Office	40.5%	38.9%	39.3%
FQHC	6.7%	12.1%	8.4%
RHC	3.9%	5.2%	6.0%

Exhibit VI.8, which appears on the next page, examines the rate of primary care access among ever enrolleds for two age groups—children and adults. Although it would be expected that HHW children would be more likely to have accessed a primary care visit than HHW adults, it is interesting to note that the access rate among HIP adults is higher than it is for HHW children for all MCEs among all provider specialties, with the exception of FQHCs at Anthem. Although a lower percentage of HHW adults accessed primary care among ever enrolleds than HHW children, this difference appears to be among PMP office visits only. The percentage of adults and children in HHW receiving primary care from FQHCs and RHCs was similar.

Exhibit VI.8
Members Receiving a Primary Care Service in CY 2012
as a Percent of Ever Enrolled
By Age Group

All MCEs Combined

Provider Specialty	HHW Children	HHW Adults	HIP Adults
Primary Care Office	33.0%	28.2%	43.2%
FQHC	8.2%	9.2%	8.3%
RHC	3.0%	2.7%	4.9%

Anthem Only

Provider Specialty	HHW Children	HHW Adults	HIP Adults
Primary Care Office	33.3%	28.6%	43.0%
FQHC	9.0%	9.7%	7.1%
RHC	1.7%	1.9%	4.0%

MHS Only

Provider Specialty	HHW Children	HHW Adults	HIP Adults
Primary Care Office	38.3%	30.0%	40.8%
FQHC	8.9%	9.4%	13.0%
RHC	2.6%	2.8%	5.4%

MDwise Only

Provider Specialty	HHW Children	HHW Adults	HIP Adults
Primary Care Office	28.8%	26.6%	41.5%
FQHC	7.1%	8.6%	9.0%
RHC	4.5%	3.5%	6.2%

When examined by race/ethnicity, the disparities found when examining results using the HEDIS® CAP and AAP methodology also hold true when examining results using the ever enrolled methodology. That is, access to primary care by African-Americans and Hispanics is consistently lower than it is for Whites in HHW. In HIP, the gap is not as wide for Anthem as it is for MHS and MDwise. Another interesting point to note is where the primary care service was delivered. In both HHW and HIP, more African-Americans and Hispanics received primary care at FQHCs than Whites, while more Whites received primary care from RHCs. This is most likely due to the geographic location of the FQHCs, many of which are in urban areas where a higher proportion of minorities are concentrated in the State of Indiana.

Exhibit VI.9
Members Receiving a Primary Care Service in CY 2012
as a Percent of Ever Enrolled
By Race/Ethnicity

	HOOSIER HEALTHWISE				HEALTHY INDIANA PLAN			
	All MCEs Combined				All MCEs Combined			
Provider Specialty	**Black**	**Hispanic**	**White**	**Other**	**Black**	**Hispanic**	**White**	**Other**
Primary Care Office	27.3%	28.5%	34.2%	29.4%	40.1%	37.9%	43.9%	42.3%
FQHC	10.7%	12.7%	6.8%	10.8%	14.7%	13.4%	7.4%	6.6%
RHC	0.3%	1.1%	4.4%	0.9%	0.4%	0.8%	5.8%	0.8%
	Anthem Only				Anthem Only			
Provider Specialty	**Black**	**Hispanic**	**White**	**Other**	**Black**	**Hispanic**	**White**	**Other**
Primary Care Office	25.5%	26.6%	35.0%	28.7%	41.9%	38.6%	43.2%	44.2%
FQHC	12.2%	17.8%	7.1%	10.8%	14.2%	11.8%	6.3%	5.1%
RHC	0.1%	0.8%	2.4%	0.5%	0.3%	1.0%	4.7%	0.6%
	MHS Only				MHS Only			
Provider Specialty	**Black**	**Hispanic**	**White**	**Other**	**Black**	**Hispanic**	**White**	**Other**
Primary Care Office	30.3%	29.6%	40.0%	32.6%	34.7%	36.2%	41.7%	41.7%
FQHC	11.3%	16.5%	6.8%	13.8%	24.5%	14.7%	11.5%	15.2%
RHC	0.4%	1.6%	3.5%	1.0%	0.8%	0.0%	6.4%	0.0%
	MDwise Only				MDwise Only			
Provider Specialty	**Black**	**Hispanic**	**White**	**Other**	**Black**	**Hispanic**	**White**	**Other**
Primary Care Office	26.6%	28.8%	29.0%	27.9%	35.7%	35.4%	43.2%	36.8%
FQHC	9.4%	8.0%	6.5%	8.6%	12.0%	15.3%	8.2%	7.2%
RHC	0.3%	1.0%	6.8%	1.3%	0.3%	0.7%	7.8%	1.3%

Exhibits VI.10 and VI.11 examine the trends for access among ever enrolleds by region. Exhibit VI.10 shows the results for HHW and Exhibit VI.11 shows the results for HIP. One key finding is that the rate of access to primary care among HHW members is significantly lower in the West Central Region at primary care offices than was found in other regions. To a lesser degree, this was also found among HIP members. Some of this lower access appears to be made up from services delivered at RHCs in that region of the state. Overall, however, access appears to be lowest in Region 4. For comparison, Region 6 also has lower access in primary care offices than most other regions but there is about the same level of access at FQHCs and RHCs in Region 6 as was found in Region 4. Among ever enrolleds, the northern regions appear to have higher access to primary care than the central and southern regions in HHW. This is less true for the HIP population where access is more consistent across regions.

Exhibit VI.10
Members Receiving a Primary Care Service in CY 2012
as a Percent of Ever Enrolled
By Region - Hoosier Healthwise

All MCEs Combined

Provider Specialty	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast
Primary Care Office	34.4%	34.1%	33.5%	15.7%	29.3%	31.1%	39.6%	40.1%
FQHC	11.4%	10.1%	3.4%	9.5%	10.7%	9.9%	3.8%	2.9%
RHC	0.5%	1.1%	1.5%	8.6%	0.3%	8.1%	6.7%	6.9%

Anthem Only

Provider Specialty	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast
Primary Care Office	25.6%	29.9%	42.0%	19.9%	28.4%	25.8%	40.2%	43.3%
FQHC	15.7%	14.9%	4.8%	13.0%	9.9%	13.5%	4.0%	3.3%
RHC	0.3%	1.4%	0.5%	4.6%	0.3%	4.3%	5.2%	2.1%

MHS Only

Provider Specialty	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast
Primary Care Office	31.7%	34.9%	36.0%	20.7%	39.1%	41.5%	39.4%	42.0%
FQHC	14.4%	10.2%	5.5%	20.4%	7.7%	13.4%	1.4%	3.1%
RHC	1.0%	0.2%	5.3%	8.8%	0.3%	5.1%	6.6%	4.7%

MDwise Only

Provider Specialty	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast
Primary Care Office	42.2%	35.0%	27.6%	12.7%	23.8%	27.1%	37.6%	35.4%
FQHC	6.7%	6.8%	1.6%	4.9%	13.5%	6.7%	6.7%	2.4%
RHC	0.4%	2.9%	0.4%	9.8%	0.3%	11.0%	12.5%	13.5%

Exhibit VI.11
Members Receiving a Primary Care Service in CY 2012
as a Percent of Ever Enrolled
By Region - Healthy Indiana Plan

All MCEs Combined

Provider Specialty	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast
Primary Care Office	41.1%	48.9%	34.0%	32.4%	49.4%	46.5%	44.3%	38.1%
FQHC	15.3%	9.9%	2.9%	8.7%	9.1%	11.9%	3.9%	4.3%
RHC	0.9%	2.4%	1.4%	15.6%	0.8%	7.4%	9.5%	11.1%

Anthem Only

Provider Specialty	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast
Primary Care Office	35.9%	47.9%	29.1%	33.2%	57.1%	45.3%	42.4%	35.3%
FQHC	15.7%	9.0%	2.2%	6.4%	6.9%	11.0%	3.7%	2.9%
RHC	1.0%	1.5%	1.3%	10.8%	0.7%	6.4%	8.3%	8.8%

MHS Only

Provider Specialty	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast
Primary Care Office	31.3%	44.0%	39.2%	20.2%	48.4%	52.6%	33.9%	32.5%
FQHC	26.7%	14.7%	6.1%	17.0%	14.0%	16.7%	4.2%	5.6%
RHC	1.3%	1.0%	5.1%	13.7%	1.6%	7.9%	8.4%	13.5%

MDwise Only

Provider Specialty	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast
Primary Care Office	52.9%	51.2%	41.8%	31.3%	34.0%	43.9%	54.2%	45.1%
FQHC	9.8%	6.9%	3.2%	8.9%	11.3%	11.5%	4.2%	7.8%
RHC	0.5%	8.3%	0.2%	22.7%	0.8%	8.6%	14.2%	14.8%

Review of MCEs' Approach to Provider Relations

On June 18 and 19, 2013, B&A EQR staff met with each of the MCE's Provider Relations staff as a means to inform the interviews that would be conducted in the field with individual providers. B&A asked the MCEs questions regarding:

- The quantity of provider services resources devoted to in-field service versus telephonic service
- The types of services offered by field representatives versus telephonic customer services representatives
- The way the MCE divides its field representatives across the State
- The MCE's approach to setting field visits

- The content of the provider office visit including whom the field office staff meet with at the provider offices and the content of meetings
- Participation in regional meetings sponsored by the OMPP
- Any specific outreach to FQHCs, RHCs or CMHCs

Findings Common to All MCEs

All of the MCEs reported that it is their goal to have at least one face-to-face visit with each PMP office per year. High-volume providers (defined differently by each MCE) may be visited more often. The provider services staff at each MCE serves both HHW and HIP providers. Since all of the MCEs utilize provider services staff at a regional level for primary care, it is typical that the provider representative will coordinate provider meetings during a period that they are visiting that region of the state.

Most often, the MCE provider services staff meets with the office manager and/or billing staff when onsite with the provider. On occasion, the meeting will also include coders, front line staff, or the clinician(s) in the office.

Although the MCE staff goes into the meeting with a pre-set agenda, the MCEs reported that often this agenda is superseded by the unique needs of the provider at that time. When the agenda is used, the MCE provider services staff will review specific MCE or OMPP programs or policies on a rotating basis. Each MCE stated that they have a 'Provider Toolkit' which is a binder of materials that provider services staff have at their disposal to share with providers while in the field. Some of the examples of materials that all of the MCEs reported in their 'Provider Toolkit' include the following:

1. Transportation – information about it and contact numbers
2. Women's Preventive Health Screening Information
3. Prenatal Care Information
4. Nurse Line Contact Information
5. Information on when to go to the ER
6. MCE Contact List
7. Prior Authorization Quick Reference Guide and PA Form
8. Bright Futures/Well Child Information
9. Web Portal Reference Guide
10. HIP POWER Account Billing Guide
11. Right Choices Program FAQs
12. Enrollment and Credentialing Information
13. Member PMP Change Request Form
14. Member Request for PMP Disenrollment
15. HEDIS® Measures Quick Reference Guide
16. Panel Hold and Add Request Forms
17. Claim Dispute Form
18. MedTox (lead screening) Kit
19. Tobacco Quit Line Information
20. Case/Disease Management Referral Form (MHS Only)

Other topics cited by all of the MCEs that are commonly covered in a provider site visit include review of Gaps in Care reports, specific coding changes/billing changes such as the change in Enhanced Primary Care Payments effective in January 2013, or the changes to behavioral health CPT coding also effective in January 2013.

All MCEs also participate in provider meetings sponsored by other entities, such as HP (OMPP's fiscal agent) quarterly meetings for all Indiana Medicaid contracted providers, an annual HP-sponsored seminar, and CMHC-sponsored Revenue and Billing meetings.

Findings Specific to Each MCE

The MCEs have structured their provider services unit differently. Anthem reported having six full-time practice consultants (all RNs) and one statewide behavioral health representative. MHS has five representatives for physical health and three behavioral health representatives including the manager. MDwise has a much larger provider service staff which includes six individuals at the corporate level including one statewide behavioral health representative. Since MDwise is organized by delivery system, each delivery system also has its own provider services staff (which cover physical health, whereas the corporate office covers behavioral health). There are 23 representatives combined at MDwise's delivery systems. At MDwise, these front line staff also do provider contracting and credentialing. At Anthem and MHS, these functions are completed by staff outside of provider services.

Each MCE also conducts telephonic support to providers, but the structure is unique to the MCE. Anthem utilizes an outside vendor to handle easy questions from providers about HIP. Other questions about HIP and all HHW questions are handled by Anthem's in-house customer service representatives (CSRs). More complicated provider questions are handled by the provider services team. Anthem estimates that its provider services staff spends 50 percent of their time on the road and 50 percent handling calls or other in-office duties.

MHS has eight staff dedicated solely to telephonic support of providers. This staff handles adding and terminating providers, some authorization questions, and other research. Other staff handle claims questions. Cenpatico, MHS's subcontracted managed behavioral health organization, has its own provider hotline. MHS estimates that its provider services staff spends 70 percent of their time on the road and 30 percent handling calls or other in-office duties.

MDwise staffs a combined Member and Provider Services call center with a separate research office for more involved claims-based provider inquiries. MDwise estimates that its corporate provider services staff spends most of their time on the road.

All MCEs reported tracking which providers received face-to-face meetings and when. Both MHS and MDwise (corporate) reported that they maintain documentation of the topics covered in the onsite meeting and any follow-ups required in a database.

Each MCE also mentioned meetings which it hosts or attends that were unique to the MCE. Anthem provider services staff facilitated 36 Anthem Clinic Days at provider offices where the focus was improving well child and adolescent well care visits. Anthem also met with practice consultants at FQHCs. MHS held semi-annual meetings in nine regions across the state for its providers. Cenpatico held meetings with individual psychiatric hospitals to discuss items such as 7-day follow-up appointments, readmissions, and utilization and outcome trends comparing the hospital to other contracted hospitals. MDwise's corporate office has a Network Improvement Team that meets with MDwise delivery system staff to review utilization data of providers contracted with that delivery system or to help with provider health fairs (days focused on Medicaid patients to improve HEDIS® scores). At the invitation of the delivery system, the Network Improvement Team may also join delivery system staff at provider offices to review gaps in care reports.

Methodology for Conducting Provider Interviews

At the outset, it was B&A's intent to conduct 60 interviews with PMPs, FQHCs, RHCs and CMHCs. B&A wanted to ensure representation not only among each provider type but also among the MCEs and the regions of the state. In order to identify a representative sample to choose from to conduct the interviews, B&A followed the methodology described below.

Step 1: Determine all eligible providers

Each of the three MCEs was asked to provide B&A with a list of every PMP, FQHC, RHC, and CMHC provider that the MCE visited face-to-face in CY 2012. As part of this request, the MCEs were asked to supply the reason for the visit to the provider.

Step 2: Determine the sample of providers to visit

1) The top 30 providers in each of the four provider type categories (PMP, FQHC, RHC, and CMHC) were independently identified based on paid claims by B&A from analysis of MedInsight data.
2) The providers reported in Step 1 were compiled into a master list of providers.
3) The master list was stratified by providers that were visited by more than one MCE and limited to providers whose visit included topics that were beyond just billing questions.
4) Providers were flagged that were either (a) visited by more than one MCE, (b) appeared on the top 30 MedInsight lists, and/or (c) were visited by an MCE for a reason other than just billing questions were identified as potential onsite visit candidates.
5) This list of potential onsite visit candidates was stratified by the eight OMPP defined geographic regions.
6) A non-random sample was constructed to ensure that there was representation among the parameters identified in Step 4. An oversampling of 25 percent produced a list of 38 PMPs and 13 each of FQHCs, RHCs, and CMHCs for a total of 77 potential provider offices to visit.
7) The potential provider office visit list was sent to each of the MCEs to obtain office contact information for each of the providers. Upon return of the contact information it was determined four providers were no longer eligible for an onsite visit (i.e., provider has retired).
8) From the list of 73 providers in Step 7, a final list of 60 providers was selected ensuring representation in each region of the state. Additional consideration was given to include both providers which the MCEs stated were visited in CY 2012 and those that were not visited. The final interview list contained 60 providers (30 PMPs and 10 each of FQHCs, RHC, and CMHCs) with the other 13 providers remaining as alternates if needed.

Step 3: Scheduling onsite visits

1) A tentative schedule was developed to cover various regions of the state over an eight week period from July 15 to September 6.
2) A script was developed to ensure consistent information was provided to provider offices when scheduling onsite visits. Phone calls to provider offices requesting onsite visits began July 8 and continued over a four week period.
3) Due to provider scheduling conflicts or provider refusal to participate in the interview, seven providers from the oversample were substituted for providers in the original list. Because of this, only 29 primary care providers participated in the interview instead of the originally intended 30 providers.

A summary of providers visited by region and by MCE is below. Note that the unique number of providers is 59, but the MCEs contract with many of the same providers in a single region.

Exhibit VI.12
Providers Interviewed by Region and by MCE

Summary by Region					
Region	**PMP**	**FQHC**	**RHC**	**CMHC**	**TOTAL**
Northwest	4	1	1	0	6
Northeast	6	1	1	2	*10*
North Central	8	0	0	1	*9*
West Central	0	2	2	1	*5*
Central	2	3	0	2	*7*
East Central	3	1	1	2	*7*
Southwest	2	1	3	1	*7*
Southeast	4	1	2	1	*8*
TOTAL	***29***	***10***	***10***	***10***	***59***

Summary by MCE					
Region	**PMP**	**FQHC**	**RHC**	**CMHC**	**TOTAL**
Anthem	17	9	5	9	***40***
MHS	20	9	1	8	***38***
MDwise	20	10	9	10	***49***

Step 4: Conducting onsite visits

Two members of the B&A Review Team (Brian Kehoe and Linda Gunn or Kristy Lawrance) conducted the interviews. The interviews included anywhere from one to twelve provider staff members. Interviewees included physicians, nurses, practice managers, office managers, billing managers, client services managers, chief financial officers, chief executive officers, and other office staff. Physicians were not required to participate but several attended some or part of the sessions. The CMHCs generally had the greatest number of staff in attendance at the meetings. A semi-structured interview was conducted at each site. Specific questions were asked of all providers with pre-set responses to be captured. The questions were focused on interactions with specific MCEs as well as the providers' experiences with the HHW and HIP programs as a whole. This interview tool appears in Appendix D.

In an effort to allow for a free-flowing conversation, the review team ensured that all questions on the tool were covered during the interview but not necessarily in the order in which they appear in the tool. B&A also asked providers the open-ended question "If you could change anything about HHW and HIP, what would you change?" This question elicited conversation on a variety of topics which are discussed in the next section.

The interviews ranged from 20 to 100 minutes in length. B&A only requested 20 to 30 minutes of provider staff time but often the providers would have more information to share and voluntarily extended the meeting time.

Findings Related to Conducting Provider Interviews

B&A discovered that there was a variance between the MCEs' records of which providers were visited in CY 2012 and the recollection of these same providers regarding which MCEs visited them during this time. When determining the sample of providers to visit, each MCE was asked to indicate which of the providers on the list it had visited in CY 2012. MCEs' self-reporting to B&A did not match the providers' reporting that the MCEs visited them, as noted below. This was true among all of the MCEs. Figures are provided for non-CMHC provider types. CMHCs are reviewed in detail later in this section.

Exhibit VI.13
Variance in Recollection of MCE Visits among PMPs, FQHCs and RHCs
MCE Reported vs. Provider Reported

MCE	MCE Noted Visits	Provider Noted Visits	Variance*
Anthem	31	21	11
MHS	30	27	6
MDwise	39	30	9

*Variance takes into consideration two different situations: one is when the MCE reported that they visited the provider and the provider stated no; the other situation is the opposite case.

Provider feedback pertaining to the HHW and HIP programs in general and with MCEs in particular ranged from satisfaction to frustration. B&A analyzed the key factors related to provider satisfaction which included the quality of the MCEs' provider field staff, the quality of assistance and training the office staff received from the MCEs, and the ease in getting paid by the MCE. The key factor related to frustration from providers related to consistency across MCEs and programs (i.e., prior authorization submission and adjudication, a single Medicaid manual rather than one for fee-for-service (FFS) Medicaid and separate manuals for each MCE, consistent and accurate claims processing, and consistent responses from customer service representatives). Among B&A's sample of providers interviewed that contract with more than one MCE, three quarters of them cited areas such as this.

It should be noted that among all of the items mentioned in the open-ended question on improving either HHW or HIP, the rate of reimbursement was mentioned infrequently. In fact, only four providers cited this as something they would like to see changed. This contrasts with the results of a mail survey of 1,084 HHW primary medical providers (PMPs) that B&A conducted in its 2009 EQR where 40 percent of respondents (n=-247) were very unsatisfied with the rate of reimbursement.

Responses from the survey tool and the open-ended question including the following topics:

- Provider representative staff
- MCE customer service staff
- PMP assignment
- Incentives/Pay for Performance
- Gaps in Care or HEDIS® reports
- Interpretation services
- Transportation
- Information systems
- Timely filing requirements
- Feedback specific to behavioral health services
- Feedback specific to FQHCs and RHCs
- Feedback specific to specialists

Each topic is discussed in turn below.

Provider Representative Staff

Across the state, B&A found that providers' opinion of Medicaid, HHW, HIP, and individual MCEs is directly related to the quality, experience, and attentiveness of the provider representatives. Providers who have frequent contact with helpful, engaged, and responsive representatives are favorable to the programs. B&A could not identify the MCE that left the providers most satisfied because the MCE that would be highly favored in one region would be the least favored in another region. Differences cited by

providers within a particular region in the state or within a provider type were consistently connected to the effectiveness of the individual provider representative that served the particular region of the state or provider type.

Several providers stated that their representative was overworked. One provider noted, "She is great when she comes [onsite], but never has time to."

Providers value the information that the representatives provide and the human contact offered to get claims issues resolved. Providers are happier having a face-to-face meeting about difficult claim issues than telephonic customer service representatives. The reported ease of reaching an appropriate contact at an MCE has a very high correlation to the responsiveness of the provider representative. However, there was variance identified between MCEs as noted below.

Exhibit VI.14
Providers' response to ease of reaching the appropriate contact at an MCE

Response	Anthem (n=45)	MDwise (n=47)	MHS (n=47)
Very Easy	47%	64%	68%
Somewhat Easy	16%	17%	13%
Somewhat Difficult	16%	11%	9%
Very Difficult	22%	9%	11%

Exhibit VI.15
Providers' response to appropriate follow-up from provider representative

Response	Anthem (n=45)	MDwise (n=47)	MHS (n=47)
Yes	51%	68%	68%
Sometimes	16%	11%	13%
No	33%	21%	19%

Office managers and billers build meaningful relationships with their representatives. Many can list the names of the last two or three representatives serving them at each MCE. Because of these relationships, they are unhappy when a trusted representative leaves an MCE or a delivery system and no notice or alternate contact name is sent to them. "My e-mail bounced back and I don't know where else to turn," stated an East Central provider and nine providers stated, "Can you tell me who my representative is?"

