Managed Care Program Annual Report (MCPAR) for Indiana: Pathways for Aging

Due date	Last edited	Edited by	Status
12/27/2025	12/19/2025	Cinthia Gonzales Cruz	Submitted

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected
	Did you submit or do you plan on submitting a Network Adequacy and Access Assurances (NAAAR) Report for this program for this reporting period through the MDCT online tool? If “No”, please complete the following questions under each plan.	Plan to submit on 12/27/2025

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Indiana
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Cinthia Gonzales
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	cinthia.gonzalescruz@fssa.in.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Cinthia Gonzales Cruz
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	cinthia.gonzalescruz@fssa.in.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	12/19/2025

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2024
A5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2025
A6	**Program name** Auto-populated from report dashboard.	Pathways for Aging

Add plans (A.7)

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

	Indicator	Response
	Plan name	Anthem United Healthcare Humana

Add BSS entities (A.8)

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

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

Indicator	Response
BSS entity name	Maximus Health Services Inc.

Add In Lieu of Services and Settings (A.9)

Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** Guidance on In Lieu of Services on Medicaid.gov.

Indicator	Response
ILOS name	Not answered

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	1,953,147
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	1,598,974

Topic III. Encounter Data Report

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

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter "No PI activities were performed during the reporting period" as your response. "N/A" is not an acceptable response.	During the reporting period, focused activities included analysis on ABA therapy, UV lens coating, attendant care and home health.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	8.4 Program Integrity Overpayment Recovery
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard selected in indicator B.X.2.	In cases involving wasteful or abusive provider billing or service practices (including overpayments) identified by the OMPP PI Unit, FSSA may recover any identified overpayment directly from the provider or may require the MCEs to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by the OMPP PI Unit. The OMPP PI Unit may also take disciplinary action against any provider identified by the MCEs or the OMPP PI Unit as engaging in inappropriate or abusive billing or service provision practices. If the fraud referral from an MCE generates an

		action that results in a monetary recovery, the reporting MCE does get a share of the final monetary amount (the contract does allow for the State and MFCU to retain the cost of pursuing the final action). If the State makes a recovery from a fraud investigation and/or corresponding legal action where the MCE has sustained a documented loss but the case did not result from a referral made by the MCE, the State shall not be obligated to repay any monies recovered to the MCE but may do so at its discretion.
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	The MCEs submit monthly, quarterly, and yearly reports that detail ongoing activities and status of overpayments. The reported data includes self-disclosures, self-disclosure recoveries, investigation cases initiated, number of claims at risk, dollars at risk, recoveries from investigations, overpayments recovered, and cost avoidance. Additionally, PI officials meet with each MCE monthly to discuss ongoing activities.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	The Benefit Enrollment and Maintenance (834) file is sent to the health plans on a daily basis to account for changes in status. Additionally, the State sends the health plans a weekly reconciliation file. The MCEs review the files to identify any discrepancies in enrollment. The MCEs are responsible for verifying member eligibility data and reconciling with capitation payments for each eligible member on a monthly basis. If an MCE discovers a discrepancy in eligibility or capitation information, the MCE must notify FSSA and the State fiscal agent within thirty (30) calendar days of discovering the discrepancy and no more than ninety (90) calendar days after FSSA delivers the eligibility records.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider “for cause” terminations in a	Yes

	timely manner under 42 CFR 438.608(a)(4)? Select one.	
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.	No

BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter “No such audits were conducted during the reporting year” as your response. “N/A” is not an acceptable response.	FSSA recognizes the importance of monitoring MCE performance throughout the contract year, and as a result the MCEs are required to submit quarterly encounter data quality reports. Each quarterly report includes year-to-date information and must be verified to a degree of at least ninety-eight percent (98%) completeness for all claims. State actuaries, in collaboration with their OMPP compliance officer, review the report to reconcile whether results differ more than (+/-) 2%, which may result in financial penalties. Further, the State's EQRO completed CMS' Protocol 5: Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan.

Topic XIII. Prior Authorization

Beginning June 2026, Indicators B.XIII.1a-b–2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?**	Yes
BXIII.1a	**Timeframes for standard prior authorization decisions** Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and within state-established timeframes. For rating periods that start before January 1, 2026, a state's time frame may not exceed 14 calendar days after receiving the request. For rating periods that start on or after January 1, 2026, a state's time frame may not exceed 7 calendar days after receiving the request. Does the state set timeframes shorter than these maximum timeframes for standard prior authorization requests?	Yes
BXIII.1b	**State's timeframe for standard prior authorization decisions** Indicate the state's maximum timeframe, as number of days, for plans to provide notice of their decisions on standard prior authorization requests.	5
BXIII.2a	**Timeframes for expedited prior authorization decisions** Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and no later than 72 hours after receipt of the request for service. Does the state set timeframes shorter than the maximum timeframe for expedited prior authorization requests?	Yes
BXIII.2b	**State's timeframe for expedited prior authorization decisions** Indicate the state's maximum timeframe, as number of hours, for plans to provide notice of	48

	their decisions on expedited prior authorization requests.

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Indiana Medicaid has separate contracts with each MCE: Anthem (Contract #82034), Humana (Contract #82035), United Healthcare (Contract #82036)
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	07/01/2024
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Long-term services and supports (LTSS) Dental Transportation
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter “N/A” if not applicable.	The Pathways for Aging program launched July 1, 2024 and enrolls Hoosiers aged 60 and over who receive Medicaid (or Medicaid and Medicare) benefits. The MCEs must provide their Pathways members one of two packages of service. The first, State Plan Medicaid, which includes nursing facilities, home health and hospice care is available to all enrolled individuals. The second, State Plan Medicaid plus Home and Community Based Services (HCBS), is available to all who have been

		determined to meet the nursing facility level of care.
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	117,097
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter “There were no major changes to the population or benefits during the reporting year” as your response. “N/A” is not an acceptable response.	There were no major changes to the population or benefits during the reporting year.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data corrections Overall data accuracy (as determined through data validation) Other, specify – completeness of encounter data
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	In AM01, Section (9.8) Encounter Data Submission and Exhibit 2 Section (6) Encounter Data Quality (previously CRCS) Report

C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	In AM01, within exhibit 2.A, section (7) noncompliance with encounter claims submission requirements and section (11) claim payments.
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	The State may recognize managed care plans that attain superior performance and/or improvement by publicizing their reports, including encounter data quality submissions. The State may seek to reward high performing MCEs through the auto-assignment logic.
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter "The state did not experience any barriers to collecting or validating encounter data during the reporting year" as your response. "N/A" is not an acceptable response.	The State experienced reimbursement challenges with crossover encounters during the reporting period. The State also experienced encounter issues with NPI versus LPI billing, leading to challenges with attendant care and assisted living waiver services. Both collection challenges have been resolved.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident", as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	Critical incidents are defined in accordance with 455 IAC 2-8-2. HCBS critical incidents include but are not limited to, injuries of unknown origin, significant injuries to a member, suicidal ideation or suicide attempt that had the potential to cause physical harm, injury, or death, admission of an individual to a nursing facility (excluding respite stays), member elopement or missing person, inadequate formal or informal support for a member, including inadequate supervision which endangers the member, medication errors resulting in outcomes that require medical treatment beyond an ER/physician evaluation or monitoring vital signs, a residence that compromises the health and safety of a member, environmental or structural problems associated with a dwelling where individuals reside that compromise the health and safety of the individuals, a residential fire, suspected or observed criminal activity, police arrest of a member or any person responsible for the care of the member, a major disturbance or threat to public safety created by a member, any use of restraint that results in harm to the member, and falls with injury, in accordance with the U.S. Center for Disease Control's (CDC) Behavioral Risk Factor Surveillance System (BRFSS).
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	The MCEs must make a decision on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal.
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3),	The MCEs must resolve each expedited appeal within forty-eight (48) hours after receiving notice of the appeal.

	states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	
C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	The MCEs must make a decision on non-expedited grievances as expeditiously as possible, but not more than thirty (30) calendar days following receipt of the grievance.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter "No challenges were encountered" as your response. "N/A" is not an acceptable response.	The MCEs experienced challenges maintaining specialty provider standards including a combination of cardiothoracic surgeons, dentists, diagnostic testing, gynecologists, SUD providers, orthodontists, and interventional radiologists. The MCEs also continue to engage any willing provider for HCBS. In some circumstances, there is a shortage of providers in rural areas making it difficult to meet the defined standard. Details by MCE can be found in the Pathways for Aging NAAAR.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	All three MCEs have an open network. To assist with gaps in the provider networks, Indiana provides the MCEs with access to the State's IHCP portal. The portal allows the MCEs to identify IHCP enrolled providers. Additionally, the State meets with the MCEs on a monthly basis to address and discuss network matters.