Among all providers that had visits from provider representatives[4], 90%, (n=50) were generally satisfied with the agenda of the onsite visits. Providers indicated the main purposes of the MCEs' visit are billing questions/issues (20%, n=275[5]), reviewing gaps in care reports (16%), and Quality/HEDIS® report reviews (13%). Even though most were satisfied with the agenda of the onsite visits, many providers commented they would like more assistance with billing issues and less assistance with HEDIS® measurement. Providers also expressed frustration when a provider representative was not trained in all areas of the MCE (i.e., billing and quality) or in both HHW and HIP policies and procedures.

Office and billing managers prefer that MCE representatives schedule a time to meet rather than just stopping by the office unannounced or dropping materials off with a receptionist. One office manager shared that she had to run out into the parking lot after a representative because the representative did not attempt to meet with anyone other than the receptionist. The experience described by this provider was not unique and may contribute to the discrepancy between MCE noted visits and provider noted visits indicated in Exhibit VI.13.

[4] Six CMHC providers and three non-CHMC providers indicated they did not have an MCE provider representative visit onsite in CY 2012.
[5] 275 is the sum of all provider responses for purpose of an MCE's visits. Providers could state more than one reason for a site visit.

B&A's conversations with providers showed that many of the MCE provider representatives do not have knowledge of the Disease Management/Care Management/Case Management (DM/CM) programs or have not scheduled time with the providers to educate them about the programs. Few providers had any knowledge about the MCE DM/CM programs (27%, n=59). Of the providers that did know about the programs, most only knew about it because they had received a letter about a particular patient. It was unclear to the reviewers if these letters were from an MCE or from the Care Select program (a non risk-based program administered by the OMPP). Even those providers that had any knowledge of the program typically did not know what the programs were about, what they are to do to collaborate with the DM/CM team or how to refer members to the programs. Only five providers (9%) indicated they knew of the ability to refer members to the DM/CM programs. No provider reported receiving any materials or information on the DM/CM programs from their provider representative.

MCE Customer Service Staff

Satisfaction with MCE customer service phone assistance varied widely. Several themes surfaced when discussing customer service with the providers. Providers indicated they are often transferred numerous times at each MCE and must repeat their questions multiple times. This may be due to the way each MCE has organized its customer service department. Providers consistently indicated they get different answers from different customer service representatives when asking the same question. One provider indicated they typically call member services to get around "unhelpful and rude" provider customer service.

B&A has concluded that a policy that one MCE has created for what appears to meet Helpline Performance Report expectations by the OMPP has the unintended consequence of reducing the quality of customer service. Providers stated that this MCE only allows the discussion of three claims per call regardless of how many claims the provider would like to discuss. The provider must then go back into the call queue and start over again, even if the claims to be discussed are on the same Remittance Advice. When put back into the call queue, providers often have a different representative answer and must repeat the issue they were just discussing.

PMP Assignment

Efforts by the MCEs to reach newly enrolled members are perceived by providers to be ineffective. Providers reported numerous members going to non-assigned PMPs or to clinics for services because they do not know who their PMP is. Providers also noted that family members are being assigned to different PMPs. Providers expressed frustration with members not being able to see other providers within their own practice without a prior authorization. Overall, 52 percent (n=29) of the PMPs interviewed expressed concerns with the PMP assignment process.

Providers were split on their opinions of the change from twice monthly to daily auto-assignment. Some providers appreciated not waiting 15-45 days for a PMP change while others, especially behavioral health providers, miss being able to only check assignments on the 1st and the 15th.

Incentives/Pay for Performance

B&A did not ask a question about provider/member incentive programs or provider Pay for Performance (P4P), but the topic frequently came up during the conversations. Providers like getting bonus checks, but several stated that the MCE did not provide enough data to tie the checks back to specific members receiving or not receiving a service. This frustrated providers who missed a payment for lack of meeting a target by one member or two. One pediatrician indicated she provided an MCE with boxes of proof that her members had received the services but her bonus was not recalculated.

Member incentives were not as popular with the interviewees. One provider stated that it was an insult for a member to get a gift card for a service when the gift card was worth more than the provider was paid for rendering that service. Another provider indicated it seemed like a waste of taxpayer money to pay people to go to the doctor when they already get free healthcare. Additionally, providers do not want the administrative burden of filling out a form after a service for a member to get a reward. In fact, three PMPs indicated they refuse to fill out the paperwork. Providers that had concerns with the member incentive programs recommend those resources to be used toward enhancing member education and outreach programs. Another provider recommendation was to spend the member incentive resources on enhancing the transportation benefit to reduce appointment "no-shows."

Gaps-in-Care and HEDIS® Reports

A majority of the PMPs, FQHCs and RHCs visited (92%, n=49) liked the concept of a report defining which of their patients need well-care, vaccinations, laboratory tests, screenings, and other preventative care. However, 67 percent stated that the reports provided by the MCEs are out of date due to the claims lag and put unnecessary administrative burdens on the provider. Providers indicated that using the reports requires significant staff time to first verify the accuracy of the reports and then to contact the members. Providers with large member panels were especially frustrated with the administrative burden of inaccurate MCE reports. One provider scheduled appointments based on the report and then was denied payment from the MCE because the patient received a service in the time between the report generation and its distribution. The providers interviewed would prefer a real-time online solution that could be used to generate a current list of members needing services. Some MCEs offer a web-based member look-up function, but the offices do not have time to look up each individual member before making outreach calls.

Interpretation Services

B&A asked about provider use of MCE interpretation services. Nearly all providers (93%, n=59) were unaware that the MCE offered such services. However, all providers developed their own solutions to this ranging from, among other things, phone interpretation to bilingual staff, hired interpreters, local community services, and members bringing an interpreter to the appointment. Several rural providers stated that the only service that they needed was sign language.

Transportation

When asked what providers' biggest issues are with the HHW and HIP population, they frequently answered "no-shows". The reviewers followed up that response with a question on transportation access. Twenty of the providers indicated a contributing factor to their no-show rates are directly related to the transportation vendors (34%, n=59). There were regional as well as urban/rural differences between the providers' responses. In rural service areas, there simply were no transportation vendors available. In more urban areas, transportation vendors are available, but the quality and service of the vendors were lacking. One provider in South Bend shared a story of a mother and baby waiting from 4:00 PM until 9:30 PM for the transportation company to return to pick them up after the doctor's appointment. Long wait times were a consistent theme throughout the state.

Scheduling transportation can also be difficult for members. Several providers do same-day appointments to minimize the no-show rates for Medicaid patients. This does not work with the transportation vendors' requirements of a 48-hour scheduling notice. Additionally, one provider shared that the transportation brokers contracted by the MCEs do not have Spanish interpretation services available at their appointment scheduling call centers.

Information Systems

While B&A did not specifically ask questions about MCE information systems, the systems, data feeds, and interconnectivity are the root of several areas of provider dissatisfaction. The first area is eligibility verification. There was confusion among providers as to using webinterChange (a tool supported by HP, the OMPP's fiscal agent) or the MCEs' individual web portals as their main source of eligibility information. Providers stated that MCEs have advised them that their own (the MCE's) portal should be the main source of eligibility. Providers indicated that the MCEs have refused to use webinterChange printouts as proof of eligibility on appeal. Appointment schedulers do not have time to check multiple systems while a patient is on the phone waiting to schedule an appointment. However, they often must use both systems in order to get up-to-date PMP and Third Party Liability (TPL) information. Forty-one percent (n=59) of providers reported mismatched information between webinterChange and the MCE's portals.

Additionally, several providers cited instances where the MCEs' claims systems do not match webinterChange or the MCE's authorization system. They would have proof of eligibility or a prior authorization approval notice and the claim would still deny.

The issue of varying requirements was also mentioned related to prior authorizations (PAs). The State implemented a universal PA form in 2011. However, B&A learned that some MCEs are requiring extra information to process the PA. For example, the form does not have a space for facility data (it must be attached separately). A provider commented that "It feels like we are dealing with four different Medicaid programs with four different sets of rules."

Another information system issue surrounds TPL, since 29 percent (n=59) of providers expressed concerns related to TPL claims processing. Three specific issues were given related to this concern.

First, the TPL information in webinterChange does not match the information in the MCE eligibility system. B&A is unclear why this occurs with daily eligibility files transferring between HP and the MCEs.

Second, when a provider learns that the TPL for a member is invalid, MCEs make it difficult for the provider to prove that it is invalid. The FFS Medicaid instructions for a provider to bill when TPL is invalid are found in Chapter 5 of the Indiana Health Coverage Programs Provider Manual:

> (Page 18) When a member has other insurance, and the primary insurer denies payment for any reason or applies the payment in full to the deductible, a copy of the denial, such as an explanation of payment (EOP), explanation of benefits (EOB), or Remittance Advice (RA) must be attached to the Indiana Health Coverage Programs (IHCP) claim, or the claim is denied. When an EOP, EOB, or RA is used for documentation, the procedure code listed on the claim to the IHCP must be listed on the EOP, EOB, or RA, as well.
> - If an EOP, EOB, or RA cannot be obtained, attach to the claim a copy of the statement or correspondence from the third-party carrier.
> - Providers billing electronically and choosing not to complete the process for submitting a paper attachment after electronic submission of a claim when a third-party payer has denied payment of a claim, can allow IndianaAIM to deny the claim. The provider must then resubmit the claim to HP on paper and attach documentation of the claim denial from the insurer.
>
> (Page 20) When a third-party insurance carrier fails to respond within 90 days of the billing date, the provider can submit the claim to the IHCP for payment consideration.

Instead of following the rules above, in order for the MCEs' providers to verify to the MCEs that TPL is invalid, they must provide the MCE with a letter from the insurer. Insurers do not provide these letters to

providers, so the member must get the letter. The MCEs require their providers to prove that TPL is invalid rather than researching the TPL themselves. HP does this research for FFS Medicaid.

Third, the MCEs take a long time to update TPL information. HP updates IndianaAIM (its claims repository) in less than 24 hours when providers provide proof of TPL. Providers shared experiences where they had multiple claims deny for TPL after they had submitted documentation for an earlier date of service. Providers have learned to retain the TPL denial notice so they would have it to submit with each subsequent claim.

Timely Filing Requirements

Issues related to the MCEs' requirement of its provider to file claims within 90 days of the service date was mentioned by 31 percent of providers (n=59). The MCE's Contract Scope of Work states that:

> the [MCE] provider agreements must meet the following requirement: require each provider to submit all claims that do not involve a third party payer for services rendered to the Contractor's members within ninety (90) calendar days or less from the date of service. The Contractor shall waive the timely filing requirement in the case of claims for members with retroactive coverage, such as presumptively eligible pregnant women and newborns.

Specific concerns expressed around this timely filing requirement included the following:

1. Newborns: Several billing professionals mentioned that MCEs are not systematically waiving the filing limit in cases of newborns. Some newborns are not entered into the system for 60 days. Even if the provider bills immediately upon eligibility entry, there is no time to re-file the claim if it does not pay correctly or denies. The MCEs will often waive the filing limit upon appeal, but this becomes very onerous for providers in their opinion.

2. Third Party Liability: Many providers have had problems with claims denying for TPL when the patient no longer has outside coverage. As discussed previously, the time it takes to resolve these issues frequently exceeds the 90-day filing limit. A specific example of this came from obstetrics providers. They stated that they have frequent filing limit issues due to commercial insurance requirements for bundling all prenatal services into the delivery claim. When the obstetrician bills the listed TPL at delivery and learns that the mother is no longer covered or was only covered for part of the pregnancy, the dates of service for the unbundled individual prenatal visit codes required by Medicaid exceed the filing limit. Additionally, the providers have no date of service denials to attach to the claims for each prenatal date of service.

3. MCE errors: In cases where an MCE error results in a denial or an erroneous payment, the MCEs are not consistently waiving the filing limit or the 60-day requirement to dispute the claim adjudication. Providers expressed that they should not have to "jump through hoops" to get paid when the error is the MCE's. Several providers were concerned that they had to resubmit claims that the MCE had erroneously processed rather than the MCE mass adjusting the claims. This was administratively burdensome and often resulted in denials with the reason being the timely filing limit.

Feedback Specific to Behavioral Health Services

The B&A reviewers learned that MCE representatives seldom visit CMHCs. Only four out of 10 CMHCs interviewed had ever been visited by MCEs for anything other than initial contracting or credentialing and it was noted that these visits were less frequent than annually. As discussed previously, Anthem and

MDwise have only one representative serving this provider group statewide. In general, the MCEs use the quarterly Revenue and Billing Committee meetings (which are sponsored by the CMHCs) to communicate with the CMHCs. While the CMHCs appreciate having this forum, they stated that the meetings limit the number of questions that can be asked and often result in MCE responses of "we will get back to you with an answer." To maximize the meeting time, the CMHCs meet prior to the Revenue and Billing Committee meetings to select questions that affect the majority of the centers. These are then presented at the meeting. This does not allow time for all of the CMHCs to ask their center-specific questions.

The need for personalized attention from the MCEs was also evident when B&A interviewed CMHCs who have been through an MCE audit. CMHCs stated, "Our charts have passed our other audits, why are we not meeting the [specific] MCE's standards? Why did they not tell us sooner?"

Additionally, the CMHCs expressed frustration with the fact that OMPP, HP and MCE decision-makers do not attend the Revenue and Billing Committee meetings. They cited "We will research that and get back to you" as too frequent an answer from the MCE representatives in attendance.

CMHCs brought numerous administrative issues to the table when they met with B&A. The top two issues, indicated by all CMHCs interviewed, were PA and unsolved problems resulting from the early 2013 CPT code changes.

The CMHC providers noted the PA process is different with each of the MCEs. For example, MHS/Cenpatico only authorizes five initial services versus Anthem which allows 24. The early 2013 behavioral health CPT Code changes are still an issue for providers. These changes were driven by national coding changes, not OMPP or MCE-specific changes, but the MCEs must adhere to changes in national coding practices and be able to replicate OMPP's fee-for-service rate schedule in some situations. Providers reported that some MCEs still have not properly paid claims. B&A learned that the MCEs are expecting the providers to resubmit the erroneously paid claims rather than mass adjusting them. Then, in some instances, the MCEs are denying the claims for timely filing limit.

In addition to issues raised specifically by the CMHCs, B&A also examined the perception of the coordination of behavioral and physical health care across all providers interviewed. Most providers expressed that coordination has improved in the last several years. Physical health providers report getting treatment notes and medication information, though no physical health provider appeared to be sure if this information was coming from the MCEs or from the behavioral health providers. Not as many behavioral health providers reported getting information about their patients' physical health care. The exception was when a behavioral health provider owns primary care practices or there is a close tie or contractual relationship between a physical health and behavioral health provider. Providers with these types of relationships were very favorable about the increase in care coordination and patient outcomes.

B&A asked physical health providers about the MCE Behavioral Health Summary Reports. Some providers knew that they get the reports and others do not. Of the ones that acknowledged they received the report, most stated that they did not understand the purpose of the report nor did they know what actions to take with the report. They also stated they were unsure if the reports were coming from behavioral health providers or the MCEs. Providers with Electronic Medical Records (EMRs) noted that it is difficult to transfer the information on the report from the paper copy provided into the EMR without administrative burden.

Feedback Specific to FQHCs and RHCs

In general, the experiences cited by FQHCs and RHCs with the MCE provider representatives were similar to those of the PMPs. The reviewers found that FQHCs and RHCs are more informed about HHW and HIP program changes than PMPs. They also have fewer complaints about HHW and HIP and accept program modifications more readily than the other providers interviewed.

B&A found a few issues that were isolated to these provider types, however. The first is that some FQHCs believe that it is not possible to bill both behavioral and physical health services on the same date of service. Some do not perform behavioral and physical health coordination because they believe that they cannot get paid for both services. Yet, the reviewers interviewed other FQHCs that have effectively co-located services and integrated behavioral health service into their clinics.

The second issue is that FQHCs and RHCs cannot get bonuses for HEDIS® participation. Many feel that presentations by representatives on Gaps-in-Care or HEDIS® measures are not useful. They choose to participate in MCE outreach days based on their mission-focus rather than financial gain.

The third concern is that FQHCs and RHCs desire expedited provider enrollment processing. PMPs, FQHCs and RHCs all shared that the HP provider enrollment process can take 90-180 days. HP will backdate the enrollment to the application date, but the MCEs cannot begin their 30-60 day process until HP enrollment is complete. The MCEs will not backdate enrollment to the HP enrollment date to allow for retroactive payment for services. This is especially hard on safety net providers who have few non-Medicaid patients.

Feedback Specific to Specialists

B&A asked PMPs, FQHCs, and RHCs about local access to specialists both within HHW and HIP as well as traditional Medicaid. With the exception of Indianapolis and Seymour, all regions of the state reported issues with locating a dermatologist. In Jeffersonville, a pediatric practice interviewed shared a two-story building with a dermatology practice that would accept non-Medicaid patient referrals from the pediatricians, but would not accept their Medicaid patients.

The reviewers learned of other regional specialist access concerns:[6]

- Northwest: Pain management specialist
- North Central: Orthopedist, psychiatrist
- Northeast: Neurologist, orthopedist (2), endocrinologist, podiatrist
- West Central: no specific specialty was noted as a gap, but long wait lists were noted
- East Central: Neurologist, rheumatologist, endocrinologist, gynecologist, psychiatrist
- Central: Pain management specialist (2), orthopedist, gastroenterologist, psychiatrist (2)
- Southwest: Behavioral health (3), orthopedist, allergist, obstetricians accepting new HHW patients, gynecologist, ear/nose/throat physician, neurologist (2), rheumatologist, pain management specialist
- Southeast: Presumptive eligibility provider, psychiatrist (2), neurologist, nephrologist, orthopedist, pain management specialist (3), endocrinologist

B&A discovered that many times there are specialists in a community but they either refuse to accept Medicaid, will only accept traditional Medicaid rather than through the MCEs, cap the number of

[6] Numbers in parentheses indicate that more than one interviewed provider noted the specialist access issue.

Medicaid patients seen per month, or have long wait times. A Muncie office manager shared that her doctor could only refer a patient with a bone fracture to an orthopedist by first sending the patient to the emergency department. Another provider indicated that specialists will see a patient when they are doing rounds and a member is inpatient, but when there is recommended outpatient follow-up with the specialist the specialist will refuse to see the member since the member had Medicaid. One New Albany provider explained that several of the providers that she historically referred to withdrew from Medicaid when faced with the administrative burden of the Ordering Prescribing Referring (OPR) paperwork.

Recommendations to the OMPP and MCEs Related to Access to Care

The findings revealed in Section III that showed the five-year trend in access to primary care services in both HHW and HIP have been flat to modest improvement at each age cohort. Although, generally speaking, the results that appeared at the beginning of this section of the report showed little difference between the MCEs in the percentage of HHW and HIP members accessing primary care services, there were some differences revealed for all MCEs between age, race/ethnicity and regional cohorts.

Since access to primary care services is the linchpin for improving health outcomes among all HHW and HIP members, the feedback gained from providers at the front lines of delivering these services is important to consider as potential ways to improve access. Additionally, feedback from primary care providers and their counterparts delivering mental health services at CMHCs can provide valuable insight to improve physical and mental health integration.

From what was learned through this quantitative and qualitative focus study, B&A has put forth recommendations to the OMPP for program-wide improvements or continuous improvements directed to all MCEs. Additionally, we provide recommendations to all MCEs related to operational aspects of the ways that they work with this group of providers. Finally, B&A offers a summary of feedback specific to each MCE and offers recommendations specific to the MCE to address this feedback.

<u>Recommendations to the OMPP</u>

Provider Services and Customer Service Recommendations

1. OMPP should consider enhancing contract language around the provider services representative position. This may include experience requirements, training standards, monitoring requirements and possibly MCE withholds for poor performance in these areas.
2. From an ongoing monitoring perspective, the OMPP may want to consider tracking the number of provider representatives at each MCE and the number of face-to-face visits at provider sites. For MDwise, this would require that its delivery systems report up to an MCE-wide report.
3. In recognition of feedback from providers of getting bounced around in customer service call centers, the OMPP may want to include the rate of call transfers in the MCEs' reporting of first-call resolution.
4. OMPP should consider studying the effects of limiting caller questions to a set number of claim issues.

Transportation Recommendations

5. Although not specific to this year's review, the OMPP should consider evaluating access to transportation services and transportation reimbursement rates as part of a future focus study in or outside of an External Quality Review. This would include evaluating MCE oversight of their

transportation brokers that would include, but not be limited to, how transportation brokers oversee individually contracted providers.

6. The OMPP should require verification from the MCEs that their contracted transportation companies have interpretation services available to members.

Information Systems Recommendations

7. The OMPP should work with the MCEs to investigate the root cause of why the MCE eligibility systems do not match webinterChange. Once information is gathered, the OMPP can clarify to providers when to use webinterChange and when to use MCE portals for eligibility information. This decision could then be published in a bulletin to providers.
8. When a provider questions a TPL denial, OMPP should consider making it the MCE's responsibility to verify the TPL. When webinterChange indicates no TPL, the OMPP could require the MCEs to force the claim through the TPL edits and collect on the back-end if necessary.
9. Having a universal PA form is not enough for standardization. The OMPP should consider convening the MCEs to standardize the expectations for completing the form and the documentation attachments required.

Filing Limit Recommendations

10. The OMPP should provide additional guidance to its provision to MCEs where they shall waive the 90-day claims filing limit. One option would be to have MCEs offer an automatic 180-day filing limit in circumstances such as retroactive coverage. If enacted, then the OMPP should consider reviewing a sample of each MCEs' claims where these situations occur to ensure that the plans are complying with OMPP policies.
11. When it is a known systematic issue, the error is the MCEs' fault, or it is a TPL change, the OMPP should consider extending the filing limit to 90 days past the issue resolution date and then require the MCEs to systematically reprocess the claims rather than requiring the providers to resubmit the claims.

Behavioral Health Recommendations

12. The OMPP and MCE decision-makers are encouraged to attend the CMHC's Revenue and Billing meetings.
13. OMPP, the Division of Mental Health and Addiction, and the MCEs should consider working together to develop consistent PA, documentation, and chart audit expectations of CMHCs.

Recommendations Related to FQHCs/RHCs

14. The OMPP may consider working with HP to perform a root cause analysis to determine why IHCP provider enrollment takes so long. OMPP may want to include performance standards in the HP contract around this process.

Specialist Recommendations

15. If it has not been done already, the OMPP should work jointly with the MCEs to examine why the specific specialties listed in each region in our findings are problematic and to brainstorm on policies or incentive jointly in an effort to increase access.

Recommendations to all MCEs

Provider Services and Customer Service Recommendations

1. The MCEs should implement a standard notification process for providers when their representative changes.
2. The MCEs should consider ways to ensure that provider representatives are knowledgeable about all the programs being offered by the MCE when this information is conveyed to providers in the field.
3. The MCEs should consider initiating an education campaign to providers on the DM/CM programs in HHW and HIP. This could be a series of "Lunch and Learns" or other provider presentations. MCEs should also consider providing copies of the DM/CM materials to practitioners who can help distribute them to members, especially members who are difficult to contact.
4. Providers wish to refer members to DM/CM programs, but do not wish to complete a large amount of paperwork to do so. The MCEs should consider developing a joint DM/CM referral form.