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://www.in.gov/medicaid/partners/medicaid-partners/maximus/
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	Member materials must be written at a fifth grade reading level. Alternative formats must be made available; these formats must consider the requirements of the Americans with Disabilities Act and the special needs of those who, for example, may be visually limited or have limited English proficiency. If a member calls with their own TTY services, Maximus will accept those calls and handle those calls as they would any other calls. Also, if a member requests TTY services for hearing impaired members Maximus will refer them to TTY services that are offered.
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	Maximus is the beneficiary support system (BSS) contractor, overseeing both enrollment broker and member support services (MSS) requirements, utilizing separate helplines. The contractor is therefore required to have knowledge and experience in Medicaid and LTSS managed health care delivery systems. Maximus enrollment broker supports member's health plan selection, health plan changes, and disenrollment's. Maximus MSS assists members experiencing issues accessing care, supports the member in navigating issues with their MCE or providers, and provides education on the grievance and appeals process, as well as providing assistance filing a grievance or appeal at the members' request. Helpline staff under both enrollment broker and MSS must be prepared to respond to member questions on the procedures for submitting a member grievance or appeal. If a member requests assistance resolving issues with an MCE or filing a grievance or appeal regarding the services delivered by an MCE and they are speaking to Maximus Enrollment Broker, staff shall facilitate access to the Member Support Services line via “warm” transfer. When the member is speaking with Maximus MSS, the agent will educate the member on the grievance and appeal process,

		give them their rights related to grievances and appeals and will direct the member to call the health plan's member services number to file the appeal, if they choose to do so. Maximus MSS will assist the member with filing the grievance or appeal, when requested. The MCEs must accept verbal appeals facilitated by Maximus MSS, but Maximus MSS cannot represent members in state fair hearings. Maximus MSS provides monthly reporting on their complaints, grievances and appeals related inquiries they received during the month. Lastly, Maximus MSS also immediately escalates any possible critical incidents to OMPP for awareness so OMPP can review and escalate these issues to the MCEs as needed. Maximus MSS is instructed to report to Adult Protective Services (APS) and the long-term care ombudsman as necessary.
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	Oversight of Maximus is completed by a state official that serves as their contract manager. The contract manager ensures that Maximus is completing all the deliverables outlined in the contract and reviews monthly and quarterly reports submitted with performance metrics. Maximus must provide the state with monthly program data, that includes their performance measure and statistics regarding its efficiency and overall operations. The Helpline's call statistics, the number of member enrollments, disenrollment by reason, auto-assignment rate, and grievance data are examples of the types of data within the monthly report. Lastly, Maximus must conduct end-of-call surveys of consumers to evaluate their satisfaction and whether they were given sufficient information on the managed care plan options. The survey must be conducted on a quarterly basis with a minimum of one hundred-fifty (150) completed surveys each quarter.

Topic X: Program Integrity

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

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	**Does this program include MCOs?** If "Yes", please complete the following questions.	Yes
C1XII.5	**Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?** (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	Yes
C1XII.6	**Did the State or MCOs complete the most recent parity analysis(es)?**	State
C1XII.7a	**Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?** (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	No
C1XII.8	**When was the last parity analysis(es) for this program completed?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	11/01/2025
C1XII.9	**When was the last parity analysis(es) for this program**	04/05/2024

	submitted to CMS? States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	
C1XII.10a	**In the last analysis(es) conducted, were any deficiencies identified?**	No
C1XII.12a	**Has the state posted the current parity analysis(es) covering this program on its website?** The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.	No
C1XII.12c	**When will the state post the current parity analysis(es) on its State Medicaid website in accordance with 42 CFR § 438.920(b)(1)?**	01/31/2026