Other MCE Services Recommendations

5. The MCEs may want to consider making its bonus program calculation methodology more transparent to its providers.
6. The MCEs should consider developing real-time Gap-in-Care solutions (website, smart phone app, electronic medical record feed, etc.). Providers want Gap-in-Care information but do not have the time or staff to determine whether or not information on the MCE reports is accurate. If a real-time Gap-in-Care solution is not possible, MCEs should consider developing a more effective process to deliver accurate and timely Gap-in-Care information to providers.
7. The MCEs may want to develop additional marketing materials to make providers and non-English speaking members more aware of interpretation services.
8. The MCEs should examine member incentive programs for ways to minimize additional administrative burden to providers.

Information Systems Recommendations

9. The MCEs should consider working with the OMPP and HP in developing a consistent TPL removal process and method of communicating the changes to one another.

Behavioral Health Recommendations

10. Due to the discrepancy found between the MCE's individual interaction with physical health providers and behavioral health providers, the MCEs should visit its contracted CMHCs face-to-face in their individual offices annually at a minimum and outreach to other large mental health providers as well in this manner rather than relying on the CMHC Revenue and Billing meetings.
11. Provider representatives need a better understanding of the Behavioral Health Summary Report so that they can train the providers in using it. The MCEs should consider reviewing the content of the cover sheets to the Behavioral Health Summary Report to ensure that they clearly define the actions PMPs are to take with the information given.

Recommendations Related to FQHCs/RHCs

12. The MCEs should ensure that there is communication with each contracted FQHC on their ability to bill for behavioral health and physical health services on the same date of service.
13. The MCEs may want to evaluate non-monetary ways to incentivize FQHCs and RHCs who participate in HEDIS® activities.

MCE Specific Observations and Recommendations

Anthem

Provider concerns with Anthem centered on claims payment. B&A found that many of the claims payment issues were HHW specific. Providers that have issues with HHW claims payment state that they do not have the same issues with HIP or commercial Anthem.

Several CMHCs shared that Anthem is still having issues paying claims affected by the 2013 CPT code change. They stated that Anthem has finally paid the claims, but they were paid wrong which has mostly resulted in Anthem overpaying the services. Providers indicated that rather than recouping these overpayments, Anthem is requiring providers to manually refund each overpayment. One provider noted that they had refunded one of these overpayments, had the cleared check to prove it, yet Anthem still sent the provider to a collection agency.

Providers feel that resolution of claims issues is fragmented. Providers must speak to multiple departments to get one issue resolved. One provider stated, "We shouldn't have to fight to get paid what is in our contract."

Anthem Recommendations:

1. Anthem should gain an understanding of what are the differences in claims processing between its systems paying HHW and HIP claims to evaluate if the feedback from providers about claims processing better for HIP than for HHW is pervasive.
2. Anthem should consider developing a more effective claims resolution policy/process so providers do not have to get transferred to multiple departments.
3. Anthem should consider offering providers recoupment rather than requiring the providers to send back the overpayments caused by the 2013 CPT code changes or sending them to collections.

MHS

Providers expressed two main difficulties with MHS. The first was from the CMHCs. Cenpatico, MHS's behavioral health unit, only authorizes five behavioral health services at a time. Cenpatico will not authorize additional units until the previous five have been exhausted. This is troublesome for patients who have three to five sessions per week or a combination of group and individual therapy. The second difficulty was with the calculations of bonuses. The providers stated that they have proof that the services were rendered, but MHS does not accept that as evidence for bonus recalculation. One specific example was the Hepatitis vaccine. The pediatrician's patients had the first dose in the hospital and then were given the second dose in the office. The hospital dose was not counted toward her bonus metric even though the Children and Hoosier Immunization Registry Program showed the child's vaccinations complete. The provider stated she "sent a box to MHS, but the documentation did not result in additional payment."

MHS Recommendations:

1. MHS should provide its rationale to the OMPP about Cenpatico's authorization practices. Although we are not recommending an overreach by the OMPP on how each MCE utilizes prior authorization, the OMPP may consider if, in some cases, Cenpatico's practices should be more in line with those of the other MCEs.
2. MHS should consider making its bonus program calculation methodology more transparent to its providers.

MDwise

Most of the issues that concerned the providers about MDwise either stemmed from navigating its multiple delivery system model or there were concerns directed at one of the delivery systems specifically. The interviewees who see patients from multiple delivery systems found it challenging to navigate MDwise when the requirements differ from delivery system to delivery system.

MDwise providers do not understand why authorization is required to see a patient from another delivery system. A New Castle provider shared the story of a pregnant woman who was retroactively assigned to a PMP in an Indianapolis delivery system that was different from that of the MDwise provider that she had been seeing the entire pregnancy. That retroactive delivery system refused to grant authorization for the services that she had already received.

Providers indicated when they try to contact the MDwise corporate offices they are referred back to the delivery systems. Providers do not know how to elevate issues when they have not gotten resolution through delivery system channels.

Two other issues were specific to the Hoosier Alliance delivery system. Three different West Central region Hoosier Alliance PMPs stated that they cannot reach anyone at Hoosier Alliance. Their provider representative left and none of them were notified of this. One provider fought for another representative, but the other two have no Hoosier Alliance contact. Another provider stated that Hoosier Alliance told them that they deny all claims disputes and force all providers to appeal. This provider wanted to know why they must first dispute the claim and cannot directly appeal it.

Regarding behavioral health, a southern Indiana CMHC stated that the MDwise HIP claims system frequently does not recognize behavioral health PAs. This provider had to call three times and was transferred several times to obtain a resolution.

MDwise Recommendations:

1. Recognizing that MDwise has recently developed enhancements to its delegated oversight tool, MDwise should provide the OMPP with assurances in how its delegated oversight tool specifically addresses provider relations at the individual delivery system level.
2. MDwise should review requirements around PA and other areas that impact providers most specifically across delivery systems to identify areas where they should be standardized.

SECTION VII: FOCUS STUDY ON MENTAL HEALTH UTILIZATION AND CARE COORDINATION

Introduction

In last year's External Quality Review (EQR), Burns & Associates' (B&A's) clinical team reviewed 134 care plans for members enrolled in Hoosier Healthwise (HHW) or the Healthy Indiana Plan (HIP) who were also assigned to the Office of Medicaid Policy and Planning's (OMPP's) Right Choices Program (RCP). The RCP is a program where members are eligible for all HHW or HIP services are restricted to one primary medical provider, one hospital and one pharmacy in an effort to combat member abuse of services. Many of the individuals who are enrolled in the RCP were found to have mental[7] health diagnoses. Therefore, one component of the care plan review was to gauge whether or not mental health diagnoses and medications were being tracked in the care plan. B&A offered the recommendation to the managed care entities (MCEs) that tracking both of these elements could be improved in the documentation of the care plans for RCP members.

Another aspect of last year's EQR was the review of all quarterly reports submitted by the MCEs to the OMPP. Meetings were held with B&A, OMPP staff and relevant staff from each of the three MCEs in attendance to understand how report instructions were being interpreted differently. One area where there were differences in interpretation were related to the quarterly reports that are required to be submitted documenting MCE members enrolled in complex case management, moderate case management and disease management. An outcome of these meetings was that new reports were constructed related to these submissions that took effect January 1, 2013. Since the reports are due quarterly, the first experience period reported was for 1st Quarter 2013 and these reports were due to the OMPP on April 30, 2013. One key difference between the reports examined in CY 2012 and the new reports developed is that now the stratification of members for complex and moderate case management are divided into two reports—one for physical health conditions and another for mental health conditions.

B&A developed a focus study for this year's EQR which is a continuation of the work conducted in last year's EQR. In this year's EQR, a review of mental health utilization was conducted more broadly for all members of HHW and HIP, not just the RCP members. Additionally, B&A reviewed the first submissions of the new complex and moderate case management reports for mental health conditions covering 1st Quarter 2013.

Specific elements of this year's focus study included the following:

- A quantitative claims-based utilization analysis to assess who among HHW and HIP members have mental health diagnoses, how many members with these diagnoses are receiving mental health services, and from whom do they receive these services;
- A qualitative component that included interviews with the MCEs about the delivery of mental health services to members; and
- A clinical component included the review of case files for individuals enrolled in the MCE's case management program due to mental health diagnoses.

[7] Throughout this section, the terms "mental health" and "behavioral health" are used synonymously.

The quantitative component of the study was completed by Mark Podrazik (EQR Project Lead) and Carol Weller (B&A SAS programmer/analyst). The qualitative and clinical components were completed by a six member clinical team led by Dr. CJ Hindman. Dr. Hindman was the Clinical Team Lead of the EQRs conducted in 2009-2012 for HHW and HIP. He was previously the Chief Medical Officer for Arizona's Medicaid program and also served as the Corporate Medical Director of a Medicaid managed care program. Dr. Hindman was assisted by Dr. Dan Asimus who is board certified in psychiatry, neurology, child psychiatry as well as holistic medicine. Dr. Asimus participated in interviews with the MCEs and oversaw the review of case files for the focus study related to mental health utilization and care coordination. In the review of the care plan files, the doctors were assisted by three nurses and an administrative lead.

Each component of the focus study is discussed in the sections below.

Methodology for Measuring Access to Care

B&A utilized the same dataset that was used in Sections III and VI of this report to measure access to primary care across key demographic domains. This included encounters with a paid status reported to the OMPP and stored in the OMPP data warehouse, MedInsight, as of May 1, 2013 for dates of service in Calendar Year (CY) 2012.

B&A also utilized OMPP enrollment and provider files to assign attributes to each encounter as was described in Section VI. The attributes assigned include the member's age, race/ethnicity, and region of the state where they live. The specialty of the provider who delivered the service as also assigned to each encounter.

The provider specialties considered in the mental health utilization analysis differed from those used in the analysis of primary care utilization. The specialties considered were categorized as follows:

- Primary Care Services: Provider specialties include Family Practitioner (code 315), General Practitioner (code 318), obstetrician/gynecologist (code 328), General Internist (code 345) and General Pediatrician (code 345). These are the specialty codes that the OMPP uses to define a primary medical provider (PMP).
- Community Mental Health Provider: Provider specialties include Psychologist (code 112), Certified Psychologist (code 113), Certified Clinical Social Worker (code 115), Social Worker (code 116), Psychiatric Nurse (code 117) and Psychiatrist (code 339).
- Outpatient Mental Health Clinic: Provider specialty code 110
- Community Mental Health Center: Provider specialty code 111

Since the purpose of the study was to analyze mental health utilization in community settings, services were limited to the provider specialties above that were billed on a professional (CMS-1500 claim form). The actual services included in the analysis are those in the CPT range 90801-90899 or 96101-96155. When diagnoses were reviewed, the focus was limited to diagnoses in the 290-319 (mental disorders) range. Information was analyzed separately for the HHW and HIP populations.

Findings Related to Measuring Mental Health Utilization

B&A first examined the prevalence of mental health diagnosis codes that appeared on professional service encounters for members in HHW and HIP in CY 2012. Next, an analysis of which provider specialties are delivering services in the community to individuals with mental health diagnoses was completed.

Among 906,669 members ever enrolled in HHW during CY 2012, there were 157,280 members (17.3%) who had a mental health diagnosis reported on an encounter in CY 2012. This is further divided between 106,048 child members (15.1% of ever enrolleds) and 51,232 adults (25.3% of ever enrolleds). Of the 52,886 members ever enrolled in HIP during CY 2012 (all adults), 15,281 (28.9%) had a mental health diagnosis reported on an encounter.

The percentage of HHW and HIP members with a mental health diagnosis is being driven by Caucasian members mostly (refer to Exhibit VII.1 below). In HHW, 21.0 percent of Caucasians had a mental health diagnosis compared to 12.5 percent of African-American members and 8.7 percent of Hispanic members. A similar trend was found in HIP with 31.3 percent of Caucasian members with mental health diagnosis on an encounter compared to 20.2 percent for African-American and 16.6 percent for Hispanics.

Exhibit VII.1
Prevalence of Mental Health Diagnoses Reported by Race/Ethnicity
For Services Received in CY 2012

	HHW		HIP	
	Unique Members with a MH Diagnosis	Percent of Ever Enrolled	Unique Members with a MH Diagnosis	Percent of Ever Enrolled
African-American	25,360	12.5%	1,102	20.2%
Hispanic	8,602	8.7%	267	16.6%
Caucasian	121,102	21.0%	13,707	31.3%
Other	2,216	7.9%	205	10.3%

Exhibit VII.2 shows the prevalence of the most common diagnoses reported for HHW and HIP members in CY 2012. Recognizing that multiple diagnoses can appear on the same encounter and that multiple encounters may appear in the year for the same member, three diagnoses comprised half of all of the mental health diagnoses cited for the HHW population—attention deficit disorder (24.9% of total), anxiety or panic disorder (14.5%), and major depressive or bipolar disorder (12.9%). Among the HIP population, three diagnoses also comprised half of all mental health diagnoses—tobacco use disorder (19.6% of total), attention deficit disorder (15.5% of total), and major depressive or bipolar disorder (14.9) of total).

Exhibit VII.2
Prevalence of Mental Health Diagnoses Reported for HHW and HIP Members
For Services Received in CY 2012

ICD-9 Code Range	ICD-9 Diagnostic Range Description	Number in HHW	Percent in HHW	Number in HIP	Percent in HIP
		(n=333,479 obs)		(n=111,984 obs)	
296.xx	Major depressive or bipolar disorder	43,046	12.9%	16,647	14.9%
300.xx	Anxiety or panic disorder	48,442	14.5%	11,146	10.0%
305.1x	Tobacco use disorder	19,434	5.8%	21,950	19.6%
312.9x	Unspecified disturbance of conduct	13,190	4.0%	3,866	3.5%
313.81	Oppositional defiant disorder	14,903	4.5%	5,037	4.5%
314.xx	Attention deficit disorder	82,898	24.9%	17,311	15.5%
	All Other	111,566	33.5%	36,027	32.2%

Exhibit VII.3 below examines from whom mental health services were delivered to HHW and HIP members by tabulating the total encounters where mental health professional service codes were billed by provider specialty. Outpatient mental health clinics and CMHCs play an important role in the delivery of these services since more than 80 percent of all services were billed by these two provider types in both HHW and HIP (the exception is Anthem HIP, where the percentage is 76%). Community mental health providers, as defined in the methodology section above, delivered less than 10 percent of the services (except in Anthem HIP). It is interesting to note that in MDwise HIP, primary care providers comprise a larger proportion of mental health services delivered than the other MCEs or in MDwise HHW.

Exhibit VII.3
Where Members Received Mental Health Services in CY 2012

Hoosier Healthwise Members

Provider Specialty	Anthem	MHS	MDwise
Primary Care Office	7.6%	3.5%	3.3%
Community Mental Health Provider	7.6%	6.9%	9.2%
Outpatient Mental Health Clinic	44.4%	47.6%	39.7%
Community Mental Health Center	40.5%	42.1%	47.8%

Healthy Indiana Plan Members

Provider Specialty	Anthem	MHS	MDwise
Primary Care Office	5.2%	1.6%	12.3%
Community Mental Health Provider	18.2%	9.6%	9.6%
Outpatient Mental Health Clinic	49.4%	50.4%	36.6%
Community Mental Health Center	27.1%	38.4%	41.5%

If members received services from more than one provider specialty, they are counted in multiple categories. Mental health services are defined here as services billed on a professional claim using CPT codes 90801-90899 or 96101-96155.

The same analysis was conducted distributing the services delivered by age (refer to Exhibit VII.4 on the next page), by race/ethnicity (refer to Exhibit VII.5 on page VII-6), and by region (refer to Exhibits VII.6 and VII.7 on pages VII-7 and VII-8). In general, the patters of service delivery shown above carried through when reviewing within these demographic cohorts with the following exceptions:

- Mental health services were more likely to be delivered by community mental health providers to adults than to children in HHW (Exhibit VII.4)

- African-American members were more likely to receive services from CMHCs than other HHW or HIP members and Hispanic members were more likely to receive services from outpatient mental health clinics than other race/ethnicities (Exhibit VII.5). This was true for all MCEs.

- At the regional level, it appears that the geographic location of outpatient mental health clinics and CMHCs is what is driving the provider source for the delivery of services. For example, the proportion of services delivered in Regions 1 and 6 is much higher for outpatient mental health

clinics than in other regions. This was true for all MCEs and for both HHW and HIP. Likewise, CMHCs are delivering more services in Region 5 than in other regions. (Exhibit VII.6 and VII.7)

- The one area where the MCEs do not follow a similar pattern of predominant provider source is Region 3 where Anthem delivers more services through outpatient mental health clinics than do the other MCEs. Also, for HIP only, MDwise PMPs are delivering more services to members than the PMPs from the other MCEs.

Exhibit VII.4
Members Receiving a Mental Health Service in CY 2012
By Age Group

All MCEs Combined

Provider Specialty	HHW Children	HHW Adults	HIP Adults
Primary Care Office	5.7%	5.9%	8.5%
Community Mental Health Provider	7.0%	12.3%	11.1%
Outpatient Mental Health Clinic	42.8%	42.7%	46.6%
Community Mental Health Center	44.5%	39.1%	33.8%

Anthem Only

Provider Specialty	HHW Children	HHW Adults	HIP Adults
Primary Care Office	10.2%	9.9%	5.2%
Community Mental Health Provider	5.6%	13.8%	18.2%
Outpatient Mental Health Clinic	43.6%	41.2%	49.4%
Community Mental Health Center	40.6%	35.1%	27.1%

MHS Only

Provider Specialty	HHW Children	HHW Adults	HIP Adults
Primary Care Office	3.4%	2.0%	1.6%
Community Mental Health Provider	6.3%	10.6%	9.6%
Outpatient Mental Health Clinic	48.0%	46.6%	50.4%
Community Mental Health Center	42.3%	40.8%	38.4%

MDwise Only

Provider Specialty	HHW Children	HHW Adults	HIP Adults
Primary Care Office	5.0%	5.6%	12.3%
Community Mental Health Provider	8.4%	12.4%	9.6%
Outpatient Mental Health Clinic	38.4%	41.0%	36.6%
Community Mental Health Center	48.2%	41.0%	41.5%

If members received services from more than one provider specialty, they are counted in multiple categories. Mental health services are defined here as services billed on a professional claim using CPT codes 90801-90899 or 96101-96155.

Exhibit VII.5
Members Receiving a Mental Health Service in CY 2012
By Race/Ethnicity

	HOOSIER HEALTHWISE				HEALTHY INDIANA PLAN			
	All MCEs Combined				All MCEs Combined			
Provider Specialty	**Black**	**Hispanic**	**White**	**Other**	**Black**	**Hispanic**	**White**	**Other**
Primary Care Office	5.7%	9.0%	5.4%	8.4%	17.0%	13.8%	7.8%	0.0%
CMHP	6.4%	7.0%	8.3%	10.5%	6.0%	10.3%	11.4%	21.4%
OMHC	34.4%	50.2%	44.4%	41.1%	35.0%	62.1%	46.9%	64.3%
CMHC	53.5%	33.8%	41.9%	40.1%	42.0%	13.8%	33.8%	14.3%

	Anthem Only				Anthem Only			
Provider Specialty	**Black**	**Hispanic**	**White**	**Other**	**Black**	**Hispanic**	**White**	**Other**
Primary Care Office	8.7%	14.9%	10.1%	11.0%	5.0%	0.0%	8.1%	0.0%
CMHP	6.2%	6.8%	7.6%	9.2%	15.0%	11.8%	13.8%	25.0%
OMHC	37.6%	54.1%	43.6%	40.4%	50.0%	76.5%	51.4%	75.0%
CMHC	47.4%	24.3%	38.7%	39.4%	30.0%	11.8%	26.6%	0.0%

	MHS Only				MHS Only			
Provider Specialty	**Black**	**Hispanic**	**White**	**Other**	**Black**	**Hispanic**	**White**	**Other**
Primary Care Office	2.1%	2.0%	3.4%	8.1%	0.0%	0.0%	0.0%	N/A
CMHP	7.4%	8.6%	6.8%	5.6%	0.0%	0.0%	4.4%	N/A
OMHC	41.8%	55.5%	48.6%	43.5%	60.0%	33.3%	50.9%	N/A
CMHC	48.7%	33.9%	41.2%	42.7%	40.0%	66.7%	44.7%	N/A

	MDwise Only				MDwise Only			
Provider Specialty	**Black**	**Hispanic**	**White**	**Other**	**Black**	**Hispanic**	**White**	**Other**
Primary Care Office	6.5%	10.7%	4.1%	6.7%	26.4%	44.4%	9.5%	0.0%
CMHP	5.8%	6.3%	10.2%	15.4%	0.0%	11.1%	9.0%	16.7%
OMHC	29.1%	45.9%	41.2%	39.6%	22.6%	44.4%	37.9%	50.0%
CMHC	58.6%	37.2%	44.5%	38.3%	50.9%	0.0%	43.5%	33.3%

CMHP = Community Mental Health Provider; OMHC = Outpatient Mental Health Clinic
CMHC = Community Mental Health Center

If members received services from more than one provider specialty, they are counted in multiple categories. Mental health services are defined here as services billed on a professional claim using CPT codes 90801-90899 or 96101-96155.

Exhibit VII.6
Members Receiving a Mental Health Service in CY 2012
By Region - Hoosier Healthwise

All MCEs Combined

Provider Specialty	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast
Primary Care Office	5.2%	1.8%	8.4%	0.8%	6.9%	1.4%	13.5%	3.4%
CMHP	9.3%	3.6%	7.5%	32.6%	5.3%	8.4%	2.4%	2.7%
OMHC	69.9%	52.5%	34.8%	22.9%	26.7%	67.5%	51.4%	47.7%
CMHC	15.6%	42.2%	49.2%	43.8%	61.1%	22.7%	32.7%	46.3%

Anthem Only

Provider Specialty	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast
Primary Care Office	5.4%	0.2%	23.6%	1.7%	11.0%	1.9%	13.9%	5.8%
CMHP	7.1%	1.7%	12.9%	33.7%	6.7%	9.0%	2.5%	3.2%
OMHC	73.3%	61.4%	49.2%	16.1%	28.4%	72.7%	44.9%	39.2%
CMHC	14.3%	36.7%	14.3%	48.4%	54.0%	16.4%	38.7%	51.9%

MHS Only

Provider Specialty	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast
Primary Care Office	0.4%	0.4%	4.3%	1.1%	1.5%	0.8%	17.0%	1.7%
CMHP	14.7%	4.8%	5.0%	40.2%	3.3%	5.5%	1.5%	2.9%
OMHC	72.4%	50.9%	35.4%	28.7%	34.3%	63.0%	59.4%	56.0%
CMHC	12.5%	43.9%	55.3%	30.1%	61.0%	30.7%	22.0%	39.4%

MDwise Only

Provider Specialty	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast
Primary Care Office	7.6%	5.2%	5.0%	0.4%	7.9%	1.6%	6.2%	3.3%
CMHP	7.6%	2.2%	6.9%	29.3%	5.9%	10.0%	3.6%	2.0%
OMHC	67.1%	51.2%	29.2%	22.1%	20.2%	68.8%	51.5%	45.2%
CMHC	17.7%	41.5%	58.9%	48.2%	66.0%	19.5%	38.8%	49.5%

CMHP = Community Mental Health Provider; OMHC = Outpatient Mental Health Clinic
CMHC = Community Mental Health Center

If members received services from more than one provider specialty, they are counted in multiple categories. Mental health services are defined here as services billed on a professional claim using CPT codes 90801-90899 or 96101-96155.

Exhibit VII.7
Members Receiving a Mental Health Service in CY 2012
By Region - Healthy Indiana Plan

All MCEs Combined

Provider Specialty	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast
Primary Care Office	14.2%	2.4%	15.2%	2.2%	14.0%	2.3%	3.2%	0.0%
CMHP	5.2%	11.9%	17.4%	35.6%	9.0%	12.7%	3.2%	3.7%
OMHC	72.3%	58.3%	46.2%	21.1%	34.6%	54.5%	55.1%	36.4%
CMHC	8.4%	27.4%	21.2%	41.1%	42.4%	30.5%	38.6%	59.8%

Anthem Only

Provider Specialty	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast
Primary Care Office	11.2%	4.7%	19.3%	2.2%	7.7%	4.1%	4.4%	0.0%
CMHP	4.1%	20.9%	21.1%	51.1%	14.2%	13.0%	2.6%	6.6%
OMHC	76.5%	69.8%	44.7%	17.8%	45.0%	57.7%	54.4%	44.3%
CMHC	8.2%	4.7%	14.9%	28.9%	33.1%	25.2%	38.6%	49.2%

MHS Only

Provider Specialty	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast
Primary Care Office	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CMHP	10.0%	0.0%	6.7%	0.0%	2.7%	5.6%	12.5%	0.0%
OMHC	90.0%	60.0%	53.3%	33.3%	45.9%	44.4%	37.5%	37.5%
CMHC	0.0%	40.0%	40.0%	66.7%	51.4%	50.0%	50.0%	62.5%

MDwise Only

Provider Specialty	Region 1 Northwest	Region 2 N. Central	Region 3 Northeast	Region 4 W. Central	Region 5 Central	Region 6 E. Central	Region 7 Southwest	Region 8 Southeast
Primary Care Office	23.4%	0.0%	11.1%	2.7%	22.3%	0.0%	0.0%	0.0%
CMHP	6.4%	0.0%	13.0%	24.3%	5.7%	11.7%	3.2%	0.0%
OMHC	59.6%	31.6%	46.3%	18.9%	22.3%	53.2%	64.5%	21.6%
CMHC	10.6%	68.4%	29.6%	54.1%	49.7%	35.1%	32.3%	78.4%

CMHP = Community Mental Health Provider; OMHC = Outpatient Mental Health Clinic
CMHC = Community Mental Health Center

If members received services from more than one provider specialty, they are counted in multiple categories. Mental health services are defined here as services billed on a professional claim using CPT codes 90801-90899 or 96101-96155.

Methodology for Conducting Care Plan Reviews

B&A's intention was to complete reviews of 100 complex case management plans at each MCE for members that were enrolled in complex case management due to behavioral health diagnoses. B&A wanted to ensure that there was representation of case files for both the HHW and HIP programs as well as a profile of cases among all member age groups. B&A followed the methodology described below to ensure a representative sample at each MCE.

Step 1: Determine all eligible members

1) B&A received copies from the OMPP of the new complex case management report described previously (QR-CMBH1: Complex Case Management Report- Behavioral Health Conditions of Interest).
2) There is a value at the top of this report that tracks total members ever actively enrolled in complex case management during the reporting period. For the reports that B&A received, this covered the period of 1st Quarter of CY 2013. B&A requested an itemized listing of members from each MCE who comprised all active ever enrolled during the reporting period.

Step 2: Determine the sample of members to review

1) Upon receipt of the list of 'active ever enrolled in complex case management in 1st Quarter 2013', B&A worked with each MCE to obtain the most correct list since none of the MCEs provided an original list that tied to the totals on the QR-CMBH1 report.
2) Once the final lists were delivered to B&A, additional demographic information was added to the list of members in an effort to stratify a sample considering different age groups and gender among members. Another consideration in sampling was to include members who were enrolled for various lengths of time in complex case management.
3) Ultimately, the intended list of 100 complex case management files did not need to be stratified for Anthem and MHS.
    a. Anthem reported 101 members ever actively enrolled in complex case management during 1st Quarter 2013, so 100 percent of their sample was selected.
    b. MHS reported on 76 cases that met this criterion. All 76 members were selected for review. To round out the list of 100, MHS provided a list of members in moderate case management for behavioral health conditions. An additional 29 members that fell into this category of case management were also selected for review.
    c. MDwise identified 799 members that met the actively ever enrolled criterion during 1st Quarter 2013. A total of 100 cases were selected. In addition to considering age and gender, B&A asked MDwise to identify which of the eight delivery systems each member was assigned to so that the MDwise sample could also contain representation from each delivery system.

Step 3: Prepare Review Tool and Conduct a Pilot Test

Dr. Hindman and Mindy McKusky (an RN reviewer) conducted a pilot test on the draft case file review tool during onsite visits to the MCEs during the week of June 17. Three cases were selected from each MCE to test completing the tool. As a result of this pilot, minor adjustments were made to review tool questions and pre-set responses available to answer each question.

Step 4: Preparations for the Onsite Review

1) Once the final sample of cases was delivered to each MCE, B&A asked the MCEs to submit confirmation that the members were in fact enrolled in complex case management during 1st Quarter 2013 and that the files would be available for the EQR team to review. (The exception to this is MHS's 29 cases that were classified as moderate which were already known not to be in complex case management.)
2) B&A retrieved utilization information for each member from the OMPP data warehouse, MedInsight. Utilization profiles were created for each member that was to be reviewed. The information tabulated was from encounters submitted by the MCEs to the OMPP through May 1, 2013 for dates of service in CY 2012. A known limitation to this analysis is that B&A only had CY 2012 information available for each member even though the member was enrolled in complex case management during the 1st Quarter of 2013. Therefore, some utilization was missing for each member on these reports. Information on the utilization profiles identified:
    a. Physical health diagnoses presented on all encounters reported with an indicator as to whether the diagnosis was presented on an institutional claim or a professional claim
    b. Behavioral health diagnoses presented on all encounters reported with an indicator as to whether the diagnosis was presented on an institutional claim or a professional claim
    c. An itemization of all CPT codes (procedure codes) on professional claims during CY 2012, the CPT descriptor, and the date of service on the claim
    d. An itemization of all pharmacy scripts filled for the member during CY 2012, the NDC number and the NDC descriptor
    e. When applicable, a listing of all inpatient hospital stays for the member during CY 2012, the DRG number, the DRG description, and the date of admission.

Step 5: Conduct the Review

1) The Clinical Review Team of three nurses and two MDs performed the review of each of the care plans during the week of August 19 onsite at each MCE. The review tool was completed for each care plan by one of the RNs with a final review by one of the MDs.
2) Since each MCE uses a different software product that provides their case management and care plan templates, at each MCE the Clinical Team was assisted by case managers from the MCE to help navigate their system to find the specific items of interest as defined by the review tool.

Step 6: Tabulate Results

After the onsite reviews were completed, B&A entered the results from each review tool into a Microsoft Access database and tabulated the results presented in the section below.

The tool has two basic types of response. One type is easily tabulated 'yes' or 'no' types of questions. The other type is comments and observations that are written onto the tool by the reviewer. A sample of the tool can be found in Appendix E of this report. The written comments reported on the tool have been synthesized and are included in the findings section of this report.

It should be noted that the OMPP is now following the National Committee for Quality Assurance (NCQA) definitions of complex and moderate case management. In the NCQA definition, only individuals in complex case management are required to have care plans with documented goals to achieve improvement. Individuals in moderate case management may have a case management file that contains documentation on the member's condition and progress notes, but an actual care plan is not required. B&A factored this into our evaluation in this year's EQR when reviewing cases in both complex and moderate case management.

Findings Related to Conducting Care Plan Reviews

Although it was the intent to review 300 case files, the review team ultimately reviewed 297. Some cases were removed due to mismatches on Medicaid ID, missing utilization data, or confirmed that the person was never enrolled in case management.

Among the 297 files reviewed, children (defined below as up to age 20) represented 52 percent of the total sample (see Exhibit VII.8 below). As of December 2012, the membership in HHW and HIP combined was 79 percent children. MHS had a disproportionate percentage of the children among the three MCEs in the sample (66%). Children age 11 to 15 represented 39 of the 49 percent in the figure for children age 11 to 20 in the sample. For all three MCEs, women represented close to two-thirds of all members in the sample of case management files examined.

Both Anthem and MHS each had two members in the sample age 5. MDwise had four 6 year olds, one 5 year old and one 1 year old member in our sample. The 1 year old was apparently a profoundly developmentally disabled infant.

Exhibit VII.8
Demographic Profile of Behavioral Health Case Review Sample
Hoosier Healthwise and Healthy Indiana Plan Members Combined

Age in Years	Anthem (n=95)	MDwise (n=98)	MHS (n=104)	Total (n=297)
Up to 10	12%	11%	17%	14%
11 - 20	29%	35%	49%	38%
Children	*41%*	*46%*	*66%*	*52%*
21 - 30	16%	21%	13%	17%
31 - 40	24%	18%	13%	18%
41 - 50	17%	9%	7%	11%
> 50	2%	6%	1%	3%
Adults	*59%*	*54%*	*34%*	*48%*

Gender	Anthem	MDwise	MHS	Total
Female	65%	68%	61%	65%
Male	35%	32%	39%	35%

Another interesting observation of this sample was the relatively high percentage of pregnant women enrolled in complex case management. The review team identified any member as pregnant if the documentation included prenatal, delivery, or other pregnancy related utilization or care plan information. When controlling for women of child-bearing age only (defined as age 12-49), 12 percent of Anthem's sample was pregnant, 17 percent of MDwise's sample was pregnant and 31 percent of MHS's sample was pregnant. The higher frequency for MHS is most likely because MHS has a specific program related to maternal depression not seen at the other MCEs.

Specific questions on the review tool verified whether or not specific key information related to care management was present in the record. Exhibit VII.9 on the next page shows the percentage of time that physical health diagnoses, mental health diagnoses, or member medications were listed in the record.

The reviewer gave credit and checked "yes" if there was evidence in the care plan of any physical health diagnoses, behavioral health diagnoses, or medications. No attempt was made to verify the completeness or accuracy of the diagnoses or medications found.

None of the MCEs have a high rate of capturing the physical health diagnoses in the care plan. The MHS low figures suggest that having two separate departments handling mental health and physical health may be contributing to a lower awareness by the mental health case manager of the physical health diagnoses and issues, and perhaps vice versa.

All MCEs had high rates showing the presence of behavioral health diagnoses and medications as would be expected for a review of this sample of cases.

Exhibit VII.9
Presence of Key Information Present in the Case Management File
Hoosier Healthwise and Healthy Indiana Plan Members Combined

Key Information	Anthem (n=95)	MDwise (n=98)	MHS (n=104)	Total (n=297)
Physical health diagnoses	72%	70%	53%	65%
Behavioral health diagnoses	100%	98%	100%	99%
Medications	97%	93%	88%	92%

Exhibit VII.10 on the next page measures if the MCEs are recording utilization of services in the case management file, in particular inpatient hospital, outpatient hospital or other professional services, and pharmacy scripts. The question on the review tool asks "Based on the utilization reported...does it appear that the patient's utilization is *effectively* recorded in the file for [*service*]?" The utilization profiles that B&A built for each member's case file were used as a benchmark to assess if the MCE effectively recorded the utilization in the case file. For example, a comment that the member was hospitalized with nothing else mentioned about it in the case file did not meet the test of "effective." But, if the note went on to list the diagnosis and any other pertinent information about the inpatient encounter and/or the plan of care upon discharge, then the reviewer indicated that yes it was recorded effectively.

As a result, in some cases the reviewer indicated on the tool that the utilization was "partially" effective. This assignment may also have been given if *some* utilization, but not all critical aspects of the utilization, were recorded in the case file. An example of this could be if some pharmacy scripts were recorded but an antipsychotic script that was filled was not recorded in the case file.

Because not every type of utilization is relevant for each member's case file, the "n" for each MCE/utilization type can differ. In other words, if the question was not applicable for some case files, this was not recorded against the MCE.

With respect to inpatient utilization, when it was relevant to the case each MCE had recorded this in the member's file most all of the time. In five percent of the cases for each MCE, the reviewers noted that documentation was "partially" effective.

For outpatient hospital and other professional services, MDwise did the best job of recording these services among the MCEs since 71 percent of the time the information was documented effectively. For Anthem and MHS, this documentation was only effective in about half of the cases where it was applicable.

For pharmacy scripts, MDwise was once again most effective among the MCEs in recording this service in the member's case files. For MHS, pharmacy data was almost never recorded. The EQR Review Team learned that the pharmacy files delivered to the MCE by the OMPP have not been made available to MHS case managers. This was quickly remediated upon our review.

Exhibit VII.10
Measuring Service Utilization Recorded in the Case Management File
Hoosier Healthwise and Healthy Indiana Plan Members Combined

The N for each MCE represents members for whom there was evidence that the member used the service.

		Inpatient Hospitalizations		
	N	**Yes**	**No**	**Partial**
Anthem	79	94%	1%	5%
MDwise	64	91%	5%	5%
MHS	84	89%	6%	5%
All	**227**	**91%**	**4%**	**5%**

		Outpatient Hospital or Professional Services		
	N	**Yes**	**No**	**Partial**
Anthem	80	50%	35%	15%
MDwise	90	71%	14%	14%
MHS	95	53%	24%	23%
All	**265**	**58%**	**24%**	**18%**

		Pharmacy Scripts		
	N	**Yes**	**No**	**Partial**
Anthem	86	78%	15%	7%
MDwise	94	87%	7%	5%
MHS	104	2%	97%	1%
All	**284**	**53%**	**43%**	**4%**

There was wide variation found among the MCEs in the effectiveness of care plan development.

MHS was most successful in creating care plans that contained measurable goals (95%) followed by MDwise (77%). In the opinion of the reviewers, Anthem only contained measurable goals in 35 percent of the case files reviewed.

Exhibit VII.11
Effectiveness of Care Plan Development
Hoosier Healthwise and Healthy Indiana Plan Members

Does the Care Plan contain measureable goals?	**Yes**	**No**
Anthem (n=95)	35%	65%
MDwise (n=98)	77%	23%
MHS (n=75)	95%	5%
All Combined (n=268)	**67%**	**33%**

Note: MHS sample cases identified as moderate case management that were included in previous exhibits have been excluded here and in subsequent exhibits.

The reviewers then focused on the sample where care plans were found to be meaningful (177 out of the total 268 potential case files). One area reviewed was to determine if the member's diagnoses were considered in the care plan development. Exhibit VII.12 shows that in almost all cases, the mental health diagnoses of the member were factored into care plan development. This was not the case for physical health diagnoses. Individuals with behavioral health conditions often have co-morbidities which need to be considered in developing plans for improving a member's overall health holistically. MDwise did the best job in factoring in physical health diagnoses since they were addressed 47 percent of the time in the care plans reviewed. This was far less true for the other MCEs. The reviewers did factor in situations where there may not be physical health co-morbidities present in the case (this was often seen in the case of children). When this situation occurred, the reviewers answered this question on the tool as Not Applicable (N/A).

Exhibit VII.12
Incorporating Diagnoses into Care Plans
Hoosier Healthwise and Healthy Indiana Plan Members Combined

Does the Care Plan address mental health diagnoses in its goals?

	N	Yes	No
Anthem	32	100%	0%
MDwise	75	92%	8%
MHS	70	100%	0%
All Combined	**177**	**97%**	**3%**

Does the Care Plan address physical health diagnoses in its goals?

	N	Yes	No	N/A
Anthem	32	9%	50%	41%
MDwise	75	47%	37%	16%
MHS	70	21%	71%	7%
All Combined	**177**	**30%**	**53%**	**17%**

Note: Only care plans that contained measureable goals are counted in this exhibit.

For the most vulnerable populations such as those enrolled in complex case management, coordination with and between the member's providers is critical. The reviewers examined case files to see evidence of correspondence and coordination with the member's providers which was often present. More specifically, the reviewers examined to see if there was coordination between the MCE and the providers on the development of the care plan itself. The key word in answering the question is "coordination". Although the providers may not have a scheduled time to meet with a case manager to build a member's care plan from scratch, there is an expectation that the case manager would, at minimum, alert the provider that the care plan is under development and to gain feedback on areas that should be prioritized in the care plan. Exhibit VII.13 on the next page points out the inadequate level of coordination of care by the MCEs with either PMPs or with mental health providers. It is evident that MDwise does a better job of coordinating with the PMP, though it is only about 43 percent of the time for this sample. MHS has the best rate of coordinating with mental health providers (60%). However, none of these numbers are at levels expected by the OMPP.

Exhibit VII.13
Care Plan Coordination with Providers
Hoosier Healthwise and Healthy Indiana Plan Members Combined

Is there evidence of care plan coordination with the member's PMP?

	N	Yes	No	Unable to Confirm
Anthem	95	15%	83%	2%
MDwise	98	43%	55%	2%
MHS	75	13%	83%	4%
All Combined	**268**	**25%**	**73%**	**3%**

Is there evidence of care plan coordination with the member's mental health providers?

	N	Yes	No	Unable to Confirm
Anthem	95	12%	85%	3%
MDwise	98	23%	74%	2%
MHS	75	60%	37%	3%
All Combined	**268**	**29%**	**68%**	**3%**

Even if providers did not participate in the care plan development, it would be expected that they would at least be given the care plan so that they are aware of the MCE's approach to addressing the member's health concerns. Exhibit VII.14 shows that this does not occur with mental health providers at all. MHS does a fair job in getting the care plan to the member's PMP (79% of the time this was evident in the file) and MDwise is going this about half of the time. One reason why these numbers may be so low is because the software used to create the care plans do not lend themselves to easy distribution to providers.

Exhibit VII.14
Communication of Care Plan with Providers
Hoosier Healthwise and Healthy Indiana Plan Members Combined

Was the PMP sent the care plan?

	N	Yes	No	Unable to Confirm
Anthem	95	1%	98%	1%
MDwise	98	59%	35%	6%
MHS	75	79%	19%	3%
All Combined	**268**	**44%**	**53%**	**3%**

Were any mental health providers sent the care plan?

	N	Yes	No	Unable to Confirm
Anthem	95	0%	98%	2%
MDwise	98	2%	98%	0%
MHS	75	3%	96%	1%
All Combined	**268**	**1%**	**97%**	**1%**

Conclusions Resulting from Onsite Interviews and Review of Policies, Procedures and Care Plans

The clinical portion of the EQR was divided into two sections--interviews of MCE staff and medical record care plan reviews. The interviews were conducted in two parts. The first was held in June 2013 and was led by Dr. Hindman. The second part was held in August 2013 to coincide with the onsite review of care plans and included Dr. Hindman and Dr. Asimus.

At the first session of interviews, each MCE was asked the same set of questions. Based on the responses, and on findings specific to each MCE during the care plan reviews, the second set of questions were customized to each MCE. The results of these interviews are included in the findings section of this report.

Findings and observations from the EQR clinical team related to MCE policies and procedures, responses to interview questions and qualitative reviews of care plans are organized below into the following categories:

- General observations about case management in HHW and HIP
- Items relevant to all three MCEs
- Items specific to each MCE

General Observations About Case Management in HHW and HIP

The current contract between the OMPP and the MCEs has a detailed requirement for contractor scope of work pertaining to behavioral health. There is a clear statement that the contractor (the MCEs) "must demonstrate that behavioral health services are integrated with physical care services". In addition, there are requirements for the MCEs to "train its providers" to screen, identify and treat members with behavioral health disorders.

This is the third time in the past five years that the clinical team has looked at the MCEs' care plan/case management efforts for various aspects of care. Although there has been some definite improvement, overall there remains a huge gap between what is defined in the contract scope of work for the MCEs to do and the reality of what is being accomplished.

One aspect of this gap is, in the opinion of the clinical team, caused by a disconnect in the language of the contract and the reality of where case management as a discipline has evolved. This evolution has been driven by multiple factors--economics, electronic medical records, and the dynamics of the history of our health care delivery system in the United States.

Historically, mental/behavioral health has generally been separated from the physical health needs of a person, both by diagnostic criteria and techniques as well as treatment. This is illustrated best by the fact that nationwide there are separate hospitals and clinics for behavioral health. Few health care delivery entities or systems have been successful or effective in truly integrating physical health and behavioral health into one care delivery system.

There is certainly a realization that this integration is needed and important. Making it happen is the challenge. Simply putting language into a contract will not make it so. Despite significant efforts on the part of the MCEs, both financially through the purchasing of advanced computerized case management software products and the hiring or outsourcing of additional case management staff, the gap remains.

One observation is that the wording of the OMPP contract may, in fact, be outdated by the reality of computer programs being used for case management. There is always a human navigating the case

management software tools, but rarely do you find case managers making house calls or having any sort of personal (meaning non digital or non telephonic) contact with the people who are on their caseload list. Risk screenings and stratification tools are almost always done over the phone. These observations are not meant as a criticism, but as a statement of the reality of the social structure we all live in and the technology now universally used in facilitating what is called case management.

The point of this observation is that the OMPP has an opportunity to review and update the expectations of the MCEs as defined in the contract to better reflect the realities of today's case management environment.

Case management software programs have flourished, but without any consistency as to format or options for the case manager. Thus, each of the MCEs has vastly different approaches to fulfilling the contractual requirement for care plans. But none of these are very effective as far as dealing with the requirement in the contract of integrating the physical health needs with the mental health needs of the members.

Pharmacy utilization remains a challenge. Having the financial risk carved out of the MCEs' contract results in the unintended consequence that it is not a high priority of focus by case managers. The Right Choices Program examined in last year's EQR is probably the most effective effort at controlling pharmacy utilization, but as was found in last year's report, it too needs some significant changes.

The requirement for a separate consent form to allow release or sharing of information about substance abuse and/or HIV status is having the unintended result of allowing high pharmacy utilizers of continuing their overuse because of the absence of this form. The case manager cannot discuss these issues with the PMP nor the mental health provider, and vice versa. So, based on what we saw on the care plans, nothing happens.

Over 50 percent of the cases reviewed in this study were members under the age of 21. In the case of two of the MCEs (Anthem and MHS), this was not intentional sampling since 100 percent of the members enrolled in complex case management for behavioral health conditions were examined. This study did not focus on appropriateness of the member being in complex case management. Other than the fact that HHW enrollment is predominantly driven by child enrollment, the reason for this age distribution is unclear.

<u>Items Relevant to All Three MCEs</u>

The reviewers noted that care plan goals are often not measureable, not specific to a particular need, nor do they address the main physical or mental health diagnosis of the member. Seldom did they address things such as substance abuse, medication compliance, steps to prevent future hospitalizations, ways to ensure and coordinate follow-up with PMP and/or mental health provider appointments, or ways to build toward a healthier lifestyle.