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Anthem** 44,963 **United Healthcare** 37,113 **Humana** 35,021
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? Numerator: Plan enrollment (D1.I.1) Denominator: Statewide Medicaid enrollment (B.I.1)	**Anthem** 2.3% **United Healthcare** 1.9% **Humana** 1.8%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Anthem** 2.8% **United Healthcare** 2.3% **Humana** 2.2%
D1I.4: Parent	**Organization: The name of the parent entity that controls the Medicaid Managed Care Plan.** If the managed care plan is owned or controlled by a separate entity (parent), report the name of that entity. If the managed care plan is not controlled by a separate entity, please report the managed care plan name in this field.	**Anthem** Elevance Health, Inc **United Healthcare** UnitedHealth Group **Humana** Arcadian Health Plan, Inc

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Anthem** N/A **United Healthcare** N/A **Humana** N/A
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Anthem** Program-specific statewide **United Healthcare** Program-specific statewide **Humana** Program-specific statewide
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**Anthem** N/A **United Healthcare** N/A **Humana** N/A
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Anthem** No **United Healthcare**

No

Humana

No

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Anthem** The MCEs must submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week. **United Healthcare** The MCEs must submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week. **Humana** The MCEs must submit via secure FTP a complete batch of encounter data for all adjudicated claims for paid and denied claims and any claims not previously submitted before 5 p.m. Eastern on Wednesday each week.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	**Anthem** N/A **United Healthcare** N/A **Humana** N/A
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting	**Anthem** N/A **United Healthcare**

year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.		N/A **Humana** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Anthem** 274 **United Healthcare** 200 **Humana** 457
D1IV.1a	**Appeals denied** Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.	**Anthem** 161 **United Healthcare** 93 **Humana** 323
D1IV.1b	**Appeals resolved in partial favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.	**Anthem** 8 **United Healthcare** 2 **Humana** 63
D1IV.1c	**Appeals resolved in favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.	**Anthem** 105 **United Healthcare** 105 **Humana** 71
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in	**Anthem** 9

	process (not yet resolved) as of	**United Healthcare** 5 **Humana** 64
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of reporting year by or on behalf applicable. An LTSS user is an one LTSS service at any point (regardless of whether the LTSS at the time that the appeal	**Anthem** 91 **United Healthcare** 204 **Humana** 521
D1IV.4	**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that of critical incidents filed within behalf of) LTSS users who reporting year. If the managed enter “N/A”. Also, if the state the reporting year via the CMS grievance report (because the were new or serving new reporting year), and the submitted for at least 6 months “N/A”. The appeal and critical been “related” to the same been filed by (or on behalf of) critical incident nor the appeal relation to delivery of LTSS — any reason, related to any an LTSS user. To calculate this	**Anthem** 2,758 **United Healthcare** 3,724 **Humana** 2,563

	number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Anthem** 264 **United Healthcare** 98 **Humana** 389
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Anthem** 9 **United Healthcare** 86 **Humana** 62
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Anthem** 262 **United Healthcare** 200 **Humana** 155
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan	**Anthem** 12 **United Healthcare** 0

	during the reporting year that reduction, suspension, or authorized service.	**Humana** 278
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of during the reporting year that denial, in whole or in part, of already rendered.	**Anthem** 0 **United Healthcare** 0 **Humana** 24
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of during the reporting year that failure to provide services in a the state).	**Anthem** 0 **United Healthcare** 0 **Humana** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of during the reporting year that failure to act within the §438.408(b)(1) and (2) regarding grievances and appeals.	**Anthem** 0 **United Healthcare** 0 **Humana** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of during the reporting year that denial of an enrollee's request CFR §438.52(b)(2)(ii), to obtain (only applicable to residents of	**Anthem** 0 **United Healthcare** 0 **Humana** 0

D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Anthem** 0 **United Healthcare** 0 **Humana** 0

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Anthem** 7 **United Healthcare** 12 **Humana** 6
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Anthem** 102 **United Healthcare** 12 **Humana** 4
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**Anthem** 13 **United Healthcare** 1 **Humana** 11
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or	**Anthem** 4 **United Healthcare** 0

	substance use services. If the cover outpatient behavioral	**Humana** 0
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of during the reporting year that prescription drugs covered by managed care plan does not drugs, enter “N/A”.	**Anthem** 134 **United Healthcare** 107 **Humana** 32
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of during the reporting year that the managed care plan does services, enter “N/A”.	**Anthem** 1 **United Healthcare** 1 **Humana** 2
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of LTSS or LTSS provided through (HCBS) services, including services. If the managed care services, enter “N/A”. (Appeals a service already rendered D1.IV.6c).	**Anthem** 1 **United Healthcare** 0 **Humana** 332
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of during the reporting year that If the managed care plan does “N/A”.	**Anthem** 12 **United Healthcare** 14 **Humana**