Care plans are not really care plans. They are a repository of chronologic events in a member's health care needs. This chronology is imperfect and generally without any real focus on impacting in a positive way the members' health and/or utilization of medical services. It is more focused on helping with appointments, assigning PMPs, etc. These are important tasks, but not really what a care plan is all about.

Each MCE uses a different software product for case management. Each product has its own challenges. From an outsider's perspective, they are cumbersome, fragmented, and difficult to navigate. Without extensive training for internal users, this could lead to missed information, especially in regards to the integration of physical health issues/needs with the mental health issues/needs of the member. Even if the end user is well trained in the use of the software, it is difficult in any of the MCE's software packages

to easily obtain the entire picture of the clinical and social issues/needs of the member in a consolidated way. This has been a consistent finding in each of the past EQRs of the MCEs as well.

The issue of absence of consistent and accurate utilization data available to the case manager is a significant deficiency at all three MCEs. The cause of this includes policies that "freeze" reference to data when someone falls off case management, as well as those that do not allow the case manager easy access to data. Another issue is the accuracy of important information such as diagnoses, both physical and mental. These need to be readily available and accurate.

At all three MCEs, there was little documentation of coordination and integration of information between the PMPs and the mental health providers.

There is little, if any, documentation in the care plan or case management record at any of the MCEs of encouraging members to sign consent forms to allow for the release or sharing of information about substance abuse and/or HIV status as is required by the contract.

It was a general feeling from all of the MCEs that the file provided to them by the State related to the Medicaid Rehabilitation Option (MRO) that is intended to assist in documentation of care plans is not very user friendly.

There is at least one CMHC that has incorporated a physical health clinic at the same location. This is currently being done through a funding grant. Payment of claims is an issue that has yet to be successfully worked out, however.

<u>Items Relevant to Specific MCEs</u>

Anthem

Anthem has a total of four case managers--three licensed behavioral specialists and one nurse. Their caseload is between 100 and 120 members with 40 to 50 of these members active in complex case management. Feedback from the interview indicated that high caseloads may be impacting effective case management.

If a member is stratified for moderate case management on the intake risk assessment tool, then no care plan is required. This is consistent with the OMPP's requirements for moderate case management now that the OMPP is following the NCQA definitions of complex and moderate case management. In the NCQA definition, only individuals in complex case management are required to have care plans with documented goals to achieve improvement. The issue found at Anthem is that even though some members were stratified for moderate case management, they were assigned to complex case management or, at minimum, reported as such to OMPP on the new quarterly report.

Once a member is terminated from complex case management, their pharmacy data becomes locked such that the case manager can no longer have access to it. This is not true of other utilization information. This impacts a reviewer's ability to get a complete picture of utilization for anyone who was enrolled in the program during the review period.

Two items that need improvement in Anthem's care plans are that there was no consistent documentation in care plans that the case manager addresses medication compliance or overuse. Also, care plans are not being sent to the PMPs or the mental health providers.

Anthem expressed some concern about sending specific personal health information (PHI) in communications to providers due to risk of HIPAA violations.

One case at this MCE stands out. A 26 year old woman was found to have over 70 diagnoses, over 100 filled prescriptions, five inpatient admissions, and over 180 professional service claims paid during the review period. Yet the EQR team found no measurable goals or any follow-up notes with the mental health providers or the CMHC about her care.

MHS

MHS has six case managers plus one care coordinator. The average caseload is 90 to 120 members.

Overall, it was observed that the physical health diagnoses and information was infrequently found in the care plans that were reviewed. This may be due to MHS's structure for assigning responsibilities for managing behavioral health to Cenpatico. Although it was reported that there is one care plan for a member, there are two separate care management departments--one at MHS (for physical health) and one at Cenpatico (for mental/behavioral health). Although both entities reported doing "rounds" each week on combined cases, there was evidence that there may be missing information among complex cases where there are both physical and behavioral health needs to be addressed.

The only routine "coordination" between MHS and the PMP about members on complex case management for mental health issues is to send a form with diagnoses and documentation of an admission. No actual care plans or goals are included. In addition, there is scant evidence that the case managers are obtaining physical health diagnoses and/or treatment information from the PMPs. MHS also does not send any care plan information to mental health providers on a routine basis (or, if it is done, there was no documentation of this in the member's file).

There were several files where no documentation could be found that the case manager encouraged the member to see the PMP when there was documentation of potentially serious physical health problems such as asthma or diabetes. We realize the mental health case manager may assume that the physical health case manager should do this, but this does not excuse the absence of such documentation.

There was consistent documentation that the case managers are tracking 7-day and 30-day follow-up appointments after an inpatient psychiatric hospitalization in compliance with HEDIS®. However, there was little, if any, documentation that any tracking is being done after 30 days, even though it is required by the OMPP rule that post-hospitalization members remain in complex case management for 180 days post-discharge. To comply with this OMPP requirement, MHS keeps the member on complex care management for the full 180 days, but only interacts with the member if there is a crisis or issue. There was little of this found to be consistently documented.

Many of the files reviewed showed the member had been dropped from case management. The care plans rarely recorded the reason for being dropped. This is important to know because it could be something to be anticipated (i.e. eligibility paperwork requirements) and the case manager could help avoid an unnecessary interruption in coverage for a very needy individual.

Case management staff have not had access to pharmacy utilization data. MHS acknowledged receiving pharmacy reports from the OMPP, but the case management supervisor assisting the EQR review team was not aware of them. When this issue was brought up during the interview, it was stated that there was in fact a way for the case managers to access the pharmacy data and the reviewers were assured that this will become a regular part of their procedure and process. The issue, however, is that this will require the case managers to retrieve pharmacy data from a separate software program.

Many cases in complex case management at MHS were there because of a "Pregnancy Screen Form" that picked up depression, both pre- and post-partum. The maternal depression program is specific to MHS and is not explicitly required by the OMPP contract. MHS identified the issue of not having enough providers statewide that are willing to see pregnant members who also have substance abuse and serious mental illness (SMI) diagnoses.

MDwise

MDwise has eight subcontracted delivery systems which each conduct their own case management. It was estimated that the caseload at each delivery system is about 150 active members per case manager. During the interview it was noted that "about 75%" of those referred to behavioral health case management are lost to follow up or unreachable.

The unique design of MDwise's network system with eight separate delivery systems continues to be a challenge from the perspective of consistency of compliance. Several of the smaller systems contract with a local firm which still uses all paper care plans. The few samples of care plans that were reviewed from these systems showed similar deficiencies in documentation of coordination and communication between the PMP and the mental health provider or the CMHC. The MDwise Behavioral Health Medical Director does audit the contracted delivery systems. Notwithstanding the comments above, MDwise seems to be somewhat ahead of the other MCEs as far as meeting the contractual requirements pertaining to case management for behavioral health conditions, at least among those areas looked at in this EQR.

Hoosier Alliance, the largest delivery system in the MDwise network, has a solid case management software package ("JIVA") and they use it well. This is the same product used at the corporate level. Also, Hoosier Alliance has RNs on the team that deal with the complex mental health cases and there was clear evidence of strong leadership both at Hoosier Alliance and MDwise corporate. This is a positive finding and should be acknowledged.

Another positive noted was that there is close and frequent interaction between the MDwise Behavioral Health Medical Director and the case managers.

The transition by MDwise Corporate to the JIVA software package was effective June 2013. Although JIVA allows access to pharmacy claims data for each member, this was not integrated prior to the transition. One limitation of the JIVA software is that goals must be selected from a drop down menu. The available selections are not very specific nor always measureable. The "Notes" and "Interventions" sections in the software do more clearly state the goals; however, many lacked measurability.

The care plans are usually documented as being sent to the PMPs, but not to the mental health providers.

There is a pilot project currently underway with seven CMHCs utilizing the JIVA software. This is a positive finding for better access of information to behavioral health providers.

Recommendations to the OMPP and MCEs Related to Care Plans

<u>Recommendations to the OMPP</u>

1. The OMPP should consider re-writing the contract requirements for case/care management to better reflect current methodologies of care plan development and case management. Definitions of care "coordination" and "effective communication between physical health providers and mental health providers" are two important examples of clarification needed.

2. If care plans continue to be a contract requirement, the OMPP should consider precisely defining what should be in them, how they should be measured and monitored, and how the documentation of communication and coordination should be accomplished.

3. The OMPP should consider financial incentives to the MCEs to reach certain goals in integrating the communication between the PMP and mental health providers.

4. OMPP should consider either revising or adding clarification language to the "180 day rule" for requiring case management to all members discharged from mental health inpatient stays. It is unclear exactly what the goal or intent of requiring 180 days of case management. Many times in our sample, members were kept on for 180 days, but nothing effective was accomplished. In some cases, it may have been because retaining the member in complex case management for a full 180 days was unnecessary.

5. In the case of all three MCEs, the use of the QR-CMBH1 report as the starting point for B&A to use in identifying HHW and HIP members enrolled in complex case management was problematic. The MCEs submitted multiple versions of member lists to tie out the totals reported on this report to actual members. This puts the validity of the results being reported on this report (and other case management reports like it) in question. The OMPP should reconvene the OMPP/MCE workgroup created in CY 2012 to ensure common understanding of the requirements related to these report submissions.

<u>Recommendations to All MCEs</u>

1. All MCEs need to focus on developing measurable care plan goals that focus both on physical health needs as well as mental health needs.

2. All MCEs need to aggressively look at incentive programs for providers (P4P) in order to have better cooperation and availability. Chronic pain management is one area in need of more providers statewide.

3. All MCEs need to significantly improve sending and documenting that the care plan went to the member's mental health provider(s).

<u>Recommendations to Anthem</u>

1. Anthem needs to come up with a system that consistently allows care plan information to be sent to PMPs. They described a quarterly mailing to the PMP but, if this is actually happening, it is not being well documented.

2. Anthem needs to review staffing needs in case management as this appears to be an issue.

3. Case managers should be required to address medication compliance and/or utilization, both under and over utilization. This should include having pharmacy utilization recorded in or accessible to the care plan.

4. There was definitely less evidence in Anthem's care plans than the other MCEs in having measurable goals. These need to focus on both physical health diagnoses and mental health diagnoses.

5. There needs to be more documented regular interaction of the complex case management program with the Anthem Medical Director.

Recommendations to MHS

1. Corrective action has already begun to allow case managers access to pharmacy data. This needs to be monitored as to its effectiveness and use by the case managers.

2. Efforts need to be made to better integrate the daily communication and collaboration between the physical health case managers and the mental health case managers.

3. MHS needs to come up with a better and more effective method to coordinate care between the mental health provider and the PMP. Simply sending a form with diagnoses and documentation of inpatient stays is inadequate. Information about treatment, post discharge plans, and measurable goals that focus on diagnoses and utilization is what is needed.

4. There needs to be more documented regular interaction of the complex case management program with the MHS Medical Director.

Recommendations to MDwise

1. MDwise should continue to refine their JIVA case management software and consider requiring all subcontracted delivery systems to use it. One suggestion is to modify the drop down tabs to allow more options of truly measurable goals.

2. MDwise needs to do a better job of capturing the physical health diagnoses into the care plans.

3. Care plan coordination with the member's mental health providers needs improvement and better documentation.

APPENDIX A
2013 EXTERNAL QUALITY REVIEW GUIDE FOR THE HOOSIER HEALTHWISE AND HEALTHY INDIANA PLAN

2013 EXTERNAL QUALITY REVIEW GUIDE FOR THE HOOSIER HEALTHWISE AND HEALTHY INDIANA PLAN PROGRAMS
(Review of CY 2012 Operations)

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Separate Attachments

Preferred Meeting Time Form (Word file)
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Template for Submission of Desk Review Item #3 (Excel file)

A. Summary of This Year's Topics, Timeline and Review Team

Overview

Burns & Associates, Inc. (B&A) was hired by Indiana's Office of Medicaid Policy and Planning (OMPP) to conduct an External Quality Review (EQR) for both Hoosier Healthwise (HHW) and the Healthy Indiana Plan (HIP). This review will encompass activities in Calendar Year (CY) 2012 and some case file reviews from the 1st Quarter of CY 2013.

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

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

There are many optional activities that EQROs may also complete. A comprehensive review of Activity #1 was completed last year. Therefore, for this year's EQR, B&A met with the OMPP to determine the topics selected for this year's EQR which include the following:

- Validation of Performance Measures related to Primary Care
- Validation of MCE Performance Improvement Projects (still to be determined)
- Optional EQR Activity: Calculation of Performance Measures (Selected CMS Child Core Measures)
- Optional EQR Activity: Conduct a Focus Study on Access to Care
- Optional EQR Activity: Conduct a Focus Study on Mental Health Utilization and Care Coordination

All topics will be reviewed for both the HHW and HIP populations.

Timeline

The OMPP is requesting that B&A deliver the draft report for this EQR by September 30. The final report is due October 31. The schedule effectively begins with the release of this EQR. The first items that are being requested from the MCEs are due June 5. Onsite meetings are scheduled during the weeks of June 17, August 5, and August 19. All data collection activities and MCE responsibilities are scheduled to be concluded by August 30. A full schedule may be found in Section C of this Guide.

There will be an opportunity for the MCEs to provide accessory information if B&A needs further clarification on a specific review item after the onsite meetings are concluded.

The OMPP has customarily asked B&A to offer a debriefing session with each MCE. The dates for these sessions have yet to be determined. Each MCE/health plan will also receive a copy of the final EQR report that will be delivered to CMS once it has been reviewed by the OMPP.

The B&A Review Team

This year's EQR Review Team consists of the following members:

- Mark Podrazik, Project Manager: Mark has previously conducted seven EQRs of the HHW program, four EQRs of the HIP and an external review of the Care Select program. He will participate in all administrative review sessions and oversee the entire project and final report.

- Dr. CJ Hindman, MD, Kachina Medical Consultants: Dr. Hindman is an independent contractor who served as the Clinical Team Lead of the EQRs conducted in 2009-2012 for HHW and HIP and the Care Select review conducted in 2009. He was previously the Medical Director for Arizona's Medicaid program and also served as Medical Director of a Medicaid managed care program. He will lead the clinical portion of the focus study related to mental health utilization and care coordination.

- Dr. Dan Asimus, a psychiatrist consultant of Kachina Medical Consultants: Dr. Asimus brings significant expertise as board certified in psychiatry, neurology and child psychiatry. He will participate in interviews with MCEs and the review of case files for the focus study related to mental health utilization and care coordination.

- Phyllis Click, RN, MNP, and Helena Perez, MS, Kachina Medical Consultants: Both will assist Dr. Hindman and Dr. Asimus in the review of case files for the focus study related to mental health utilization and care coordination.

- Melinda McKusky, RN, Brightstar Healthcare: Melinda will once again join our clinical team in the review of case files for the focus study related to mental health utilization and care coordination. Melinda participated in the clinical portion of the EQRs in 2011 and 2012.

- Brian Kehoe, Senior Consultant, B&A: Brian brings his experience working with the Indiana provider community to assist in this year's EQR by participating in the interviews with selected primary care providers, FQHCs, RHCs and CMHCs.

- Jesse Eng, SAS Programmer, B&A: Jesse has been working on B&A's engagement with the OMPP since 2009, focusing primarily on our independent evaluation of the CHIP. For this year's EQR, he will be the lead analyst in the validation of performance measures, the calculation of CMS Child Core Measures, and the focus study on primary care.

- Carol Weller, SAS Programmer, B&A: Carol participated in the B&A EQRs of HHW and Care Select conducted in 2009. This year, she will be the lead on all encounters-related analyses for the focus study related to mental health utilization and care coordination.

- Lucy Hagar, Consultant, B&A: Lucy will contribute her analytical skills in the desk review items of reports submitted by the MCEs that will be used as benchmarks on the validation of performance measures portion of this year's EQR.

- Dr. Linda Gunn, PhD, Subcontractor: Linda has assisted B&A on four previous HHW EQRs, three HIP EQRs and the Care Select review. She will participate in the interviews with selected primary care providers, FQHCs, RHCs and CMHCs.

- Kristy Lawrance, Subcontractor: Kristy joins us in this year's EQR with previous experience working for the OMPP on various projects as well as for Advantage under its contract with the OMPP for Care Select. She will participate in the interviews with selected primary care providers, FQHCs, RHCs and CMHCs as well as the validation of performance improvement projects.

B. Details on Topics in this Year's EQR

Topic #1— Validation of Performance Measures related to Primary Care

The purpose for this review is to validate the results of quarterly report submissions from the MCEs to the OMPP. B&A will replicate the methodology instructions in the CY 2012 Reporting Manual to compute the results for the selected measures and compare these results to what each MCE reported for the time period under review (which is experience period CY 2012). The measures that are being validated include:

- QR-CA4: Well Child Visits in the First 15 Months of Life (the basis of which is HEDIS measure W15);
- QR-CA5: Well Child Visits in the 3rd through 6th Years of Life (the basis of which is HEDIS measure W34);
- QR-CA6: Adolescent Well Care Visits (the basis of which is HEDIS measure AWC);
- QR-CA3: Children and Adolescents' Access to Primary Care Practitioners (the basis of which is HEDIS measure CAP);
- QR-PCC1: Adults' Access to Preventive Ambulatory Services (the basis of which is HEDIS measure AAP); and
- QR-PCC10: Utilization of Imaging Studies for Low Back Pain (the basis of which is HEDIS measure LBP).

The first four measures will be computed for the HHW population while the last two measures will be computed for the HHW and HIP populations.

B&A recognizes that the MCEs submit results for the measures above on a quarterly basis using "HEDIS-like" definitions. These results use the administrative method only. The MCEs also submit annual HEDIS results using true HEDIS definitions. For some measures, the certified HEDIS vendor uses the administrative method only; for other measures, the hybrid method is used.

It is understood at the outset that there will be differences between the results reported quarterly and those reported annually due to the definitional changes as well as the methodology used (administrative only or hybrid). B&A is using the encounters reported to the OMPP and stored in the OMPP data warehouse, MedInsight, as of May 1, 2013 as the source data for this analysis. This validation exercise is intended to match B&A's results using the method for the quarterly submissions (administrative method only) against the results reported by the MCEs. B&A will also show to the OMPP where the quarterly-based results differ from the annual HEDIS audited results and will attempt to provide explanations between these differences. It is B&A's intention to share our results with each MCE individually and compare to what the MCE submitted. If large differences are found, we will work with the MCE to determine the root cause of the differences.

B&A will use the CMS EQR Protocol 2, Attachment A (updated September 2012)[1] to report our findings related to the validation of these measures. This will be accompanied by a brief writeup in the EQR report. At this time, the only potential MCE interaction on this topic will be our discussion of findings from our desk review. The discussion of preliminary findings is scheduled in onsite meetings during the week of June 17.

[1] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

Topic #2— Validation of Performance Improvement Projects

The purpose for this review is to fulfill our requirement to validate the results of selected performance improvement projects (PIPs). B&A has received each MCE's initial Quality Management and Improvement Work Plan for CY 2012 (Report QR-Q3) from the OMPP as well as the Program Evaluations for CY 2012 directly from the MCEs. B&A will CMS EQR Protocol 3, Attachment A (updated September 2012) as the basis for reporting our validation of three PIPs at each MCE. This will be accompanied by a brief writeup in the EQR report.

Because each MCE has selected PIPs unique to their delivery system, the validation of PIPs may be common across MCEs or may be MCE-specific. B&A is in the process of reviewing the initial work plans and the program evaluation documents to make the selection of the three PIPs for each MCE. It is our intention to notify each MCE of the PIPs that we have selected for their MCE by May 31. We will then request any ancillary documents or data analytics that may be relevant to our PIP validation process that was not included in the Program Evaluation document. These ancillary documents will be due to B&A by June 28. During the week of August 5, Mark Podrazik and Kristy Lawrance will conduct onsite meetings with each MCE to go over the PIPs under review. This will include follow-up questions from our desk review as well as a discussion with the relevant staff who had primary responsibility for the interventions that were put in place for the PIPs that were selected. It is expected that the B&A Review Team will spend a half-day with each MCE (about one hour to discuss each PIP). If additional information is required, the MCEs will have the opportunity to provide this information to B&A by August 21.

Topic #3— Optional EQR Activity: Calculation of Performance Measures (Selected CMS Child Core Measures)

B&A will conduct a desk review for this topic and anticipates limited interaction with the MCEs.

Section 2108(a) and Section 2108(e) of the Social Security Act provides that the States must assess the operation of their CHIP programs in each Federal Fiscal Year (FFY) and report to CMS by January 1 following the end of the FFY on the results of the assessment. One component of this annual submission is to provide results on the Initial Core Set of children's health care quality measures (as authorized by CHIPRA 2009). Since the release of this core set, the State of Indiana has reported on most of the measures, predominantly HEDIS measures as reported by the MCEs. This topic, which is an optional activity that may be completed by EQROs, is to calculate the results of the measures that have not been reported by the OMPP in its annual CHIP report to CMS.

B&A will use MCE encounters to calculate the results of these measures and will report both a statewide and MCE-specific result for each measure. Specific measures to be calculated include:

- Measure 3: Live Births Weighing Less than 2,500 Grams;
- Measure 4: Cesarean Rate for Nulliparous Singleton Vertex;
- Measure 7: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Body Mass Index Assessment for Children/Adolescents;
- Measure 8: Developmental Screening in the First Three Years of Life;
- Measure 18: Ambulatory Care- Emergency Department Visits;
- Measure 20: Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit; and
- Measure 22: Annual Pediatric Hemoglobin (HbA1c) Testing.

B&A is using the encounters reported to the OMPP and stored in the OMPP data warehouse, MedInsight, as of May 1, 2013 as the source data for this analysis. We will use the methodology as outlined in CMS technical guidance to compute the results of each measure.[2]

On an as needed basis, B&A will consult with each MCE about our findings for these measures. We would discuss findings with an MCE if we found that the results for an MCE differed greatly from the other MCEs. Most likely, these discussions would occur during our onsite meetings the week of June 17 when we are also discussing findings from our analysis in Topic #1. We will give each MCE notice if we intend to cover any of the measures in Topic #3 during this onsite meeting so that the appropriate staff can be available to answer questions.

Topic #4— Optional EQR Activity: Conduct a Focus Study on Access to Care

In a way, Topic #4 is an extension of Topic #1. Although our validation tests (Topic #1) will focus on experience period CY 2012, our focus study (Topic #4) will cover utilization over the five-year period CY 2008 – CY 2012. B&A will replicate the calculations for each measure in Topic #1 on an annual basis for each of the five years in our period of study. These results will be computed at a statewide level and at an MCE level. Then, B&A will stratify the results by other factors. It is anticipated that these factors will include by race/ethnicity and by region (and possibly county).

Analyses will be completed to identify any differences in the rates reported within and across years for each measure in the following categories:

- Between MCEs on a statewide basis;
- Between race/ethnicities on a statewide basis;
- Between regions on a statewide basis;
- Between race/ethnicities within an MCE; and
- Between regions within an MCE.

When reviewing MCE-specific results, B&A will cross-reference any quality strategy initiatives that have been employed by the MCE to assist in explaining changes in results for a given measure over time.

B&A will report its preliminary findings to each MCE during the onsite meetings to be held the week of June 17. If follow-up discussion or analytics are required, these will be conducted during the month of July.

Another component of this study is a qualitative review. B&A will be conducting face-to-face interviews with high volume primary care offices, FQHCs and RHCs that contract with the MCEs. It is anticipated that these interviews will be conducted at the provider's office. The MCEs will not be present at these meetings. Although it is not our intent to burden the MCEs, we may ask in some instances for assistance in facilitating meetings with the selected providers. B&A anticipates conducting 30 primary care office meetings, 10 FQHC meetings and 10 RHC meetings. We will ensure that there is appropriate representation among the providers selected so that there is an equitable split of the interviews among providers contracting with each MCE, recognizing that some providers that are selected may contract with more than one MCE. The selection of providers will cover all geographic regions of the state. B&A will look at encounter data submitted by the MCEs to the OMPP as one method for stratifying a sample of providers to interview. We will also be asking the MCEs for information on site visits that the

[2] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Qualityof-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html

MCE's provider relations staff conducted during CY 2012 as another source for developing the sample. This information is due back to B&A by June 5.

A semi-structured interview protocol will be developed which may be customized to each provider type (that is, the primary care office protocol may differ somewhat from the FQHC/RHC protocol). The types of questions that will be asked will most likely not be focused on specific MCEs but rather the HHW and HIP programs as a whole. One item that may be MCE-specific, however, will be questions about any information or tools that specific MCEs offer to these providers to assist them in delivering care to HHW or HIP members. To that end, we plan to meet with each MCE during our onsite meetings the week of June 17 to discuss the level of interaction that each MCE has with each of these provider types and to go over any types of materials that are typically provided by the MCE's provider relations staff during periodic site visits. We ask that copies of these materials be available during our onsite visit. Once we have had a chance to see what the array of materials may include, we will most likely ask for copies of some of the materials (or blank templates of them) to take back with us.

By June 21, B&A will provide a list to each MCE of the MCE's providers that we intend to meet with. We will ask for a file with primary contact information for each provider site by June 28.

B&A Review Team members will schedule the interviews with these providers. Two members of the B&A Review Team (Brian Kehoe, Linda Gunn, and/or Kristy Lawrance) will be present for each interview. B&A anticipates that each onsite interview will take 20 to 30 minutes. The key informant at each site will most likely be the office manager, a billing manager, or a lead nurse. Physicians will not be required to attend but are more than welcome to attend some or part of the session.

The actual interviews will be conducted over a 10-week period from July 8 – September 13. B&A will summarize key findings from these interviews which will be included in our focus study report along with the quantitative component (claims-based analysis) of the report.

Topic #5— Optional EQR Activity: Conduct a Focus Study on Mental Health Utilization and Care Coordination

This focus study will examine:

- Who among the HHW and HIP members are receiving mental health services;
- Where they are receiving these services;
- How the MCEs assist mental health service providers in delivering care to HHW and HIP members; and
- How the MCEs assist HHW and HIP members in receiving necessary care.

As such, the study has three main components which include:

- A quantitative claims-based utilization analysis;
- A qualitative component that will include interviews with CMHCs and the MCEs; and
- A clinical component that will include the review of case files for individuals enrolled in the MCE's complex case management program due to mental health diagnoses.

Steps of Review

1. B&A will use the encounters reported to the OMPP for the experience period CY 2012 and stored in the OMPP data warehouse, MedInsight, as of May 1, 2013 as the source data for this analysis to stratify utilization of mental health services by MCE for the HHW and HIP populations separately. Some of the ways that the data is intended to be stratified will be:
    a. By provider specialty (mental health specialties vs. non mental health specialties)
    b. By age
    c. By race/ethnicity
    d. By region (or county)
    e. By diagnosis groupings
    f. By combinations of a – e

2. B&A will review the results from each MCE's QR-CMCM2 report recently submitted to the OMPP for the experience period CY 2013 Q1.

3. B&A will ask each MCE for a file listing out each individual who was counted as 'Active Ever Enrolled' on their 2013 Q1 QR-CMCM2 report. This is due back to B&A by June 5.

4. B&A will stratify a sample of MCE members among those listed in the June 5 submission. The list of members for each MCE will be no greater than 100. B&A will use information from the claims-based analysis in Step #1 to inform the final sample selection.

5. B&A will develop a case file review tool much like what has been done in prior year EQRs. This tool will be used to document findings from the clinician's onsite review of care plans. A report of the utilization statistics of each member in the sample will also be completed.

6. During the onsite meetings the week of June 17, Dr. Hindman will conduct preliminary interviews with each MCE about aspects of the delivery of behavioral health services. Questions will be centered around RFS Section 5.7.3 (Case Management for Members Receiving Behavioral Health Services) and Section 5.7.4 (Behavioral Health Care Coordination).

7. Also during the onsite meetings the week of June 17, Dr. Hindman and one of the nurse reviewers will examine up to five case files as a pilot test for the full review to be conducted in August. The MCEs will be given 7 days notice of the five members selected for the pilot. As was done in recent years, B&A expects that the review of the case files will be done using computer terminals in a dedicated room at the MCE's site. The MCE will be asked to provide navigation in the care management software during this pilot study (and possibly during the full study in August).

8. B&A will deliver to each MCE the list of all 100 case files to be reviewed by June 28.

9. B&A will request confirmation from the MCE that all case files to be reviewed were active in Q1 2013 and available for review by July 31.

10. The B&A Clinical Review Team will conduct the review of the care plans in each MCE's online system in the same manner that was done in last year's EQR during the week of August 19.

11. During the visit the week of August 19, Dr. Hindman and Dr. Asmus will also conduct a second interview with behavioral health representatives from the MCE. The focus of this interview will be an extension of questions related to RFS requirements as well as questions that may result from the review of the case files in Day 1 of the review.

12. During the 10-week period from July 8 – September 13, the B&A Review Team members responsible for field interviews (Brian Kehoe, Linda Gunn, and/or Kristy Lawrance) will also conduct interviews with 10 of the contracted CMHCs. B&A will work with the MCE to obtain key informant information on each CMHC in the same manner that is being done for the primary care interviews. B&A anticipated that each onsite interview will take 20 to 30 minutes. The key informant at each site will most likely be the office manager, a billing manager, or a lead nurse/mental health counselor.

The results of the quantitative analysis, the qualitative interviews, and the case file reviews will be summarized in a report specific to this focus study.

C. Detailed Schedule and Document Request

The table below presents all information requests of the MCEs as well as all meetings scheduled for this year's EQR. We have some flexibility as to which day we visit each MCE. As has been done in prior years, we are happy to accommodate specific MCE staff schedules wherever we can. Therefore, we ask you to indicate your preferences for the onsite meetings in the form that accompanies this EQR Guide. Please provide feedback to us about your preferences no later than **May 21**. We will confirm all onsite meeting appointments by **May 31**. Specific times for meetings on each day will be scheduled with the MCE in advance of each meeting.

Unless specifically requested below, MCE staff do not need to bring any materials to the interview sessions.

Please note that all onsite interviews will cover both the HHW and HIP programs. If the staff in a functional area differs between the two programs, we ask that representatives from each program attend the interview.

Date	Participants or Responsible Party	EQR Item
May 10	B&A	EQR Guide released to the MCEs.
May 21	MCEs	Completed Appendix A sent to B&A.
May 31	B&A	Confirmation of all onsite meeting times sent to the MCEs. Notification to the MCEs of the 3 PIPs selected for review.
June 5	MCEs	Deliver to B&A two of the required desk review items: 1. The list of all primary care offices, FQHCs, RHCs and CMHCs visited by Provider Relations staff during CY 2012. 2. The list of individuals classified as Active Ever Enrolled on the MCE's Q1 2013 QR-CMCM2 report.
June 10	B&A	Notification to each MCE of the five members in case management during Q1 2013 that have been selected for the pilot to be conducted the week of June 17.
June 18	MCEs, B&A	Onsite Interviews with MCE #1 (tentative schedule below)
	1:00 – 2:00	Dr. Hindman leads discussion with MCE's BH staff.
	2:00 – 4:30	Dr. Hindman and RN conduct pilot study of 5 case files.
	2:00 – 3:00	Mark Podrazik leads discussion with Provider Relations Staff.
	3:00 – 4:30	Mark Podrazik reviews preliminary results of B&A's data analysis related to Topics #1, 3 and 4.
June 19	MCEs, B&A	Onsite Interviews with MCE #1 (tentative schedule below)
	8:30 – 9:30	Dr. Hindman leads discussion with MCE's BH staff.
	9:30 – 12:00	Dr. Hindman and RN conduct pilot study of 5 case files.
	9:30 – 10:30	Mark Podrazik leads discussion with Provider Relations Staff.
	10:30 – 12:00	Mark Podrazik reviews preliminary results of B&A's data analysis related to Topics #1, 3 and 4.
June 19	MCEs, B&A	Onsite Interviews with MCE #1 (tentative schedule below)
	1:00 – 2:00	Dr. Hindman leads discussion with MCE's BH staff.
	2:00 – 4:30	Dr. Hindman and RN conduct pilot study of 5 case files.
	2:00 – 3:00	Mark Podrazik leads discussion with Provider Relations Staff.
	3:00 – 4:30	Mark Podrazik reviews preliminary results of B&A's data analysis related to Topics #1, 3 and 4.

Date	Participants or Responsible Party	EQR Item
June 21	B&A	List of Primary Care offices, FQHCs, RHCs and CMHCs selected for field interviews sent to each MCE.
June 28	MCEs	Primary contact information of providers selected for field interviews delivered to B&A.
	MCEs	Any ancillary materials related to provider field visits that were requested by B&A during onsite meeting are delivered to B&A.
	MCEs	Any ancillary materials related to the PIPs selected for validation delivered to B&A.
	B&A	Full list of 100 case files for BH case management review is sent to each MCE.
July 31	MCEs	Confirmation sheet of file readiness for each case file sent back to B&A (format of the file will be delivered on June 28).
August 6 & 7	MCEs, B&A	Onsite Interviews with MCEs on their PIPs (assume 1 hour discussion per PIP; time slot for each PIP to be determined)
	Aug 6, 8:30 - 11:30	Meeting with MCE #1
	Aug 6, 1:00 - 4:00	Meeting with MCE #2
	Aug 7, 8:30 - 11:30	Meeting with MCE #3
August 19-23	MCEs, B&A	Onsite Case File reviews for BH sample and interviews with MCEs (assume 1.5 hour interview; time slot to be determined)
	Aug 19, 8:30 - 5:00 Aug 20, 8:30 - 12:00	Meeting with MCE #1
	Aug 20, 1:30 - 5:00 Aug 21, 8:30 - 5:00	Meeting with MCE #2
	Aug 22, 8:30 - 5:00 Aug 23, 8:30 - 12:00	Meeting with MCE #3
August 21	MCEs	Any follow-up materials requested from the MCEs from the meetings on PIPs that occurred August 6 & 7 delivered to B&A.
August 30	MCEs	Any follow-up materials requested from the MCEs from the case file reviews that occurred August 19-23 delivered to B&A.

Document Request

The documents requested in this year's EQR are much less than prior years. Because most documents also do not include PHI, for convenience we ask that you submit most documents directly to Mark Podrazik at mpodrazik@burnshealthpolicy.com. If a document must be transmitted securely due to PHI, then submit the information to Mark either:

(a) via the MCE's secure email system; or
(b) via the OMPP SharePoint site. If using OMPP's SharePoint, please upload your data under the \2013\EQR directory under your MCE name. *Please place HHW-specific and HIP-specific information in the same location under the HHW section of SharePoint.*

Each desk review item has been numbered to assist in tracking. As we have asked in prior years, please include the desk review item number and your MCE name at the beginning of the electronic files that you are submitting. For example, the list of all primary care offices, FQHCs, RHCs, and CMHCs visited by

the Provider Relations staff in CY 2012 should be titled "Item 1 [MCE name] CY 2012 Provider Site Visit List.xlsx". Files may be transmitted in Word, Excel, Powerpoint or PDF format.

If more than one file is required to satisfy a request item: Please number the electronic files with the item number but put a consecutive letter after each document [e.g. Item 1a.. , Item 1b.., etc.].

If documents have been uploaded to Sharepoint, please email Mark Podrazik when they have been uploaded.

Also, please notify Mark Podrazik if some items are only available in hard copy format.

Item #	**Item**	**Due to B&A**
1	The list of all primary care offices, FQHCs, RHCs and CMHCs visited by Provider Relations staff during CY 2012. Use the Excel file format provided that accompanies this EQR Guide.	June 5
2	The list of individuals classified as Active Ever Enrolled on the MCE's Q1 2013 QR-CMCM2 report. Use the Excel file format provided that accompanies this EQR Guide.	June 5
3	Primary contact information of providers selected for field interviews delivered to B&A. Use the Excel file format provided that accompanies this EQR Guide.	June 28
4	Any ancillary materials related to provider field visits that were requested by B&A during the June 18-19 onsite meetings.	June 28
5	Any ancillary materials related to the PIPs selected for validation.	June 28
6	Confirmation sheet of file readiness for each case file sent back to B&A (format of the file will be delivered on June 28).	July 31
7	Any follow-up materials requested from the MCEs from the meetings on PIPs that occurred August 6 & 7.	August 21
8	Any follow-up materials requested from the MCEs from the case file reviews that occurred August 19-23.	August 30

APPENDIX B

PERFORMANCE IMPROVEMENT PROJECT VALIDATION WORKSHEETS

MCO	Anthem
Focus Period	1/1/12 - 12/31/12
HHW/HIP/Both	Both

Name of Performance Improvement Project (PIP)	
Comprehensive Diabetes Care	
Is this a Recurring PIP? If yes, state # years	5 for HHW, 3 for HIP

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No		*Is the PIP consistent with the demographics and epidemiology of the enrollees?*
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No		*Was the study question/objective of the PIP clearly stated and properly defined?*
X			Defaulted to HEDIS specfications

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No		*Did the indicators track performance over a specified period of time?*
X			Anthem chose to track three HEDIS diabetes measures (HbA1c, DRE, and LDL-C) to evaluate the outcomes of its performance improvement efforts. This gave them a more comprehensive evaluation of diabetes care and interventions than solely looking at LDL-C rates. These were studied from 2008 to the present.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No		*In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?*
X			Beginning in RY 2010, age and region cohorts have been analyzed. Gender, race/ethnicity and primary language spoken were added in RY 2013.

Step 5: REVIEW SAMPLING METHODS

Yes	No		*Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?*
X			The sample size exceeded 411. This oversampling allows for exclusions such as pregnant women, individuals with polycystic ovary disease, members who are identified as diabetic only due to one emergency department claim with a diagnosis of high blood sugar, and case where a physician notes pre-diabetes.

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No		*Did the study design clearly specify the data to be collected?*
X			Defaulted to HEDIS specfications
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
X			Though no data analysis plan was specified, Anthem's analysis includes a comparison of the results with the goals. They evaluate if they have met the goals and or achieved the benchmark. They then use this information to set goals for the next year. Anthem's quantitative analysis also includes a comparison with previous measurements including trends, changes in performance or statistical significance. These analyses are performed by a biostatistician. Anthem's qualitative analysis includes root cause analysis performed by the internal quality committee as well as discussions with other managed care entities.

MCO	Anthem
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
Comprehensive Diabetes Care

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	
			Were interventions developed to change behavior at the provider level? If yes, state below.
X			-Interventions: quarterly notices to providers that include the following member specific information: risk stratification level, utilization of services, medications dispensed and any co-morbid conditions; real-time HEDIS reports provided to providers; Gaps in Care reports; focused education delivered to 25 providers who had non-compliant records during HEDIS audits; visits from practice consultants -Other educational activities: Diabetes resource page on website, webinars
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			-Interventions: quarterly educational phone calls including screening for case management, Lab in Envelop, Diabetes Health Fairs, outbound calls to non-compliant members -Other educational activities: mailings, diabetes calendar, DRE reminder booklet, diabetes packet, newsletter article, information specific to Hispanics and African Americans
			Were interventions developed to change behavior at the MCE level? If yes, state below.
X			-Interventions: Implemented real-time HEDIS reports that identifies members with gaps in care; "Deep Dive" focus groups -Other educational activities: Meetings with the other MCOs to discuss system-wide interventions
			Are the interventions sufficient to be expected to improve outcomes?
X			Yes, but analytics will need to be conducted to assess their effectiveness

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	
			Did the MCE conduct an analysis of the findings according to its data analysis plan?
X			Every year after HEDIS results are recorded, Anthem Medicaid and Commercial health plans from across the country joined together to do a "Deep Dive" analysis of the national HEDIS results. They discuss what differentiated high performing states and low performing states. They discuss differences between urban and rural states and other. Together they develop/share intervention strategies and select ones for each state based on individual needs and state regulations.
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
X			
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
X			Clear documentation of recorded changes in HEDIS definitions year to year
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?

MCO	Anthem
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
Comprehensive Diabetes Care

X			Anthem performed a detailed analysis of the Lab in an Envelope intervention. They only got 11 kits returned for 6 months of effort. It "would have been cheaper to send a nurse door-to-door." Anthem did face-to-face meetings with 25 providers. These did not really impact the rates because the small diabetic population is spread across the state leaving each PMP with only a handful of diabetic members.
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
	X		With the exception of the Lab in an Envelop intervention, Anthem did not have a firm grasp on the success or failure of each intervention.

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	
			Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence?
	X		Although there were improvements made in these measures there was no clear evidence to point to specific interventions that caused these increases.
			Was there any documented, quantitative improvement in processes or outcomes of care?
	X		
			Does the reported improvement in performance have "face" validity (does it appear to be the result of the planned interventions)?
		X	For HHW, yes for DRE in the first year of this PIP. For HIP, the HbA1c and LDL measures had face validity in Year 1 of the PIP; the DRE measure had face validity in Year 2 of the PIP.
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
X			Yes, statistical tests were conducted to measure the level of improvement or decline, but there was no statistically significant improvement shown on HbA1c or LDL measures since the baseline. There was for diabetes retinal exam in the first year of the PIP for HHW.

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	
			Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?
X			Yes for Diabetic Retinal Exams and LDL-C but more moderate for HbA1c.

ACTIVITY 2: VERIFYING STUDY FINDINGS (Not completed- Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

High confidence in reported MCO PIP results	X
Confidence in reported MCO PIP results	
Low confidence in reported MCO PIP results	
Reported MCO PIP results not credible	

Anthem has provided clear and consistent analysis on the measure results. B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued.

MCO	Anthem
Focus Period	1/1/12 - 12/31/12
HHW/HIP/Both	HIP only

Name of Performance Improvement Project (PIP)	
Assessment of 7-Day and 30-Day Follow-up After Discharge from an Inpatient Stay for a Mental Health Diagnosis	
Is this a Recurring PIP? If yes, state # years	3

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No		*Is the PIP consistent with the demographics and epidemiology of the enrollees?*
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No		*Was the study question/objective of the PIP clearly stated and properly defined?*
X			Defaulted to HEDIS specfications

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No		*Did the indicators track performance over a specified period of time?*
X			Anthem chose to track two HEDIS follow-up measures, 7-day and 30-day, to evaluate the outcomes of its performance improvement efforts. These were studied from 2010 to the present.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No		*In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?*
X			Beginning in RY 2012, age, gender and region cohorts have been analyzed. Race/ethnicity and primary language spoken were added in RY 2013.

Step 5: REVIEW SAMPLING METHODS

Yes	No		*Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?*
	X		All eligible members as per the HEDIS definition were included using claims as the basis for the calculation of the measures.

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No		*Did the study design clearly specify the data to be collected?*
X			HEDIS® Measures: Follow-Up After Hospitalization 7-day and 30 day
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
X			Though no data analysis plan was specified, Anthem's analysis includes a comparison of the results with the goals. They evaluate if they have met the goals and or achieved the benchmark. They then use this information to set goals for the next year. Anthem's quantitative analysis also includes a comparison with previous measurements including trends, changes in performance or statistical significance. These analyses are performed by a biostatistician. Anthem's qualitative analysis includes root cause analysis performed by the internal quality committee as well as discussions with other managed care entities.

MCO	Anthem
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
Assessment of 7-Day and 30-Day Follow-up After Discharge from an Inpatient Stay for a Mental Health Diagnosis

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	
			Were interventions developed to change behavior at the provider level? If yes, state below.
X			-Interventions: New contracts presented to HIP participating facilities. The transition program was implemented with the signing of the new contracts; contracted facilities are able to complete a transition appointment on the day of discharge for HIP members; sharing ongoing facility specific metrics with participating facility providers
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			-Interventions: Live member outreach calls to educate and remind the member to attend after care appointments; the care manager actively works with the discharge planner during the admission to schedule appropriate aftercare appointments -Other educational activities: a letter enclosure with the authorization letter to promote the benefits of after care.
			Were interventions developed to change behavior at the MCE level? If yes, state below.
X			-Interventions: Participation in a Six Sigma BH unit process improvement project focusing on the discharge and outreach processes. Best practice work group developed to promote interventions that support compliance with members seeing outpatient provider within 7 days from discharge from an acute psychiatric setting; UM managers and member outreach staff meet weekly to map out process to improve efficiency.
			Are the interventions sufficient to be expected to improve outcomes?
X			Yes, but analytics will need to be conducted to assess their effectiveness

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	
			Did the MCE conduct an analysis of the findings according to its data analysis plan?
X			
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
X			
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
X			Clear documentation of recorded changes in HEDIS definitions year to year
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
X			Anthem performed a Six Sigma project on the communication flow between Utilization Management, Case Management and Member Outreach departments. They outlined the process and did a Failure Mode and Effects Analysis to determine improvement areas. Anthem has assessed the Bridge Appointments. They noted a 5% readmission rate of people who had had the appointment and an 11% rate for those who did not.
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
	X		This was not in the report.

MCO	Anthem
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
Assessment of 7-Day and 30-Day Follow-up After Discharge from an Inpatient Stay for a Mental Health Diagnosis

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	*Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence?*
X			
			Was there any documented, quantitative improvement in processes or outcomes of care?
X			Anthem has assessed the Bridge Appointments. They noted a 5% readmission rate of people who had had the appointment and an 11% rate for those who did not.
			Does the reported improvement in performance have "face" validity (does it appear to be the result of the planned interventions)?
X			
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
X			The rates increased for the first two years of the PIP and then were sustained at a statistically similar rate for the third year.

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	*Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?*
X			

ACTIVITY 2: VERIFYING STUDY FINDINGS (Not completed- Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

High confidence in reported MCO PIP results	X
Confidence in reported MCO PIP results	
Low confidence in reported MCO PIP results	
Reported MCO PIP results not credible	

Anthem has provided clear and consistent analysis on the measure results. B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued.