		6
D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of during the reporting year that managed care plan does not	**Anthem** 0 **United Healthcare** 0 **Humana** 0
D1IV.7k:	**Resolved appeals related to durable medical equipment (DME) & supplies** Enter the total number of during the reporting year that supplies. If the managed care service, enter “N/A”.	**Anthem** 0 **United Healthcare** 51 **Humana** 18
D1IV.7l:	**Resolved appeals related to home health / hospice** Enter the total number of during the reporting year that and/or hospice. If the managed type of service, enter “N/A”.	**Anthem** 0 **United Healthcare** 0 **Humana** 36
D1IV.7m:	**Resolved appeals related to emergency services / emergency department** Enter the total number of during the reporting year that services and/or provided in the include appeals related to behavioral health – those D1.IV.7d. If the managed care service, enter “N/A”.	**Anthem** 0 **United Healthcare** 0 **Humana** 1
D1IV.7n:	**Resolved appeals related to therapies**	**Anthem** 0

	Enter the total number of during the reporting year that language pathology services or respiratory therapy services. If not cover this type of service,	**United Healthcare** 2 **Humana** 1
D1IV.7o	**Resolved appeals related to other service types** Enter the total number of during the reporting year that not fit into one of the managed care plan does not in items D1.IV.7a-n paid “N/A”.	**Anthem** 0 **United Healthcare** 0 **Humana** 8

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.	**Anthem** 2 **United Healthcare** 0 **Humana** 3
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Anthem** 1 **United Healthcare** 0 **Humana** 2
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Anthem** 2 **United Healthcare** 0 **Humana** 3
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Anthem** 0 **United Healthcare** 0 **Humana** 6
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the	**Anthem** 2 **United Healthcare** 0

	reporting year that were the enrollee. If your state does review process, enter defined and described at 42	**Humana** 3
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an process, enter the total number decisions rendered during the adverse to the enrollee. If your medical review process, enter defined and described at 42	**Anthem** 18 **United Healthcare** 0 **Humana** 5

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Anthem** 1,051 **United Healthcare** 191 **Humana** 1,980
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Anthem** 33 **United Healthcare** 11 **Humana** 161
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Anthem** 489 **United Healthcare** 202 **Humana** 2,141
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the	**Anthem** 2,758 **United Healthcare** 3,724 **Humana** 2,563

	same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed the state should enter “N/A” in state already submitted this the CMS readiness review (because the managed care serving new populations during readiness review tool was of the reporting year, the state calculate this number, states or first identify the LTSS users for filed during the reporting year, enrollees had filed a grievance whether the filing of the the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances provided by plan during the §438.408(b)(1) for requirements of grievances.	**Anthem** 1,027 **United Healthcare** 174 **Humana** 1,971

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 49 **United Healthcare** 2 **Humana** 8
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Do not include grievances related to outpatient behavioral health services - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 661 **United Healthcare** 45 **Humana** 35
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 6 **United Healthcare** 0 **Humana** 0
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that	**Anthem** 6 **United Healthcare**

	were related to outpatient substance use services. If the cover this type of service, enter	0 **Humana** 3
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of during the reporting year that prescription drugs covered by managed care plan does not "N/A".	**Anthem** 46 **United Healthcare** 4 **Humana** 106
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of during the reporting year that the managed care plan does enter "N/A".	**Anthem** 9 **United Healthcare** 2 **Humana** 4
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of during the reporting year that LTSS or LTSS provided through (HCBS) services, including services. If the managed care service, enter "N/A".	**Anthem** 74 **United Healthcare** 3 **Humana** 921
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of during the reporting year that If the managed care plan does enter "N/A".	**Anthem** 42 **United Healthcare** 6 **Humana** 24

D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 80 **United Healthcare** 53 **Humana** 128
D1IV.15k	**Resolved grievances related to durable medical equipment (DME) & supplies** Enter the total number of grievances resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 0 **United Healthcare** 9 **Humana** 116
D1IV.15l	**Resolved grievances related to home health / hospice** Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 0 **United Healthcare** 4 **Humana** 6
D1IV.15m	**Resolved grievances related to emergency services / emergency department** Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem** 0 **United Healthcare** 0 **Humana** 4
D1IV.15n	**Resolved grievances related to therapies** Enter the total number of grievances resolved by the plan during the reporting year that	**Anthem** 0 **United Healthcare**

	were related to speech occupational, physical, or the managed care plan does enter “N/A”.	0 **Humana** 6
D1IV.15o	**Resolved grievances related to other service types** Enter the total number of during the reporting year that not fit into one of the managed care plan does not in items D1.IV.15a-n paid “N/A”.	**Anthem** 78 **United Healthcare** 63 **Humana** 619

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service.Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Anthem** 103 **United Healthcare** 19 **Humana** 192
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management.Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Anthem** 228 **United Healthcare** 29 **Humana** 973
D1IV.16c	**Resolved grievances related to network adequacy or access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Anthem** 231 **United Healthcare** 34 **Humana** 538
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care.Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Anthem** 140 **United Healthcare** 48 **Humana** 72
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the	**Anthem** 21

	reporting year that were related to communication grievances include accuracy of enrollee materials or other enrollee's access to or the accessibility communications.	**United Healthcare** 30 **Humana** 23
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances reporting year that were filed for a issues.	**Anthem** 195 **United Healthcare** 19 **Humana** 12
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances reporting year that were related to grievances include suspected cases of by a provider, payer, or other entity. should only include grievances not grievances submitted to another Office of the Inspector General.	**Anthem** 13 **United Healthcare** 0 **Humana** 16
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances reporting year that were related to exploitation. Abuse/neglect/exploitation potential or actual patient harm.	**Anthem** 0 **United Healthcare** 0 **Humana** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a prior authorization/service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances reporting year that were filed due to a	**Anthem** 20 **United Healthcare** 0 **Humana**

	service authorization or appeal request extend appeals).	0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances reporting year that were related to the for an expedited appeal. Per 42 CFR timeframe for timely resolution of than 72 hours after the MCO, PIHP or denies a request for an expedited representative have the right to file a	**Anthem** 0 **United Healthcare** 0 **Humana** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances reporting year that were filed for a above.	**Anthem** 100 **United Healthcare** 12 **Humana** 154

Topic VII: Quality & Performance Measures

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

Quality & performance measure total count: 1

Complete

D2.VII.1 Measure Name: None available. Performance Data will be available in the 2026 MCPAR

1 / 1

D2.VII.2 Measure Domain

None available. Performance Data will be available in the 2026 MCPAR

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

None available. Performance Data will be available in the 2026 MCPAR

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

Yes

D2.VII.8 Measure Description

None available. Performance Data will be available in the 2026 MCPAR

Measure results

Anthem

N/A

United Healthcare

N/A

Humana

N/A

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. The state should include all sanctions the state issued regardless of what entity identified the non-compliance (e.g. the state, an auditing body, the plan, a contracted entity like an external quality review organization).

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

Sanction total count: 24

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

1 / 24

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Humana

D3.VIII.4 Reason for intervention

MCE did not meet deadlines, performance expectations, and its care and service coordination duties. MCE used incorrect and/or unapproved materials.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

02/14/2025

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

Yes, remediated 05/16/2025

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

2 / 24

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Humana

D3.VIII.4 Reason for intervention

MCE was noncompliant with critical incident reporting requirements. MCE was not responsive to care and service coordination duties. MCE was noncompliant with call center requirements.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed
09/19/2024

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 05/29/2025

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Corrective action plan

3 / 24

D3.VIII.2 Plan performance issue
Financial issues

D3.VIII.3 Plan name
Humana

D3.VIII.4 Reason for intervention

MCE was noncompliant with claim payment procedures.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$0

D3.VIII.7 Date assessed
09/19/2024

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 10/27/2025

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Liquidated damages

4 / 24

D3.VIII.2 Plan performance issue
Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name
Humana

D3.VIII.4 Reason for intervention

MCE did not meet reporting requirements in the Q3 2024 encounter data reconciliation report.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