MCO	Anthem
Focus Period	1/1/12 - 12/31/12
HHW/HIP/Both	HHW only

Name of Performance Improvement Project (PIP)	
Well Child Visits for All Age Groups (HEDIS measures W15, W34, and AWC)	
Is this a Recurring PIP? If yes, state # years	2

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No		*Is the PIP consistent with the demographics and epidemiology of the enrollees?*
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No		*Was the study question/objective of the PIP clearly stated and properly defined?*
X			Defaulted to HEDIS specfications

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No		*Did the indicators track performance over a specified period of time?*
X			Anthem chose to track three HEDIS measures (W15, W34 and AWC) to evaluate the outcomes of its performance improvement efforts. These were studied from RY 2011 to the present.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No		*In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?*
X			Beginning in RY 2012, gender, region, race/ethnicity and primary language spoken were added. These measures already stratify by age.

Step 5: REVIEW SAMPLING METHODS

Yes	No		*Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?*
X			Yes, using HEDIS logic.

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No		*Did the study design clearly specify the data to be collected?*
X			HEDIS® Measures: Well-Child Visits in the First 15 Months of Life (W15), Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W-34), and Adolescent Well-Care Visits (AWC)
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
X			Though no data analysis plan was specified, Anthem's analysis includes a comparison of the results with the goals. They evaluate if they have met the goals and or achieved the benchmark. They then use this information to set goals for the next year. Anthem's quantitative analysis also includes a comparison with previous measurements including trends, changes in performance or statistical significance. These analyses are performed by a biostatistician. Anthem's qualitative analysis includes root cause analysis performed by the internal quality committee as well as discussions with other managed care entities.

MCO	Anthem
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
Well Child Visits for All Age Groups (HEDIS measures W15, W34, and AWC)

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	*Were interventions developed to change behavior at the provider level? If yes, state below.*
X			-Interventions: physicians notified of Gaps in Care, Bright Futures provider office visits, nurse practice consultants -Other educational activities: newsletter articles, HEDIS Webinars
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			-Interventions: IVR calls, Anthem Clinic Days, W15 post partum delivery calls, W34 and AWC annual preventive care calls, rewards/incentives, calls to parents of children who had had 5 well visits -Other educational activities: reminder cards, newsletter articles, IVR calls
			Were interventions developed to change behavior at the MCE level? If yes, state below.
X			-Interventions: Deep Dive focus group conducted on improving compliance
			Are the interventions sufficient to be expected to improve outcomes?
X			Yes, the interventions dramatically increased the W15 rate from 50.85% in 2010 to 70.31 in 2013.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	*Did the MCE conduct an analysis of the findings according to its data analysis plan?*
X			Every year after HEDIS results are recorded, Anthem Medicaid and Commercial health plans from across the country joined together to do a "Deep Dive" analysis of the national HEDIS results. They discuss what differentiated high performing states and low performing states. They discuss differences between urban and rural states and other . Together they develop/share intervention strategies and select ones for each state based on individual needs and state regulations.
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
X			
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
X			Clear documentation of recorded changes in HEDIS definitions year to year
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
	X		Since so many of the interventions target the same children, it is hard to determine which interventions changed behavior. Anthem credits clinic days in conjunction with practice consultants visiting offices and delivering the Gaps in Care reports and educating the providers on the reports with the change.
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
X			Anthem Indiana is the top scoring W34 and W15 Anthem health plan. Anthem stated that it would continue to increase clinic days and Practice Consultant visits to doctor offices because it believes these are "moving the needle".

MCO	Anthem
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
Well Child Visits for All Age Groups (HEDIS measures W15, W34, and AWC)

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	
			Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence?
X			Clinic days and Practice Consultant visits
			Was there any documented, quantitative improvement in processes or outcomes of care?
X			For W15, but there has not been significant improvement for either W34 or AWC.
			Does the reported improvement in performance have "face" validity (does it appear to be the result of the planned interventions)?
X			For W15, but there has not been significant improvement for either W34 or AWC.
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
X			

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	
			Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?
X			For W15 (both RY 2011 - RY 2012 and RY 2012 - RY 2013) and for W34 (RY 2012 - RY 2013), but not for AWC.

ACTIVITY 2: VERIFYING STUDY FINDINGS (Not completed- Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

High confidence in reported MCO PIP results	X
Confidence in reported MCO PIP results	
Low confidence in reported MCO PIP results	
Reported MCO PIP results not credible	

Anthem has provided clear and consistent analysis on the measure results. B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued.

MCO	MDwise
Focus Period	1/1/12 - 12/31/12
HHW/HIP/Both	Both

Name of Performance Improvement Project (PIP)	
LDL Screening for Diabetes	
Is this a Recurring PIP? If yes, state # years	3

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No		*Is the PIP consistent with the demographics and epidemiology of the enrollees?*
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No		*Was the study question/objective of the PIP clearly stated and properly defined?*
X			Defaulted to HEDIS specfications

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No		*Did the indicators track performance over a specified period of time?*
X			

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No		*In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?*
	X		It was not defined upfront in the analysis plan but was ultimately completed for the HHW population by age and by region.

Step 5: REVIEW SAMPLING METHODS

Yes	No		*Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?*
X			MDwise used sampling for the annual hybrid results and administrative only for quarterly results.

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No		*Did the study design clearly specify the data to be collected?*
X			HEDIS® Measure: LDL-C Screening
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
X			A.) HEDIS® data B.) MDwise uses a sample of data, but they would prefer to use administrative data because those rates have proven to be more stable over time. C.) RY 2010-2013 D.) MDwise compares the sample rate with the administrative data, the rate to benchmarks, MDwise to other MCEs, delivery system to delivery system and group to group

MCO	MDwise
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
LDL Screening for Diabetes

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	
			Were interventions developed to change behavior at the provider level? If yes, state below.
X			-Interventions: financial recognition; denominator reports; fax back program for submission of shadow claims or tests results for LDL-C -Other educational activities: newsletter articles, poster, claims crosswalk to address the differences between NCQA and CMS meaningful use, diabetes toolkit
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			-Interventions: MDwise Rewards program, LDL home testing kit pilot with Hoosier Alliance -Other educational activities: newsletter articles, website, mailings, automated phone messaging
			Were interventions developed to change behavior at the MCE level? If yes, state below.
X			-Interventions: quarterly results of LDL screenings presented to each delivery system of its members by PMP; worked with Reach Out for Quality delivery system staff to identify disease management/case management activities to work with providers and members to improve LDL screenings; created a Network Improvement Team to work with delivery system staff and key provider to promote LDL screening; formed a Diabetes LDL workgroup with representatives from the delivery system to perform a full review of diabetes care options.
			Are the interventions sufficient to be expected to improve outcomes?
X			

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	
			Did the MCE conduct an analysis of the findings according to its data analysis plan?
X			Information was stratified by age, region and delivery system within the MDwise network.
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
X			
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
X			They switched from ManagedCare.com to Verisk-approved HEDIS® software.
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
	X		MDwise did not provide any numeric analysis of interventions, but did provide anecdotal information. MDwise evaluated its $50 member and provider incentives and determined that they did not change the rate. They determined that the LDL Test Kit pilot was too labor intensive.
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
X			MDwise conducted root cause analysis that identified that corporate initiatives were not being carried out by the delivery systems.

MCO	MDwise
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
LDL Screening for Diabetes

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	
			Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence?
		X	No statistically significant improvement shown on this measure since baseline.
			Was there any documented, quantitative improvement in processes or outcomes of care?
	X		
			Does the reported improvement in performance have "face" validity (does it appear to be the result of the planned interventions)?
		X	No statistically significant improvement shown on this measure since baseline.
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
X			Yes, statistical tests were conducted to measure the level of improvement or decline for RY 2012 but they were not provided for RY 2011 or 2013. There was no statistically significant improvement shown on this measure since the baseline.

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	
			Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?
	X		

ACTIVITY 2: VERIFYING STUDY FINDINGS (Not completed- Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

High confidence in reported MCO PIP results	X
Confidence in reported MCO PIP results	
Low confidence in reported MCO PIP results	
Reported MCO PIP results not credible	

B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued.

MCO	MDwise
Focus Period	1/1/12 - 12/31/12
HHW/HIP/Both	Both

Name of Performance Improvement Project (PIP)	
Assessment of 7-Day Follow-up After Discharge from an Inpatient Stay for a Mental Health Diagnosis	
Is this a Recurring PIP? If yes, state # years	HHW 3 yrs, HIP 2 yrs

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No		*Is the PIP consistent with the demographics and epidemiology of the enrollees?*
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No		*Was the study question/objective of the PIP clearly stated and properly defined?*
X			Defaulted to HEDIS specfications

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No		*Did the indicators track performance over a specified period of time?*
X			

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No		*In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?*
X			MDwise stratifies data by age, region, and delivery system.

Step 5: REVIEW SAMPLING METHODS

Yes	No		*Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?*
	X		All eligible members as per the HEDIS definition were included using claims as the basis for the calculation of the measures.

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No		*Did the study design clearly specify the data to be collected?*
X			MDwise believes that the most reliable data is HEDIS® data. However its annual nature does not allow the plan to catch problems early. To do this, they also use quarterly administrative data for early notification of issues.
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
	X		

MCO	MDwise
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
Assessment of 7-Day Follow-up After Discharge from an Inpatient Stay for a Mental Health Diagnosis

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	
			Were interventions developed to change behavior at the provider level? If yes, state below.
X			-Interventions: the inpatient facility is notified who the case manager is at the member's delivery system; Bridge Appointments; FUH report cards sent to all inpatient providers -Other educational activities: communication sent to all inpatient providers in our BH network about the need for this appointment with our HIP population
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
	X		
			Were interventions developed to change behavior at the MCE level? If yes, state below.
X			-Interventions: worked with OMPP to get the bridge codes applied to the HIP population; all delivery systems following an ICM Protocol -Other educational activities: communication sent to all Delivery System UM and CM staff about the need to add the HIP population to their tracking of this measure
			Are the interventions sufficient to be expected to improve outcomes?
X			

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	
			Did the MCE conduct an analysis of the findings according to its data analysis plan?
X			
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
X			
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
	X		
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
	X		
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
	X		

MCO	MDwise
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
Assessment of 7-Day Follow-up After Discharge from an Inpatient Stay for a Mental Health Diagnosis

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	*Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence?*
X			
			Was there any documented, quantitative improvement in processes or outcomes of care?
	X		Yes in the overall measures themselves, but no quantitative documentation of the process improvements that were completed which appear to be positively impacting the outcomes of care.
			Does the reported improvement in performance have "face" validity (does it appear to be the result of the planned interventions)?
X			Yes, for HHW.
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
	X		

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	*Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?*
X			Yes, for HHW.

ACTIVITY 2: VERIFYING STUDY FINDINGS (Not completed- Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

High confidence in reported MCO PIP results	X
Confidence in reported MCO PIP results	
Low confidence in reported MCO PIP results	
Reported MCO PIP results not credible	

B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued. Also, MDwise should run tests for statistical significance on an annual basis for this measure.

MCO	MDwise
Focus Period	1/1/12 - 12/31/12
HHW/HIP/Both	Both (HIP AWC only)

Name of Performance Improvement Project (PIP)	
Well Child Visits for All Age Groups (HEDIS measures W15, W34, and AWC)	
Is this a Recurring PIP? If yes, state # years	AWC 3 yrs, others 2

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No		*Is the PIP consistent with the demographics and epidemiology of the enrollees?*
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No		*Was the study question/objective of the PIP clearly stated and properly defined?*
X			Defaulted to HEDIS specfications. Note that this PIP includes both AWC and CAP for Age 12-19 for adolescents. For younger children, it is W15 and W34. For HIP, it is AWC only.

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No		*Did the indicators track performance over a specified period of time?*
X			

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No		*In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?*
X			MDwise found the age stratification the most telling stratification. Compliance with well care decreases with age.

Step 5: REVIEW SAMPLING METHODS

Yes	No		*Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?*
X			For AWC, W15 and W34, administrative is used on entire universe and hybrid is used on a sample only. For CAP age 12-19, administrative is used on the entire universe.

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No		*Did the study design clearly specify the data to be collected?*
X			HEDIS® Measures: Well-Child Visits in the First 15 Months of Life (W15), Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W-34), Adolescent Well-Care Visits (AWC), and Children's Access to Primary Care Ages 12-19 (CAP).
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
X			A.) HEDIS® data B.) MDwise uses a sample of data, but they would prefer to use administrative data because those rates have proven to be more stable over time. C.) RY 2010-2013 D.) MDwise compares the sample rate with the administrative data, the rate to benchmarks, MDwise to other MCEs, delivery system to delivery system and group to group. They also have a workgroup of delivery system representatives that analyze the data.

MCO	MDwise
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
Well Child Visits for All Age Groups (HEDIS measures W15, W34, and AWC)

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	
			Were interventions developed to change behavior at the provider level? If yes, state below.
X			-Interventions: NIP Team completed visits with all delivery systems and multiple provider offices; produced monthly reports, non compliant patient listings and missed opportunities; financial recognition of providers; denominator reports; fax back program; "Star Performer Program" -Other educational activities: orientation on Well Child care incorporated into new provider orientation and ongoing provider trainings (e.g., IHCP), poster, mouse pad, explanation sheets for key reports, presentation on EPSDT and Bright Futures at the annual Indiana Academy of Family Practice meeting; joint MCE presentation on EPSDT and Bright Futures; Indiana Rural Health Association lunch and learn
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			-Interventions: MDwise Rewards Program; targeted well child events with high volume providers; automated phone call made to non compliant member's homes -Other educational activities: mailing
			Were interventions developed to change behavior at the MCE level? If yes, state below.
X			-Interventions: Hiring an EPSDT Coordinator; quarterly results of Well Child Visits provided to each delivery system of its members by PMP; creation of a Network Improvement Team to work with delivery system staff and key providers to promote Well Child care; formed a Well Child workgroup with representatives from all delivery systems
			Are the interventions sufficient to be expected to improve outcomes?
X			The selected activities showed potential for increasing the rates, but they did not do so.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	
			Did the MCE conduct an analysis of the findings according to its data analysis plan?
X			MDwise has seen variation between delivery systems. For example, because of its extensive experience with Medicaid, the Wishard system has more mechanisms in place to capture the first well-child claims and thus has higher W15 rates. MDwise interviewed the doctors considered "Star Performers". Their keys to success were: having a culture of quality, having a quality "champion", strategic scheduling, a good inventory system for their patients.
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
X			
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
X			They switched from ManagedCare.com to Verisk-approved HEDIS® software.
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
	X		MDwise did not provide data to evaluate specific interventions.
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
X			MDwise admitted the PIP results were disappointing. It plans to revise its work plan, work more with the delivery systems, revise reports, and expand the Fax Back program.

MCO	MDwise
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
Well Child Visits for All Age Groups (HEDIS measures W15, W34, and AWC)

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	
			Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence?
		X	No improvement noted
			Was there any documented, quantitative improvement in processes or outcomes of care?
	X		
			Does the reported improvement in performance have "face" validity (does it appear to be the result of the planned interventions)?
		X	No improvement noted
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
X			Yes, but only partially. Statistical tests were conducted on RY 2012 data but not RY 2013 data. There was no statistically significant improvement shown on any of the measures since the baseline.

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	
			Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?
	X		

ACTIVITY 2: VERIFYING STUDY FINDINGS (Not completed- Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

High confidence in reported MCO PIP results	X
Confidence in reported MCO PIP results	
Low confidence in reported MCO PIP results	
Reported MCO PIP results not credible	

B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued.

MCO	MHS
Focus Period	1/1/12 - 12/31/12
HHW/HIP/Both	Both

Name of Performance Improvement Project (PIP)	
LDL Screening for Diabetes	
Is this a Recurring PIP? If yes, state # years	3

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No		*Is the PIP consistent with the demographics and epidemiology of the enrollees?*
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No		*Was the study question/objective of the PIP clearly stated and properly defined?*
X			Defaulted to HEDIS specfications

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No		*Did the indicators track performance over a specified period of time?*
X			Note that data for RM3 (HEDIS RY2013) was not available for this review.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No		*In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?*
	X		

Step 5: REVIEW SAMPLING METHODS

Yes	No		*Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?*
X			Yes, HEDIS sampling was used. Oversampling was conducted to account for exclusions.

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No		*Did the study design clearly specify the data to be collected?*
X			HEDIS® Measure: LDL-C Screening
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
X			A.) HEDIS® data B.) The data was collected as a sample C.) and D.) MHS started with a baseline and benchmark. They gather the data and then a small group performs analysis. The information is also communicated to the QI Committee and the Board.

MCO	MHS
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
LDL Screening for Diabetes

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	
			Were interventions developed to change behavior at the provider level? If yes, state below.
X			-Interventions: quarterly report card, fax back program, Provider Scorecard added to Provider Web Portal for viewing; Medical Director visits to low performing practitioners -Other educational activities: newsletter articles
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			-Interventions: Diabetes Disease Management- coaching and education, phone outreach, Case Management Diabetes Education call series -Other educational activities: newsletter articles, health reminders
			Were interventions developed to change behavior at the MCE level? If yes, state below.
X			Rigorous training of case managers in 2011 and more focused case management "rounds" in 2012. Also standardized the assessment tool to audit case managers.
			Are the interventions sufficient to be expected to improve outcomes?
X			The selected activities showed potential for increasing the rates, but they did not do so. In fact, MHS states that inpatient and emergency department costs for diabetics increased.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	
			Did the MCE conduct an analysis of the findings according to its data analysis plan?
X			
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
X			
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat
	X		
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
X			MHS analyzed its Diabetic Call completion rates and its Provider Fax Back reports. 28% of diabetics completed Call 1 and 13% completed the entire series of five calls. The information sent back on the Fax Back reports often duplicated delayed claims data.
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
	X		MHS listed several barriers to the PIP, but did not discuss follow-up activities.

MCO	MHS
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
LDL Screening for Diabetes

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	
			Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence?
		X	No statistically significant improvement shown on this measure since baseline.
			Was there any documented, quantitative improvement in processes or outcomes of care?
	X		
			Does the reported improvement in performance have "face" validity (does it appear to be the result of the planned interventions)?
		X	No statistically significant improvement shown on this measure since baseline.
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
X			Yes, statistical tests were conducted to measure the level of improvement or decline, but there was no statistically significant improvement shown on this measure since the baseline.

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	
			Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?
	X		

ACTIVITY 2: VERIFYING STUDY FINDINGS (Not completed- Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

High confidence in reported MCO PIP results	X
Confidence in reported MCO PIP results	
Low confidence in reported MCO PIP results	
Reported MCO PIP results not credible	

B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued. Also, MHS should run analysis based on demographic cohorts to better understand if the lack of improvement is across-the-board or focused on one demographic.

MCO	MHS
Focus Period	1/1/12 - 12/31/12
HHW/HIP/Both	Both

Name of Performance Improvement Project (PIP)	
Assessment of 7-Day and 30-Day Follow-up After Discharge from an Inpatient Stay for a Mental Health Diagnosis	
Is this a Recurring PIP? If yes, state # years	5

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No		
			Is the PIP consistent with the demographics and epidemiology of the enrollees?
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No		
			Was the study question/objective of the PIP clearly stated and properly defined?
X			Defaulted to HEDIS specfications

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No		
			Did the indicators track performance over a specified period of time?
X			Note that data for RM3 (HEDIS RY2013) was not available for this review.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No		
			In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?
	X		

Step 5: REVIEW SAMPLING METHODS

Yes	No		
			Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?
	X		All eligible members as per the HEDIS definition were included using claims as the basis for the calculation of the measures.

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No		
			Did the study design clearly specify the data to be collected?
X			HEDIS® Measures: Follow-Up After Hospitalization 7-day and 30 day
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
	X		

MCO	MHS
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
Assessment of 7-Day and 30-Day Follow-up After Discharge from an Inpatient Stay for a Mental Health Diagnosis

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	
			Were interventions developed to change behavior at the provider level? If yes, state below.
X			-Interventions: identified key discharge planners in inpatient facilities; Community Mental Health Centers (CMHC) and Cenpatico joint rounds on high-risk members; face to face outreach with high volume facilities that focused on data sharing, coordination follow up appointments are scheduled and kept; removed PA requirement for bridge appointment; included performance of 7 and 30 day FUH indicators in inpatient and outpatient preferred provider program; provided administrative incentives to facilities and provider for increased rates. -Other educational activities: Collaborative project between Hoosier Healthwise MCOs, HP, and OMPP with eight regional workshops conducted discussing bridge appointments, resources in the community, and intensive case management; training
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			-Interventions: The "Caring Voice" program provides a pre-programmed cell phone with key supports of medical and behavioral provider contacts to members with no or unstable phone access, incentives, 100% of reachable members to receive coordination of behavioral health and physical health care via intensive case management. -Other educational activities: brochures
			Were interventions developed to change behavior at the MCE level? If yes, state below.
X			-Interventions: retrained all Cenpatico clinicians responsible for discharge planning reinforcing appropriate planning, appointment types and clinician requirements -Other educational activities: internal training
			Are the interventions sufficient to be expected to improve outcomes?
X			Yes, MHS has had significant improvement since the baseline measurement.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	
			Did the MCE conduct an analysis of the findings according to its data analysis plan?
X			
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
X			
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
X			
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
	X		MHS believes that the increase in the 7 day rate is due to the Bridge appointments, but they did not have data to support the theory or data on the increase in the 30-day rate.
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
	X		

MCO	MHS
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
Assessment of 7-Day and 30-Day Follow-up After Discharge from an Inpatient Stay for a Mental Health Diagnosis

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	*Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence?*
X			
			Was there any documented, quantitative improvement in processes or outcomes of care?
X			Yes in the overall measures themselves, but no quantitative documentation of the process improvements that were completed which appear to be positively impacting the outcomes of care.
			Does the reported improvement in performance have "face" validity (does it appear to be the result of the planned interventions)?
X			
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
X			

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	*Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?*
X			

ACTIVITY 2: VERIFYING STUDY FINDINGS (Not completed- Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

High confidence in reported MCO PIP results	X
Confidence in reported MCO PIP results	
Low confidence in reported MCO PIP results	
Reported MCO PIP results not credible	

B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued.

MCO	MHS
Focus Period	1/1/12 - 12/31/12
HHW/HIP/Both	HHW only

Name of Performance Improvement Project (PIP)	
Well Child Visits for All Age Groups (HEDIS measures W15, W34, and AWC)	
Is this a Recurring PIP? If yes, state # years	2

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Yes	No		
			Is the PIP consistent with the demographics and epidemiology of the enrollees?
X			The OMPP asked each MCE to choose from a pre-defined list of potential study topics for their performance improvement projects. Therefore, although the MCE could choose the specific study topic, all of the options were ones that directly impact the HHW and HIP populations.

Step 2: REVIEW THE STUDY QUESTION(S)

Yes	No		
			Was the study question/objective of the PIP clearly stated and properly defined?
X			Defaulted to HEDIS specfications

Step 3: REVIEW SELECTED STUDY INDICATOR(S)

Yes	No		
			Did the indicators track performance over a specified period of time?
X			

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION

Yes	No		
			In addition to the defined HEDIS measure population, did the MCE define other cohorts of individuals for whom this PIP is relevant (e.g., age range, race/ethnicity, region)?
X			There was no difference in gender, race or ethnicity. For AWC, MHS identified that they need to split out data and interventions 14-16, 17-18, and 19-21.