05/28/2025

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

Yes, remediated 06/10/2025

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

5 / 24

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

Humana

D3.VIII.4 Reason for intervention

MCE did not meet reporting requirements in the Q4 2024 encounter data reconciliation report.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

06/30/2025

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

Yes, remediated 07/25/2025

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

6 / 24

D3.VIII.2 Plan performance issue

Financial issues

D3.VIII.3 Plan name

Humana

D3.VIII.4 Reason for intervention

Letter issued to MCE for inaccurate processing and paying of hospice claims.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$0

D3.VIII.7 Date assessed
05/28/2025

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 10/27/2025

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Liquidated damages

7 / 24

D3.VIII.2 Plan performance issue
Contract Noncompliance

D3.VIII.3 Plan name
Humana

D3.VIII.4 Reason for intervention

The MCE had late IQ's throughout February 2025.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$800

D3.VIII.7 Date assessed
03/14/2025

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 04/16/2025

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

8 / 24

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name
United Healthcare

Deadline
Noncompliance

D3.VIII.4 Reason for intervention

MCE missed the implementation deadline of the Waiver Liability Summary

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$0

D3.VIII.7 Date assessed
03/07/2025

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 03/13/2025

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Liquidated damages

9 / 24

D3.VIII.2 Plan performance issue
Contract Noncompliance

D3.VIII.3 Plan name
United Healthcare

D3.VIII.4 Reason for intervention

The MCE had late IQ's throughout February 2025.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$400

D3.VIII.7 Date assessed
03/11/2025

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 03/19/2025

D3.VIII.9 Corrective action plan
No

D3.VIII.1 Intervention type: Liquidated damages

10 / 24

Complete

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

The MCE had late IQ's throughout March 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$400

D3.VIII.7 Date assessed

04/23/2025

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

Yes, remediated 04/28/2025

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

11 / 24

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

The MCE had late IQ's throughout April 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$800

D3.VIII.7 Date assessed

05/28/2025

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

Yes, remediated 06/11/2025

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages 12 / 24

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

The MCE had late IQ's throughout May 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$1,600

D3.VIII.7 Date assessed

06/10/2025

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

Yes, remediated 07/15/2025

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 13 / 24

D3.VIII.2 Plan performance issue

Financial issues

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

MCE did not meet reporting requirements in the Q3 2024 encounter data reconciliation report.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

05/28/2025

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 14 / 24

D3.VIII.2 Plan performance issue

Financial issues

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

Letter issued to MCE for inaccurate processing and paying of hospice claims.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

05/01/2025

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 15 / 24

D3.VIII.2 Plan performance issue

Reporting (timeliness, completeness, accuracy)

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

The MCE erroneously reported data for HCBS services in Q1 2025, causing a large variance in the reconciliation of these funded benefit costs.

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

$0

1

D3.VIII.7 Date assessed

03/11/2025

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

Yes, remediated 04/22/2025

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

16 / 24

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

The MCE used unapproved provider materials.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

06/18/2025

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

Yes, remediated 06/26/2025

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

17 / 24

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

The MCE had late IQ's throughout May 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$400

D3.VIII.7 Date assessed

06/03/2025

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

Yes, remediated 06/27/2025

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

18 / 24

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

The MCE had late IQ's throughout April 2025.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$1,600

D3.VIII.7 Date assessed

05/28/2025

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

Yes, remediated 06/13/2025

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

19 / 24

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

The MCE had late IQ's throughout March 2025.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$800

D3.VIII.7 Date assessed
04/22/2025

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 05/06/2025

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

20 / 24

D3.VIII.2 Plan performance issue
Financial issues

D3.VIII.3 Plan name
Anthem

D3.VIII.4 Reason for intervention

MCE did not meet reporting requirements in the Q3 2024 encounter data reconciliation report.

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$0

D3.VIII.7 Date assessed
05/28/2025

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 06/10/2025

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

21 / 24

D3.VIII.2 Plan performance issue
Financial issues

D3.VIII.3 Plan name
Anthem

D3.VIII.4 Reason for intervention

Letter issued to MCE for inaccurate processing and paying of hospice claims.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

05/01/2025

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

22 / 24

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

United Healthcare

D3.VIII.4 Reason for intervention

MCE used an unapproved PowerPoint, did not accurately complete reporting, and had member helpline issues.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

06/10/2025

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

Yes, remediated 07/25/2025

D3.VIII.9 Corrective action plan

No

D3.VIII.1 Intervention type: Corrective action plan

23 / 24

Complete

D3.VIII.2 Plan performance issue

Financial issues

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

MCE was unresponsive to provider and state inquiries. MCE did not timely adjudicate nursing facility claims. MCE made incorrect LTSS provider payments. MCE incorrectly applied patient liability amount to claims. MCE incorrectly denied claims requiring a Medicare explanation of benefits (EOB).

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

01/15/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

24 / 24

D3.VIII.2 Plan performance issue

Contract Noncompliance

D3.VIII.3 Plan name

Anthem

D3.VIII.4 Reason for intervention

MCE did not timely come into compliance with onsite requirements. MCE was noncompliant with its' community health worker requirements. MCE did not provide their call center staff or member portals with liability information.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$0

D3.VIII.7 Date assessed

04/24/2025

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

Yes, remediated 08/20/2025

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Anthem** 10 **United Healthcare** 3 **Humana** 3
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Anthem** 184 **United Healthcare** 45 **Humana** 25
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Anthem** 20 **United Healthcare** 7 **Humana** 1
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Anthem** Makes referrals to the SMA and MFCU concurrently **United Healthcare** Makes referrals to the SMA and MFCU concurrently **Humana** Makes referrals to the SMA and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state**	**Anthem**

	Enter the count of program made to the state in the past unduplicated referrals.	13 **United Healthcare** 4 **Humana** 2
D1X.9a:	**Plan overpayment reporting to the state: Start Date** What is the start date of the plan's latest overpayment the state?	**Anthem** 07/01/2024 **United Healthcare** 07/01/2024 **Humana** 07/01/2024
D1X.9b:	**Plan overpayment reporting to the state: End Date** What is the end date of the plan's latest overpayment the state?	**Anthem** 06/30/2025 **United Healthcare** 06/30/2025 **Humana** 06/30/2025
D1X.9c:	**Plan overpayment reporting to the state: Dollar amount** From the plan's latest annual what is the total amount of	**Anthem** $66,688,561.93 **United Healthcare** $13,616.08 **Humana** $7,891.02
D1X.9d:	**Plan overpayment reporting to the state: Corresponding premium revenue** What is the total amount of corresponding reporting period as defined in MLR reporting	**Anthem** $0 **United Healthcare** $0 **Humana** $0

Number	Indicator	Response
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Anthem** Daily **United Healthcare** Daily **Humana** Daily

Topic XI: ILOS

Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if "Yes", which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter "0" for utilization.

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**Anthem** Not answered **United Healthcare** Not answered **Humana** Not answered

Topic XIII. Prior Authorization

Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If "Yes", please complete the following questions under each plan.	Not reporting data

Topic XIV. Patient Access API Usage

Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If "Yes", please complete the following questions under each plan.	Not reporting data

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus Health Services Inc.** Ombudsman Program Enrollment Broker Other, specify – member support services (MSS)
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus Health Services Inc.** Enrollment Broker/Choice Counseling Beneficiary Outreach LTSS Complaint Access Point LTSS Grievance/Appeals Education LTSS Grievance/Appeals Assistance Review/Oversight of LTSS Data

Section F: Notes

Notes

Use this section to optionally add more context about your submission. If you choose not to respond, proceed to “Review & submit.”

Number	Indicator	Response
F1	**Notes (optional)**	The State is not reporting any quality measures since the program went live on 7/1/2024 and HEDIS and CAHPS data is not yet available. An MLR is also not available due to the lag. Regarding topic X, program integrity, the State is providing overpayment amounts retained by the MCEs as part of their capitation. Anthem and UHC's overpayments are health plan totals and are not differentiated from the other Medicaid programs they serve. Therefore, the totals are not unique to PathWays for Aging (except Humana). Lastly, critical incidents are reported to the State through a public reporting portal (https://ddrsprovider.fssa.in.gov/IFUR/FollowUp). These are obtained from multiple independent reporting sources, including nursing homes, ATTC providers, case managers, social workers, care coordinators, managed care entities (MCEs), and members' families or neighbors. Since these sources cannot access appeal and grievance history, reliable linkage cannot be done. Therefore, the State is reporting the same data for the overall LTSS critical incident counts that occurred in reporting period.