Step 5: REVIEW SAMPLING METHODS

Yes	No		
			Did the MCE use sampling to report results? If yes, did the MCE use standard HEDIS sampling logic?
X			Yes, using HEDIS logic

Step 6: REVIEW DATA COLLECTION PROCEDURES

Yes	No		
			Did the study design clearly specify the data to be collected?
X			HEDIS® Measures: Well-Child Visits in the First 15 Months of Life (W15), Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W-34), and Adolescent Well-Care Visits (AWC)
			Did the study design prospectively specify a data analysis plan that reflected (a) the type of data to be collected, (b) if the data collected is on entire population/sample, (c) if the data collected is to be compared to prior periods, and (d) any benchmarks?
X			A.) HEDIS® data B.) The data was collected as a sample C.) and D.) MHS started with a baseline and benchmark. They gather the data and then a small group performs analysis. The information is also communicated to the QI Committee and the Board.

MCO	MHS
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
Well Child Visits for All Age Groups (HEDIS measures W15, W34, and AWC)

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 7: ASSESS IMPROVEMENT STRATEGIES

Yes	No	N/A	*Were interventions developed to change behavior at the provider level? If yes, state below.*
X			-Interventions: Health Check Health Days (goal 2 events per quarter), Provider Report Card, Provider Fax Back, Provider Scorecard added to Provider Web Portal for viewing -Other educational activities: newsletter articles, Provider Claims/ Billing FAQ, Bright Futures education and training, provider workshops, provider education regarding opportunistic visits, joint Managed Care Entities EPSDT and Bright Futures Presentation at annual Indiana Academy of Family Physicians annual meeting, annual IHCP conference reviewing EPSDT requirements and the use of Bright Futures
			Were interventions developed to change behavior at the beneficiary level? If yes, state below.
X			-Interventions: Health Check Health Days (goal 2 events per quarter), member outreach calls, Provider referrals of members to Member Connections for outreach, Member Connections Birthday Parties -Other educational activities: Start Smart for Your Baby education program, newsletter articles, on hold messages, birthday card reminders, Family Education Network education provided by the Indiana Minority Coalition in selected counties
			Were interventions developed to change behavior at the MCE level? If yes, state below.
X			-Interventions: Hiring an EPSDT Coordinator
			Are the interventions sufficient to be expected to improve outcomes?
X			The selected activities showed potential for increasing the rates, but they did not for W34 and AWC.

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Yes	No	N/A	*Did the MCE conduct an analysis of the findings according to its data analysis plan?*
X			
			Were numerical PIP results and findings accurately and clearly presented?
X			
			Did the analysis identify initial and repeat measurements including comparisons to the benchmark?
X			
			Did the analysis identify what, if any, factors influence the comparability of initial and repeat measurements?
	X		
			Did the MCE analyze the impact of any of the interventions to assist in assessing the success of the interventions?
X			The EPSDT random audits identified educational needs including opportunistic visits, coding issues, and MedTox. These had a high effect on the rate. Lead screening rates are higher in practices that have a testing machine in the office. The information sent back on the Provider Fax Back reports often duplicates delayed claims data.
			Did the MCE's analysis of the study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?
	X		MHS listed several barriers to the PIP, but did not discuss follow-up activities.

MCO	MHS
Focus Period	1/1/12 - 12/31/12

Name of Performance Improvement Project (PIP)
Well Child Visits for All Age Groups (HEDIS measures W15, W34, and AWC)

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY (continued)

Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT

Yes	No	N/A	
			Does the improvement in performance appear to have been the result of the planned interventions as opposed to some unrelated occurrence?
X			
			Was there any documented, quantitative improvement in processes or outcomes of care?
	X		
			Does the reported improvement in performance have "face" validity (does it appear to be the result of the planned interventions)?
X			Yes for W15. No improvement for W34 and AWC.
			Is there any statistical evidence presented that the observed performance improvement is true improvement?
X			Yes, statistical tests were conducted to measure the level of improvement or decline, but there was no statistically significant improvement shown on two of the three measures since the baseline.

Step 10: ASSESS SUSTAINED IMPROVEMENT

Yes	No	N/A	
			Was the MCE able to demonstrate sustained improvement through repeated measurements over comparable time periods?
	X		

ACTIVITY 2: VERIFYING STUDY FINDINGS (Not completed- Optional Activity)

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

High confidence in reported MCO PIP results	X
Confidence in reported MCO PIP results	
Low confidence in reported MCO PIP results	
Reported MCO PIP results not credible	

B&A recommends that continued effort be put into analyzing each intervention specifically. For example, how will the intervention be measured, what defines success, and how will criteria be used to decide if the implementation should be continued. Also, MHS should run analysis based on demographic cohorts to better understand if the lack of improvement is across-the-board or focused on one demographic.

APPENDIX C
CALCULATION OF PERFORMANCE MEASUREMENT WORKSHEETS

Appendix C
Calculation of Performance Measure Worksheet

Measure Name	**Measure 3: Live Births Weighing Less Than 2,500 Grams**
Measure Description	The percentage of live births that weighed less than 2,500 grams in the state during the reporting period.
Measure Steward	California Maternal Quality Care Collaborative
Measure Purpose	Federal reporting requirement of Initial Child Core measures that must be reported with each state's annual CHIP report to CMS.
Eligible Population	Deliveries where principal source of payment for delivery is Medicaid or CHIP.
Data Source	Claims and encounters from MedInsight, the OMPP data warehouse. Data retrieved May 1, 2013. [Note that measure steward recommends state vital records which were not available for this project.]
Sampling Method	N/A
Age	No restrictions
Gender	Female only
Continuous Enrollment	No restrictions
Numerator Elements or Exclusions	Workaround in absence of vital records was to utilize birth DRGs which are defined by birthweight. DRGs with birthweight less than 2,500 are 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621.
Denominator Elements or Exclusions	Workaround in absence of vital records was to utilize all birth DRGs. These are defined as all DRGs listed for the numerator plus the following: 622 623 624 626 627 628 629 630
Limitations on Data Integrity	No limitations
Numerator	Number of resident live births in the reporting period less than 2,500 grams with Medicaid and/or CHIP as the payer source.
Denominator	Number of resident live births in the reporting period with Medicaid and/or CHIP as the payer source.
Rate	Numerator / Denominator, reported as a percentage
Benchmark	Data compiled over four annual periods will be used to establish a benchmark for OMPP.

Appendix C
Calculation of Performance Measure Worksheet

Measure Name	**Measure 4: Cesarean Rate for Nulliparous Singleton Vertex**
Measure Description	The percentage of women that had a cesarean section among women with first live singleton births at 37 weeks of gestation or later.
Measure Steward	Centers for Disease Control and Prevention (National Center for Health Statistics)
Measure Purpose	Federal reporting requirement of Initial Child Core measures that must be reported with each state's annual CHIP report to CMS.
Eligible Population	Deliveries where principal source of payment for delivery is Medicaid or CHIP.
Data Source	Claims and encounters from MedInsight, the OMPP data warehouse. Data retrieved May 1, 2013. [Note that measure steward recommends state vital records which were not available for this project be used either alone or merged with discharge diagnosis data set.]
Sampling Method	N/A
Age	No restrictions
Gender	Female only
Continuous Enrollment	No restrictions
Numerator Elements or Exclusions	Limited to singleton births, defined as having presence of V27.0 ICD-9-CM code (delivery- single liveborn). Cesarean deliveries defined as DRG 370 371 650 651. Exclusions from the dataset include presence of a list of ICD-9-CM codes from measure steward identifying abnormal presentation, preterm delivery, fetal death, multiple gestation, breech or a previous Cesarean delivery in any diagnosis field.
Denominator Elements or Exclusions	Limited to singleton births, defined as having presence of V27.0 ICD-9-CM code (delivery- single liveborn). Birth deliveries defined as Cesarean deliveries identified in numerator plus vaginal deliveries defined as DRG 372 373 374 375 652. Same exclusions identified more numerator also apply here.
Limitations on Data Integrity	Not all Cesarean deliveries were defined using DRG value. Additional cases were defined by matching professional service surgeon claims with C-section surgery codes against hospital delivery claims with the same date of service to reasign cases from vaginal DRGs to Cesarean DRGs. Also, from data presented, the criterion for 37 weeks gestation or more was not applied.
Numerator	Number of Cesarean deliveries, identified by DRG (or alternate method above) if they are reported without a 7491 hysterectomy procedure and not excluded in Numerator Elements
Denominator	All deliveries defined in Denominator Elements
Rate	Numerator / Denominator, reported as a percentage
Benchmark	Data compiled over four annual periods will be used to establish a benchmark for OMPP.

Appendix C
Calculation of Performance Measure Worksheet

Measure Name	**Measure 7: Weight Assessment and Counseling for Nutrition and Physical Acticity for Children and Adolescents: Body Mass Index Assessment for Children/Adolescents**
Measure Description	The percentage of children ages 3 to 17 that has an outpatient visit with a PCP or OB/GYN and whose weight is classified based no body mass index (BMI) percentile for age and gender.
Measure Steward	National Committee for Quality Assurance
Measure Purpose	Federal reporting requirement of Initial Child Core measures that must be reported with each state's annual CHIP report to CMS.
Eligible Population	3 to 17 years old as of December 31 of the measurement year. Report two age stratifications (3 to 11 years, 12 to 17 years) and a total. The total is the sum of the two age stratifications.
Data Source	Claims and encounters from MedInsight, the OMPP data warehouse. Data retrieved May 1, 2013. All paid, suspended, pending, reversed and denied claims should be included.
Sampling Method	N/A
Age	3 to 17 years old as of December 31 of the measurement yeartwo age stratifications.
Gender	Male and female
Continuous Enrollment	The measurement year, with an allowable gap in continous enrollment of 45 days.
Numerator Elements or Exclusions	Children who have a diagnosis of pregnancy during the measurement year are excluded. This is defined as ICD-9-CM codes 630-679, V22, V23 or V28.
Denominator Elements or Exclusions	An outpatient visit with a PCP or an OB/GYN during the measurement year. This is defined by a series of CPT codes and UB revenue codes by the measure steward (Table WCC-A).
Limitations on Data Integrity	No limitations.
Numerator	Presence of the BMI percentile code (ICD-9-CM code V85.5)
Denominator	The eligible population with an outpatient visit as defined in Denominator Elements.
Rate	Numerator / Denominator, reported as a percentage
Benchmark	Data compiled over four annual periods will be used to establish a benchmark for OMPP.

Appendix C
Calculation of Performance Measure Worksheet

Measure Name	**Measure 8: Developmental Screening in the First Three Years of Life**
Measure Description	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second or third birthday.
Measure Steward	National Committee for Quality Assurance
Measure Purpose	Federal reporting requirement of Initial Child Core measures that must be reported with each state's annual CHIP report to CMS.
Eligible Population	Children who turn 1, 2 or 3 years of age between January 1 and December 31 of the measurement year.
Data Source	Claims and encounters from MedInsight, the OMPP data warehouse. Data retrieved May 1, 2013.
Sampling Method	N/A
Age	Children who turn 1, 2 or 3 years of age between January 1 and December 31 of the measurement year.
Gender	Male and female
Continuous Enrollment	Children who are continuously enrolled for 12 months prior to the child's 1st, 2nd or 3rd birthday, with an allowable gap of 45 days during this measurement year.
Numerator Elements or Exclusions	1. Children in the eligible population who turned 1 during the measurement year with CPT 96110. 2. Children in the eligible population who turned 2 during the measurement year with CPT 96110. 3. Children in the eligible population who turned 3 during the measurement year with CPT 96110. 4. The sum of numerators 1, 2 and 3.
Denominator Elements or Exclusions	1. Children in the eligible population who turned 1 during the measurement year. 2. Children in the eligible population who turned 2 during the measurement year. 3. Children in the eligible population who turned 3 during the measurement year. 4. The sum of denominators 1, 2 and 3.
Limitations on Data Integrity	No limitations.
Numerator	Presence of CPT code 96110.
Denominator	The eligible population.
Rate	Numerator / Denominator, reported as a percentage
Benchmark	Data compiled over four annual periods will be used to establish a benchmark for OMPP.

Appendix C
Calculation of Performance Measure Worksheet

Measure Name	**Measure 18: Ambulatory Care - Emergency Department Visits**
Measure Description	The rate of emergency department (ED) visits per 1,000 member months among children up to age 19.
Measure Steward	National Committee for Quality Assurance
Measure Purpose	Federal reporting requirement of Initial Child Core measures that must be reported with each state's annual CHIP report to CMS.
Eligible Population	Children up to age 19 enrolled in Medicaid and CHIP.
Data Source	Claims and encounters from MedInsight, the OMPP data warehouse. Data retrieved May 1, 2013.
Sampling Method	N/A
Age	Children up to age 19.
Gender	Male and female
Continuous Enrollment	None
Numerator Elements or Exclusions	Include counts of ED visits for three age groups: <1, 1-9 and 10-19, plus one result of the sum of the three age groups. ED visits are defined as (1) CPT 99281-99285 and UB revenue code 045x, 0981 or (2) CPT 10040-69979 with POS = 23. Exclude services for mental health or chemical dependency as defined by the measure steward. Do not count multiple services if a physician and a hospital submit separate bills pertaining to the same ED visit with the same date of service. Count only of the services.
Denominator Elements or Exclusions	Include counts of member months for three age groups: <1, 1-9 and 10-19, plus one result of the sum of the three age groups. Select a consistent day of the month for counting member months. Retroactive enrollment may be included in the counts.
Limitations on Data Integrity	No limitations.
Numerator	Presence of CPT/revenue code combinations as defined in Numerator Elements.
Denominator	The member months of the eligible population.
Rate	(Number of ED visits / number of member months) x 1,000
Benchmark	Data compiled over four annual periods will be used to establish a benchmark for OMPP.

Appendix C
Calculation of Performance Measure Worksheet

Measure Name	**Measure 20: Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit**
Measure Description	The percentage of children ages 2 to 20 diagnosed with asthma during the measurement year with one or more asthma-related emergency room visits.
Measure Steward	Alabama Medicaid
Measure Purpose	Federal reporting requirement of Initial Child Core measures that must be reported with each state's annual CHIP report to CMS.
Eligible Population	Children ages 2 to 20 during the measurement period.
Data Source	Claims and encounters from MedInsight, the OMPP data warehouse. Data retrieved May 1, 2013.
Sampling Method	N/A
Age	Children ages 2 to 20 during the measurement period.
Gender	Male and female
Continuous Enrollment	None
Numerator Elements or Exclusions	All patients who have an ER visit with one of the diagnosis codes defined in Denominator Elements.
Denominator Elements or Exclusions	All patients ages 2 to 20, diagnosed with asthma during the measurement period defined as having a service billed with ICD-9-CM code 493.00, 493.01, 493.02, 493.10, 493.11, 493.81, 493.82, 493.90, 493.91 or 493.92 as primary or secondary diagnosis. Exclude 493.20, 493.21 and 493.22.
Limitations on Data Integrity	No limitations.
Numerator	All patients who have an ER visit AND a diagnosis of asthma.
Denominator	All patients ages 2 to 20, diagnosed with asthma during the measurement period.
Rate	Numerator / Denominator, reported as a percentage
Benchmark	Data compiled over four annual periods will be used to establish a benchmark for OMPP.

Appendix C
Calculation of Performance Measure Worksheet

Measure Name	**Measure 22: Annual Pediatric Hemoglobin (HbA1c) Testing**
Measure Description	The percentage of children ages 5 to 17 with diabetes (type 1 and type 2) that had a hemoglobin A1c (HbA1c) test during the measurement year.
Measure Steward	National Committee for Quality Assurance
Measure Purpose	Federal reporting requirement of Initial Child Core measures that must be reported with each state's annual CHIP report to CMS.
Eligible Population	Children ages 5 to 17 years old as of December 31 of the measurement year.
Data Source	Claims and encounters from MedInsight, the OMPP data warehouse. Data retrieved May 1, 2013. Both pharmacy data and claim/encounter data should be used.
Sampling Method	N/A
Age	Children ages 5 to 17 years old as of December 31 of the measurement year.
Gender	Male and female
Continuous Enrollment	The measurement year, with an allowable gap of 45 days during this measurement year.
Numerator Elements or Exclusions	Presence of HbA1c test using CPT 83036 or CPT Category II 3044F, 3045F, or 3046F. Codes to identify visit as outpatient, nonacute inpatient, acute inpatient, or ED defined by measure steward. Exclude claims if presence of ICD-9-CM 256.4, 249, 251.8, 962.0, or 648.8 (polycystic ovaries, steroid induced or gestational diabetes).
Denominator Elements or Exclusions	A child need only be identified by either claim or pharmacy data, not both. Children may be identified as having diabetes during the measurement year or the prior year. Codes to identify diabetes are 250, 357.2, 362.0, 366.41 or 648.0. Visits to identify children with diabetes defined by measure steward. Prescriptions to identify children with diabetes defined by measure steward.
Limitations on Data Integrity	No limitations.
Numerator	All patients who have an ER visit AND a diagnosis of asthma.
Denominator	All patients ages 2 to 20, diagnosed with asthma during the measurement period.
Rate	Numerator / Denominator, reported as a percentage
Benchmark	Data compiled over four annual periods will be used to establish a benchmark for OMPP.

APPENDIX D
PROVIDER INTERVIEW PROTOCOL

Interview Questions for Providers Regarding MCE Provider Outreach

Date: _____

Provider Name: _____

Attendees:

							Notes/Comments
1. Which MCEs visited your office in 2012?	Anthem	Yes	No				
	MDWise	Yes	No				
	MHS	Yes	No				
3. How many times did they visit?	Anthem	1	2	3	4	Other:_____	
	MDWise	1	2	3	4	Other:_____	
	MHS	1	2	3	4	Other:_____	
4. Typically, what is the main purpose of the MCE's visit?	Anthem	Billing Questions/ Issues	Education	Quality/ HEDIS	Review reports	Medicaid updates	
		P4P	EPSDT	Lead Screening	Gaps in Care	Other: _____	
	MDWise	Billing Questions/ Issues	Education	Quality/ HEDIS	Review reports	Medicaid updates	
		P4P	EPSDT	Lead Screening	Gaps in Care	Other: _____	
	MHS	Billing Questions/ Issues	Education	Quality/ HEDIS	Review reports	Medicaid updates	
		P4P	EPSDT	Lead Screening	Gaps in Care	Other: _____	
5. Have the MCEs gone over a Gaps in Care Report with you?	Anthem	Yes	No				
	MDWise	Yes	No				
	MHS	Yes	No				
6. Other than the Gaps in Care Report, what type of materials do the MCEs' leave?	Anthem						
	MDWise						
	MHS						

Date: _____

Interview Questions for Providers Regarding MCE Provider Outreach

Provider Name: _____

7. Do you find the materials helpful?	Anthem	Yes	No	Explain:			
	MDWise	Yes	No	Explain:			
	MHS	Yes	No	Explain:			
8. What is the usual approach to setting field visits?	Anthem	Request of Provider	Request of MCE				
	MDWise	Request of Provider	Request of MCE				
	MHS	Request of Provider	Request of MCE				
9. Do you find the agenda set by the MCEs helpful during their site visits?	Anthem	Yes	No	Explain:			
	MDWise	Yes	No	Explain:			
	MHS	Yes	No	Explain:			
10. What do you find that is not helpful about the MCEs' visits or materials?	Anthem						
	MDWise						
	MHS						
11. Do the MCEs follow-up as appropriate after a site visit?	Anthem	Yes	No	Explain:			
	MDWise	Yes	No	Explain:			
	MHS	Yes	No	Explain:			
12. How would you describe the ease at which you are able to reach an appropirate contact at an MCE?	Anthem	Very Easy	Somewhat Easy	Somewhat Difficult	Very Difficult		
	MDWise	Very Easy	Somewhat Easy	Somewhat Difficult	Very Difficult		
	MHS	Very Easy	Somewhat Easy	Somewhat Difficult	Very Difficult		

Interview Questions for Providers Regarding MCE Provider Outreach

Date: _____

Provider Name: _____

13. How do the MCEs assist with cultural competance?	Anthem				
	MDWise				
	MHS				
14. Are the MCEs' helpful if a member needs assistance with language translation?	Anthem	Yes	No	Explain:	
	MDWise	Yes	No	Explain:	
	MHS	Yes	No	Explain:	
15. How do the MCEs assist you with member coordination of care (i.e., between PMP and specialist, or between PH and BH)?	Anthem				
	MDWise				
	MHS				
16. What is your biggest challenge with the Medicaid population and how do the MCEs assist you in overcoming these barriers?	Anthem				
	MDWise				
	MHS				
17. Do you have any suggestions you would like us to present regarding site visits to the OMPP or the MCEs?	OMPP				
	Anthem				
	MDWise				
	MHS				
18. Does your office attend regional meetings held by the OMPP and the MCEs?		Yes	No		
19. Do you find the agenda at these meetings helpful?		Yes	No		
20. Do you have any suggestions you would like us to present regarding regional meetings to the OMPP or the MCEs?	OMPP				
	Anthem				
	MDWise				
	MHS				

APPENDIX E
MENTAL HEALTH COMPLEX CASE MANAGEMENT
CASE REVIEW FILE TOOL USED IN 2013 EQR

MENTAL HEALTH COMPLEX CASE MANAGEMENT CASE FILE REVIEW TOOL Used IN 2013 EQR

Name of MCE *(also specify Delivery System for MDWise)*

Member Last Name | Member First Name

Medicaid RID | Age of Member | Gender

HHW (Hoosier Healthwise) of HIP (Healthy Indiana Plan) | Enrolled with MCE since

Enrolled in Complex Case Management on | Left Complex Case Management on

RN Reviewer Initials | MD Reviewer Initials

Question #		**YES**	**NO**	**N/A**	
1	Are physical health related diagnoses listed in file?				If 'YES' list them:
2	Are mental health related diagnoses listed in file?				If 'YES' list them:
3	Are medications listed in the file?				Comments:
4	Based on the utilization reported by B&A, does it appear that the patient's utilization is *effectively* recorded in the file for:				
	Inpatient hospitalizations				Partially recorded
	Outpatient hospital and/or professional services				Partially recorded
	Pharmacy scripts				Partially recorded

If there is no utilization recorded or the file is missing pertinent utilization, list examples below. Otherwise, proceed to Question 5.

5	Does the Care Plan contain measureable goals?				Comments:

Some of the MHS sample do not have care plans. When this occurs (also possible for Anthem & MDwise), check N/A then proceed to Question 6.

	5a. If yes, does it address MH related diagnoses?				Comments:
	5b. If yes, does it address PH related diagnoses?				Comments:
6	State if there was evidence of care plan coordination with:				
	6a. The patient's Primary Medical Provider				Place X to the right if Unable to confirm
	6b. The patient's Mental Health Provider(s)				Place X to the right if Unable to confirm
7	Was the PMP sent the Care Plan?				Place X to the right if Unable to confirm
8	Were any Mental Health providers sent the Care Plan?				Place X to the right if Unable to confirm

Other findings or comments: