Managed Care Program Annual Report (MCPAR) for Kentucky: Medicaid Managed Care Organization Contract

Due date	Last edited	Edited by	Status
06/28/2024	07/05/2024	Jeremy Armstrong-DeRossitt	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.	Selected

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Kentucky
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.	Jeremy Armstrong-DeRossitt
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	jeremy.armstrong@ky.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Jeremy Armstrong-DeRossitt
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	jeremy.armstrong@ky.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	07/05/2024

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2023
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2023
A6	**Program name** Auto-populated from report dashboard.	Medicaid Managed Care Organization Contract

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	Aetna Better Health Anthem Blue Cross/Blue Shield Humana Healthy Horizons Passport by Molina United Healthcare Community Plan WellCare of KY

Add BSS entities (A.8)

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

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

Indicator	Response
BSS entity name	MMIS Department for Community Based Services Integrated Enrollment and Eligibility System (IEES)

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.	1,652,205
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.	1,501,270

Topic III. Encounter Data Report

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

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter 'No PI activities were performed during the reporting period' as your response. 'N/A' is not an acceptable response.	The Kentucky Department for Medicaid Services (DMS) utilizes the Unified Program Integrity Contractor to identify overpayments in areas of pharmacy, hospital, etc. DMS also utilizes HFPP studies and HFPP fraud trend alerts to run data analytics for KY Medicaid providers.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Section 34. Program Integrity and Appendix J. Program Integrity Requirements
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	If the Department performs or contracts with an entity that performs audits of Claims paid by the Contractor and identifies an Overpayment, then the Department shall send notice to the Contractor and collect and retain any Overpayment. The Contractor shall remit the amount or balance of the provider Overpayment within ninety (90) days. If the Contractor identifies the overpayment they are able to retain. If the Department identifies the overpayment then the state retains.

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.	MCO's submit a monthly report on identified provider overpayments and is reviewed and monitored by state specific program integrity staffing in conjunction with oversight from the division of health plan oversight. MCO's are contractually required to obtain the Departments approval to administratively collect overpayments in excess of five hundred dollars ($500). DMS receives multiple reports from each MCO plan for monitoring overpayments discovered. PI-02 monitors quarterly overpayment collections; CP-06 monitors overpayment accounts that have reached 180 days. The PI-06 monthly report is submitted by MCOs to provide monthly updates on case/investigations statuses and to report on any identified overpayments. Prior to overpayments being recouped, MCOs must obtain permission from DMS Program Integrity to begin recoveries.
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).	1. Data Reporting Requirements: The state mandates that managed care plans report enrollment changes promptly. This includes changes such as enrollees becoming incarcerated, deceased, or switching plans. Plans are required to submit these updates within specific timelines to the state, typically within five (5) business days. 2. Automated Matching and Verification: The state employs automated systems that compare eligibility and enrollment data for incarcerations, death match tasks and tasks for requests to switch enrollment plans. This automated matching helps identify discrepancies or mismatches in member data. 3. Validation and Correction Processes: Upon receiving enrollment updates from managed care plans, the state validates the information for accuracy. This involves cross-referencing with other state databases (e.g., corrections department for incarcerated individuals, vital statistics for deceased enrollees), or outreach to the member/family to ensure the changes are legitimate. 4. Timely Notifications: Managed care plans are required to notify the state promptly of any changes in enrollee status that could affect payments. 5. Regular Reconciliation Cycles: The state establishes regular monthly reconciliation cycles for its eligibility and enrollment records. The managed care contractors are responsible

		to reconcile enrollee payment and submit corrections to the state within forty-five (45) days. This ensures that any discrepancies are identified and corrected promptly. 6. Resolution of Discrepancies: When discrepancies are found, the state initiates a resolution process. This may involve requesting additional documentation from managed care plans to verify the status change or conducting further investigation if discrepancies persist. 7. Policy and Procedure Compliance: Both the state and managed care plans adhere to established policies and procedures for enrollment reporting and reconciliation. These policies outline responsibilities, reporting timelines, and steps to be taken in case of discrepancies. 8. Audits and Monitoring: The state conducts audits and monitoring activities to ensure compliance with enrollment reconciliation processes. Audits may be scheduled or triggered by specific events (e.g., high discrepancy rates) to assess the accuracy and timeliness of enrollment data. 9. Training and Support: The state provides training and support to managed care plans on enrollment reporting requirements and reconciliation processes. The state also holds monthly operations meetings with each of the managed care contractors. This helps ensure that plans understand their obligations, can comply effectively, and has open access to KY Medicaid for reporting, questions, comments, or concerns.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities**	No

	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.	
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	No
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter 'No such audits were conducted during the reporting year' as your response. 'N/A' is not an acceptable response.	No such audits were conducted during the reporting year.

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.	Medicaid Managed Care Contract & Medicaid Manage Care Contract w/SKY (Aetna 1/1/2021)
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	1/1/2021 effective date
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.chfs.ky.gov/agencies/dms/dpqo/Pages/mco-contracts.aspx
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Dental Transportation
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per	1,501,270

	month during the reporting year (i.e., average member months).	
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter 'There were no major changes to the population or benefits during the reporting year' as your response. 'N/A' is not an acceptable response.	Implementation of 12-month child continuous coverage effective 10/01/2023. Implementation of 12-month post-partum coverage effective 1/01/2023.

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).	Other, specify – Accuracy, Completeness, and Timeliness
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.	16.1 Encounter Data Submission: In accordance with the terms of this Contract and all applicable state and federal laws, the Contractor shall submit complete, accurate, and timely Encounter Data to the Department within thirty (30) Days of Claim adjudication. This includes all paid and denied Claims, corrected Claims, adjusted Claims, voided Claims, and zero dollars ($0) paid Claims processed by the Contractor or by its Subcontractors.
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	16.1 Encounter Data Submission: Timeliness: The Contractor shall submit encounter data for all Claims within thirty (30) calendar days of adjudication. Completeness: The Contractor shall submit Encounters for all services received by Enrollees and for which the Contractor has incurred a claim or any financial liability, whether directly or through

	standards. Use contract section references, not page numbers.	subcontracts or other payment arrangements. The Contractor's weekly electronic Encounter data submission shall include all adjudicated (paid and denied) Claims, corrected Claims, and adjusted Claims processed by the Contractor and meet or exceed a submitted and accepted rate of ninety-eight percent (98%), as evaluated on a quarterly basis. The completeness penalties set forth in Appendix A "Remedies for Violation, Breach, or Non-Performance of Contract" will not be assessed for the first two (2) quarters following implementation of the Encounter Data Monitoring template used to determine compliance. Accuracy: The Contractor shall submit Encounter data accurately in the required file formats with all data elements completed. Encounter File transmissions that exceed a five percent (5%) threshold error rate (total Claims/documents in error equal to or exceeding five percent (5%) of Claims/documents records submitted) will be subject to penalties as set forth in Appendix A "Remedies for Violation, Breach, or Non-Performance of Contract." Encounter File transmissions with a threshold error rate not exceeding five percent (5%) will be accepted and processed by the Department. Only those Erred Encounters will be returned to the Contractor for correction and resubmission. Denied Claims submitted for Encounter processing will not be held to normal edit requirements and rejections of denied Claims will not count towards the minimum five percent (5%) rejection. Appendix A - ATTACHMENT C - Medicaid Managed Care Contract and Appendices - Encounter Data - Penalty Amounts.
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.	N/A
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating	The state did not experience any barriers to collecting or validating encounter data during the reporting year.

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.

Topic IV. Appeals, State Fair Hearings & Grievances

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

day the MCO, PIHP or PAHP receives 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.	There is a divide between what the State gets reported from the MCOs concerning Network Adequacy and feedback we receive from Enrollees that find it sometimes difficult to make timely appointments. Access to Dentists is one area we have looked at recently.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	In cooperation with our EQRO, we conduct annual Access and Availability Surveys that uses a secret shopper approach to gauge the ability of an Enrollee to make a timely appointments as dictated by the existing contract. Those guidelines follow closely with CMS direction. Corrective Action is used to address any deficiencies. We have recently developed a report that looks at Providers who have not submitted a claim for Medicaid Enrollees in the past 365 days. That report is in the early data submission stage, but we hope as that gets reported quarterly, it will allow us to have a better idea of the gaps that exist in the MCO Network. By making the MCOs aware of these claim submission issues, we hope that they are better able to communicate with those Providers in question.

Access Measures

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

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

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

Access measure total count: 2

Complete

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

1 / 2

C2.V.2 Measure standard

Appointment wait time

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Varies by Contract year.	All Regions included	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: Exception to quantitative standard

2 / 2

C2.V.2 Measure standard

Time or Distance

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Multiple Specialties	All Regions included	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

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.	Aetna: https://www.aetnabetterhealth.com/kentucky/member-portal.html, Anthem: https://mss.anthem.com/ky/benefits/medicaid-benefits.html, Humana: https://www.humana.com/medicaid/kentucky-medicaid, Passport by Molina: https://www.molinahealthcare.com/members/ky/en-us/Pages/home.aspx, United Healthcare: https://www.uhccommunityplan.com/ky/medicaid/community-plan, WellCare: https://www.wellcare.com/kentucky
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.	MCOs are committed to making their websites accessible to all plan participants, including those with visual, hearing, mobility, and other disabilities. MCO's routinely monitor and test the functionality.
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	N/A
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?	Testing, Quality Checks, Contract Monitoring of functionality and access.

Topic X: Program Integrity

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

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Aetna Better Health** 247,264 **Anthem Blue Cross/Blue Shield** 181,057 **Humana Healthy Horizons** 166,787 **Passport by Molina** 329,604 **United Healthcare Community Plan** 95,102 **WellCare of KY** 481,456
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)	**Aetna Better Health** 15% **Anthem Blue Cross/Blue Shield** 11% **Humana Healthy Horizons** 10.1% **Passport by Molina** 19.9% **United Healthcare Community Plan** 5.8% **WellCare of KY** 29.1%

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)	**Aetna Better Health** 16.5% **Anthem Blue Cross/Blue Shield** 12.1% **Humana Healthy Horizons** 11.1% **Passport by Molina** 22% **United Healthcare Community Plan** 6.3% **WellCare of KY** 32.1%

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.	**Aetna Better Health** 90% **Anthem Blue Cross/Blue Shield** 90% **Humana Healthy Horizons** 90% **Passport by Molina** 90% **United Healthcare Community Plan** 90% **WellCare of KY** 90%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Aetna Better Health** Program-specific statewide **Anthem Blue Cross/Blue Shield** Program-specific statewide **Humana Healthy Horizons** Program-specific statewide **Passport by Molina** Program-specific statewide **United Healthcare Community Plan** Program-specific statewide **WellCare of KY** 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.	**Aetna Better Health** N/A **Anthem Blue Cross/Blue Shield** N/A **Humana Healthy Horizons** N/A **Passport by Molina** N/A **United Healthcare Community Plan** N/A **WellCare of KY** 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?	**Aetna Better Health** No **Anthem Blue Cross/Blue Shield** No **Humana Healthy Horizons** No **Passport by Molina** No **United Healthcare Community Plan** No **WellCare of KY** 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.	**Aetna Better Health** Failure to submit an Encounter File with all of the Encounters within 30 days from the adjudication date. Failure to resubmit erred encounter records within 60 days from receipt of the 277U Erred Record Report. Failure to submit Encounter File within 5 business days from the scheduled submission due date (weekly Friday) **Anthem Blue Cross/Blue Shield** Failure to submit an Encounter File with all of the Encounters within 30 days from the adjudication date. Failure to resubmit erred encounter records within 60 days from receipt of the 277U Erred Record Report. Failure to submit Encounter File within 5 business days from the scheduled submission due date (weekly Friday) **Humana Healthy Horizons** Failure to submit an Encounter File with all of the Encounters within 30 days from the adjudication date. Failure to resubmit erred encounter records within 60 days from receipt of the 277U Erred Record Report. Failure to submit Encounter File within 5 business days from the scheduled submission due date (weekly Friday) **Passport by Molina** Failure to submit an Encounter File with all of the Encounters within 30 days from the adjudication date. Failure to resubmit erred encounter records within 60 days from receipt of the 277U Erred Record Report. Failure to submit Encounter File within 5 business days from the scheduled submission due date (weekly Friday) **United Healthcare Community Plan** Failure to submit an Encounter File with all of the Encounters within 30 days from the adjudication date. Failure to resubmit erred encounter records within 60 days from receipt

of the 277U Erred Record Report. Failure to submit Encounter File within 5 business days from the scheduled submission due date (weekly Friday)

WellCare of KY

Failure to submit an Encounter File with all of the Encounters within 30 days from the adjudication date. Failure to resubmit erred encounter records within 60 days from receipt of the 277U Erred Record Report. Failure to submit Encounter File within 5 business days from the scheduled submission due date (weekly Friday)

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.

Aetna Better Health

98%

Anthem Blue Cross/Blue Shield

97.5%

Humana Healthy Horizons

99%

Passport by Molina

99%

United Healthcare Community Plan

97.5%

WellCare of KY

99%

D1III.3

Share of encounter data submissions that were HIPAA compliant

What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance?
If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter

Aetna Better Health

100%

Anthem Blue Cross/Blue Shield

100%

Humana Healthy Horizons

100%

here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	**Passport by Molina** 100% **United Healthcare Community Plan** 100% **WellCare of KY** 100%

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.	**Aetna Better Health** 25,190 **Anthem Blue Cross/Blue Shield** 48,268 **Humana Healthy Horizons** 13,289 **Passport by Molina** 22,105 **United Healthcare Community Plan** 5,800 **WellCare of KY** 6,541
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**Aetna Better Health** 1,570 **Anthem Blue Cross/Blue Shield** 1,070 **Humana Healthy Horizons** 654 **Passport by Molina** 2,453 **United Healthcare Community Plan** 547 **WellCare of KY** 115

D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	**Aetna Better Health** N/A **Anthem Blue Cross/Blue Shield** N/A **Humana Healthy Horizons** N/A **Passport by Molina** N/A **United Healthcare Community Plan** N/A **WellCare of KY** N/A
D1IV.4	**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”. Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”. The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the	**Aetna Better Health** N/A **Anthem Blue Cross/Blue Shield** N/A **Humana Healthy Horizons** N/A **Passport by Molina** N/A **United Healthcare Community Plan** N/A **WellCare of KY** N/A

same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.
To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

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.

Aetna Better Health

23,620

Anthem Blue Cross/Blue Shield

32,658

Humana Healthy Horizons

13,023

Passport by Molina

21,389

United Healthcare Community Plan

5,687

WellCare of KY

6,521

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.

Aetna Better Health

1,664

Anthem Blue Cross/Blue Shield

367

Humana Healthy Horizons

266

		Passport by Molina 916 **United Healthcare Community Plan** 113 **WellCare of KY** 20
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).	**Aetna Better Health** 12,764 **Anthem Blue Cross/Blue Shield** 17,064 **Humana Healthy Horizons** 2,219 **Passport by Molina** 2,696 **United Healthcare Community Plan** 127 **WellCare of KY** 112
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Aetna Better Health** 10,284 **Anthem Blue Cross/Blue Shield** 13,756 **Humana Healthy Horizons** 564 **Passport by Molina** 592

		United Healthcare Community Plan 515 **WellCare of KY** 268
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Aetna Better Health** 586 **Anthem Blue Cross/Blue Shield** 15,432 **Humana Healthy Horizons** 8,637 **Passport by Molina** 16,839 **United Healthcare Community Plan** 4,623 **WellCare of KY** 5,854
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Aetna Better Health** 1,527 **Anthem Blue Cross/Blue Shield** 168 **Humana Healthy Horizons** 1,218 **Passport by Molina** 1,106 **United Healthcare Community Plan** 268

WellCare of KY

119

D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Aetna Better Health** 26 **Anthem Blue Cross/Blue Shield** 583 **Humana Healthy Horizons** 176 **Passport by Molina** 298 **United Healthcare Community Plan** 89 **WellCare of KY** 89
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**Aetna Better Health** 2 **Anthem Blue Cross/Blue Shield** 223 **Humana Healthy Horizons** 319 **Passport by Molina** 139 **United Healthcare Community Plan** 58 **WellCare of KY**

34

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.	**Aetna Better Health** 0 **Anthem Blue Cross/Blue Shield** 590 **Humana Healthy Horizons** 156 **Passport by Molina** 235 **United Healthcare Community Plan** 120 **WellCare of KY** 65

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".	**Aetna Better Health** 562 **Anthem Blue Cross/Blue Shield** 845 **Humana Healthy Horizons** 3,289 **Passport by Molina** 2,278 **United Healthcare Community Plan** 346 **WellCare of KY** 1,567
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Aetna Better Health** 286 **Anthem Blue Cross/Blue Shield** 3,609 **Humana Healthy Horizons** 1,573 **Passport by Molina** 3,615 **United Healthcare Community Plan** 222 **WellCare of KY** 569

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".	**Aetna Better Health** 376 **Anthem Blue Cross/Blue Shield** 1,527 **Humana Healthy Horizons** 2,218 **Passport by Molina** 1,867 **United Healthcare Community Plan** 198 **WellCare of KY** 321
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**Aetna Better Health** 1,146 **Anthem Blue Cross/Blue Shield** 1,869 **Humana Healthy Horizons** 2,945 **Passport by Molina** 2,219 **United Healthcare Community Plan** 397 **WellCare of KY** 118
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs**	**Aetna Better Health** 0

	Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**Anthem Blue Cross/Blue Shield** 69 **Humana Healthy Horizons** 734 **Passport by Molina** 376 **United Healthcare Community Plan** 115 **WellCare of KY** 49
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Aetna Better Health** N/A **Anthem Blue Cross/Blue Shield** N/A **Humana Healthy Horizons** N/A **Passport by Molina** N/A **United Healthcare Community Plan** N/A **WellCare of KY** N/A
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that	**Aetna Better Health** N/A **Anthem Blue Cross/Blue Shield**

	were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	N/A **Humana Healthy Horizons** N/A **Passport by Molina** N/A **United Healthcare Community Plan** N/A **WellCare of KY** N/A
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**Aetna Better Health** 672 **Anthem Blue Cross/Blue Shield** 2,968 **Humana Healthy Horizons** 623 **Passport by Molina** 3,248 **United Healthcare Community Plan** 369 **WellCare of KY** 615
D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	**Aetna Better Health** 126 **Anthem Blue Cross/Blue Shield** 301 **Humana Healthy Horizons**

389

Passport by Molina

164

United Healthcare Community Plan

117

WellCare of KY

126

D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i paid primarily by Medicaid, enter "N/A".	**Aetna Better Health** 83 **Anthem Blue Cross/Blue Shield** 1,820 **Humana Healthy Horizons** 1,892 **Passport by Molina** 1,908 **United Healthcare Community Plan** 235 **WellCare of KY** 438

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**Aetna Better Health** 2 **Anthem Blue Cross/Blue Shield** 4 **Humana Healthy Horizons** 0 **Passport by Molina** 1 **United Healthcare Community Plan** 2 **WellCare of KY** 4
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.	**Aetna Better Health** 0 **Anthem Blue Cross/Blue Shield** 0 **Humana Healthy Horizons** 0 **Passport by Molina** 0 **United Healthcare Community Plan** 2 **WellCare of KY** 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.	**Aetna Better Health** 2 **Anthem Blue Cross/Blue Shield** 4 **Humana Healthy Horizons** 0 **Passport by Molina** 1 **United Healthcare Community Plan** 0 **WellCare of KY** 2
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.	**Aetna Better Health** 0 **Anthem Blue Cross/Blue Shield** 0 **Humana Healthy Horizons** 0 **Passport by Molina** 0 **United Healthcare Community Plan** 0 **WellCare of KY** 0
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee**	**Aetna Better Health** 1,328

	If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Anthem Blue Cross/Blue Shield** 1,327 **Humana Healthy Horizons** 1,974 **Passport by Molina** 872 **United Healthcare Community Plan** 1,297 **WellCare of KY** 834
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Aetna Better Health** 169 **Anthem Blue Cross/Blue Shield** 1,893 **Humana Healthy Horizons** 293 **Passport by Molina** 427 **United Healthcare Community Plan** 219 **WellCare of KY** 265

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Aetna Better Health** 1,721 **Anthem Blue Cross/Blue Shield** 1,438 **Humana Healthy Horizons** 688 **Passport by Molina** 2,511 **United Healthcare Community Plan** 1,522 **WellCare of KY** 1,048
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.	**Aetna Better Health** 102 **Anthem Blue Cross/Blue Shield** 35 **Humana Healthy Horizons** 26 **Passport by Molina** 39 **United Healthcare Community Plan** 81 **WellCare of KY** 46

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.	**Aetna Better Health** N/A **Anthem Blue Cross/Blue Shield** N/A **Humana Healthy Horizons** N/A **Passport by Molina** N/A **United Healthcare Community Plan** N/A **WellCare of KY** N/A
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should	**Aetna Better Health** N/A **Anthem Blue Cross/Blue Shield** N/A **Humana Healthy Horizons** N/A **Passport by Molina** N/A **United Healthcare Community Plan** N/A **WellCare of KY** N/A

	enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Aetna Better Health** 1,619 **Anthem Blue Cross/Blue Shield** 1,403 **Humana Healthy Horizons** 662 **Passport by Molina** 2,472 **United Healthcare Community Plan** 1,441 **WellCare of KY** 1,002

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".	**Aetna Better Health** 34 **Anthem Blue Cross/Blue Shield** 32 **Humana Healthy Horizons** 36 **Passport by Molina** 112 **United Healthcare Community Plan** 46 **WellCare of KY** 226
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health** 62 **Anthem Blue Cross/Blue Shield** 68 **Humana Healthy Horizons** 15 **Passport by Molina** 56 **United Healthcare Community Plan** 116 **WellCare of KY** 329

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".	**Aetna Better Health** 38 **Anthem Blue Cross/Blue Shield** 132 **Humana Healthy Horizons** 126 **Passport by Molina** 184 **United Healthcare Community Plan** 89 **WellCare of KY** 615
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health** 121 **Anthem Blue Cross/Blue Shield** 213 **Humana Healthy Horizons** 294 **Passport by Molina** 237 **United Healthcare Community Plan** 229 **WellCare of KY** 734
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs**	**Aetna Better Health** 15

	Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Anthem Blue Cross/Blue Shield** 22 **Humana Healthy Horizons** 98 **Passport by Molina** 47 **United Healthcare Community Plan** 32 **WellCare of KY** 163
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health** N/A **Anthem Blue Cross/Blue Shield** N/A **Humana Healthy Horizons** N/A **Passport by Molina** N/A **United Healthcare Community Plan** N/A **WellCare of KY** N/A
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional	**Aetna Better Health** N/A **Anthem Blue Cross/Blue Shield**

	LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	N/A **Humana Healthy Horizons** N/A **Passport by Molina** N/A **United Healthcare Community Plan** N/A **WellCare of KY** N/A
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health** 87 **Anthem Blue Cross/Blue Shield** 158 **Humana Healthy Horizons** 117 **Passport by Molina** 207 **United Healthcare Community Plan** 113 **WellCare of KY** 592

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".	**Aetna Better Health** 13 **Anthem Blue Cross/Blue Shield** 16 **Humana Healthy Horizons** 113 **Passport by Molina** 129 **United Healthcare Community Plan** 65 **WellCare of KY** 187
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i paid primarily by Medicaid, enter "N/A".	**Aetna Better Health** 87 **Anthem Blue Cross/Blue Shield** 110 **Humana Healthy Horizons** 229 **Passport by Molina** 319 **United Healthcare Community Plan** 228 **WellCare of KY** 1,083

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.	**Aetna Better Health** 26 **Anthem Blue Cross/Blue Shield** 113 **Humana Healthy Horizons** 126 **Passport by Molina** 45 **United Healthcare Community Plan** 21 **WellCare of KY** 116
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.	**Aetna Better Health** 65 **Anthem Blue Cross/Blue Shield** 64 **Humana Healthy Horizons** 86 **Passport by Molina** 26 **United Healthcare Community Plan** 13 **WellCare of KY** 89

D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Aetna Better Health** 42 **Anthem Blue Cross/Blue Shield** 86 **Humana Healthy Horizons** 219 **Passport by Molina** 45 **United Healthcare Community Plan** 18 **WellCare of KY** 218
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.	**Aetna Better Health** 13 **Anthem Blue Cross/Blue Shield** 43 **Humana Healthy Horizons** 35 **Passport by Molina** 14 **United Healthcare Community Plan** 25 **WellCare of KY** 49
D1IV.16e	**Resolved grievances related to plan communications**	**Aetna Better Health** 52

	Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Anthem Blue Cross/Blue Shield** 18 **Humana Healthy Horizons** 46 **Passport by Molina** 23 **United Healthcare Community Plan** 36 **WellCare of KY** 38
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**Aetna Better Health** 354 **Anthem Blue Cross/Blue Shield** 136 **Humana Healthy Horizons** 189 **Passport by Molina** 187 **United Healthcare Community Plan** 86 **WellCare of KY** 293
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that	**Aetna Better Health** 29 **Anthem Blue Cross/Blue Shield**

	were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	82 **Humana Healthy Horizons** 25 **Passport by Molina** 13 **United Healthcare Community Plan** 12 **WellCare of KY** 86
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Aetna Better Health** 6 **Anthem Blue Cross/Blue Shield** 43 **Humana Healthy Horizons** 18 **Passport by Molina** 18 **United Healthcare Community Plan** 18 **WellCare of KY** 36
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved by the plan during the reporting year that	**Aetna Better Health** 37 **Anthem Blue Cross/Blue Shield** 129 **Humana Healthy Horizons**

	were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	15 **Passport by Molina** 14 **United Healthcare Community Plan** 23 **WellCare of KY** 27
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Aetna Better Health** 3 **Anthem Blue Cross/Blue Shield** 69 **Humana Healthy Horizons** 21 **Passport by Molina** 8 **United Healthcare Community Plan** 65 **WellCare of KY** 52
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Aetna Better Health** 127 **Anthem Blue Cross/Blue Shield** 328 **Humana Healthy Horizons** 319 **Passport by Molina**

127

United Healthcare Community Plan

142

WellCare of KY

222

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: 5

Complete

D2.VII.1 Measure Name: AAP Adult Access

1 / 5

D2.VII.2 Measure Domain

Primary care access and preventative care

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

Unknown

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

N: 225 D: 411 R: 57.91%

Anthem Blue Cross/Blue Shield

N: 222 D: 409 R: 57.95%

Humana Healthy Horizons

N: 189 D: 411 R: 48.66%

Passport by Molina

N: 34780 D: 69283 R: 50.50%

United Healthcare Community Plan

N: 126 D: 411 R: 42.09%

WellCare of KY

N: 190 D: 411 R: 47.93%

Complete

D2.VII.1 Measure Name: PPC Timeliness of Prenatal care

2 / 5

D2.VII.2 Measure Domain

Maternal and perinatal health

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

Unknown

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

N: 264 D: 411 R: 80.29%

Anthem Blue Cross/Blue Shield

N: 181 D: 270 R: 84.81%

Humana Healthy Horizons

N: 269 D: 411 R: 76.16%

Passport by Molina

N: 284 D: 411 R: 73.48%

United Healthcare Community Plan

N: 254 D: 411 R: 80.05%

WellCare of KY

N: 232 D: 411 R: 76.89%

Complete

D2.VII.1 Measure Name: CDC Diabetes HbA1c Poor Control (>9.0%)

3 / 5

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

Unknown

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

N: 65 D: 411 R: 30.90%

Anthem Blue Cross/Blue Shield

N: 95 D: 411 R: 36.50%

Humana Healthy Horizons

N: 76 D: 411 R: 32.12%

Passport by Molina

N: 163 D: 411 R: 50.36%

United Healthcare Community Plan

N: 117 D: 411 R: 39.17%

WellCare of KY

N: 100 D: 411 R: 39.42%

Complete

D2.VII.1 Measure Name: ADD Follow up care for children prescribed ADHD

4 / 5

D2.VII.2 Measure Domain

Behavioral health care

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

Unknown

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

N: 240 D: 415 R: 57.83%

Anthem Blue Cross/Blue Shield

N: 61 D: 121 R: 50.41%

Humana Healthy Horizons

N: 78 D: 157 R: 49.68%

Passport by Molina

N: 214 D: 436 R: 49.08%

United Healthcare Community Plan

N: 0 D: 0 R: 0

WellCare of KY

N: 387 D: 684 R: 56.57%

Complete

D2.VII.1 Measure Name: ADV Annual Dental Visit Total Rate

5 / 5

D2.VII.2 Measure Domain

Dental and oral health services

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

Unknown

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

N: 61499 D: 114491 R: 53.71%

Anthem Blue Cross/Blue Shield

N: 18034 D: 44694 R: 40.34%

Humana Healthy Horizons

N: 21299 D: 46713 R: 45.59%

Passport by Molina

N: 64642 D: 129232 R: 50.02%

United Healthcare Community Plan

N: 703 D: 2891 R: 24.31%

WellCare of KY

N: 93738 D: 174825 R: 53.61%

Topic VIII. Sanctions

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

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

Sanction total count: 71

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

1 / 71

D3.VIII.2 Intervention topic

Program Integrity - 2 full time investigators who are 100% dedicated to Kentucky.

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

Appendix A; 74 Failure to meet the provisions regarding two (2) full time investigators located in the United States with their caseload 100% dedicated to the Kentucky Medicaid Market

Sanction details

D3.VIII.5 Instances of non-compliance

18

D3.VIII.6 Sanction amount

$150,000

D3.VIII.7 Date assessed

03/22/2023

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

Yes, remediated 04/07/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

2 / 71

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

21.4 EQR PerformanceTIf during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding or deficiency is identified, the Contractor shall respond to and correct the finding or deficiency in a timely manner in accordance with guidelines established by the Department and EQRO

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

N/A

1

D3.VIII.7 Date assessed

02/20/2023

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

Yes, remediated 02/20/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

3 / 71

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

Appendix A; 79:Failure to provide a required report or deliverable set forth in Appendix C, Reporting Requirements and Reporting Deliverables" in the required timeframe; for which submission is incomplete or incorrect; or failure to resolve identified reporting or deliverable errors within five (5) Business Days or other required timelines upon notification by the Department

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$500

D3.VIII.7 Date assessed

03/13/2023

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

Yes, remediated 04/13/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

4 / 71

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

35.2 Reporting Requirements and Standards, “The Contractor shall verify and ensure the accuracy, completeness and timely submission of each report, data and other information provided to the Department

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/06/2023

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

Yes, remediated 03/20/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

5 / 71

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

4.3 Delegations of Authority, and 15.1 Contractor MIS.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/16/2023

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

Yes, remediated 04/06/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

6 / 71

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name

Reporting | Aetna Better Health

D3.VIII.4 Reason for intervention

Appendix A; 73: Failure to respond to informational or reporting requests whether recurring or a one-time request from the Department, the OIG, the OAG, or any other agent or contractor of the Department within the timeframe requested

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$500

D3.VIII.7 Date assessed

04/12/2023

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

Yes, remediated 05/12/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

7 / 71

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

34.0 Program Integrity F. Responding to informational or reporting requests timely;

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/05/2023

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

Yes, remediated 06/05/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
Aetna Better Health

D3.VIII.4 Reason for intervention

34.1 Program Integrity 7. Suspension and escrow of payments to a Network Providers for which the Department has notified the Contractor that there is a credible allegation of Fraud in accordance with 42 C.F.R. 455.23 and report payment suspension information quarterly in a manner determined by the Department. Appendix K. Program Integrity Requirements IV. Complaint System (j) Upon approval of the Department, Contractor shall suspend and escrow Provider payments in accordance with Section 6402 (h)(2) of the Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;

Sanction details

D3.VIII.5 Instances of non-compliance
2

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
05/09/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 06/10/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
Aetna Better Health

D3.VIII.4 Reason for intervention

Appendix K. Program Integrity Requirements IV. Complaint System (j) If the OIG investigation results in a referral to the MFCU and/or the U.S. Attorney, the OIG will notify the Department and the PIU of the referral. The Department and the PIU shall only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral

Sanction details

D3.VIII.5 Instances of non-compliance
2

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
10/31/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 11/30/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

10 / 71

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
Aetna Better Health

D3.VIII.4 Reason for intervention

26.13 Monitoring Compliance with Network Adequacy and Access Requirements and 26.4 Provider Network Access and Adequacy

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
08/04/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 09/04/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

11 / 71

D3.VIII.2 Intervention topic
Program Integrity requirement relating to conducting 3 provider on-site visits quarterly.

D3.VIII.3 Plan name
Aetna Better Health

D3.VIII.4 Reason for intervention

34.0 Program Integrity B. Conducting a minimum of three (3) on-site visits per quarter and Appendix K. Program Integrity Requirements II Function (aa) Conduct a minimum of three (3) on-site visits per quarter related to investigations of suspected fraud and abuse. The site visit shall be approved within a minimum (10) calendar days by the Department;

Sanction details

D3.VIII.5 Instances of non-compliance

9

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/07/2023

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

12 / 71

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

Appendices 78; Failure to provide a required report or deliverable set fourth in Appendix C, Reporting Requirements and Reporting Deliverables in the required timeframe; for which submission is incomplete or incorrect; or failure to resolve identified reporting or deliverable errors within five (5) Business days or other required timelines upon notification by the Department

Sanction details

D3.VIII.5 Instances of non-compliance

9

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/07/2023

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

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

34.0 (E) Program Integrity Plan, "Effective lines of communication between the Compliance Officer and the Contractor's employees; 34.0 (H) Program Integrity Plan, "Ensuring formal case tracking and case management of provider and Enrollee cases; 34.0 (J) Program Integrity Plan, "Meeting the requirements of Appendix K Program Integrity Requirements."

Sanction details

D3.VIII.5 Instances of non-compliance

9

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/19/2023

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

Yes, remediated 01/22/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

34.1 Program Integrity Amendment 3, The contractor is required to submit the PI Plan at a minimum of one (1) time each calendar year, the first of which is due by January 31, to the Division of Program Integrity ("DPI")

Sanction details

D3.VIII.5 Instances of non-compliance

9

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

11/21/2023

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

Yes, remediated 01/22/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

15 / 71

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

21.4 EQR Performance If during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding or deficiency is identified, the Contractor shall respond to and correct the finding or deficiency in a timely manner in accordance with guidelines established by the Department and EQRO.

Sanction details

D3.VIII.5 Instances of non-compliance

15

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/10/2023

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: Civil monetary penalty

16 / 71

D3.VIII.2 Intervention topic

Provider Complaints

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

Appendix A; 73: Failure to respond to informational or reporting requests whether recurring or a one-time request from the Department, the OIG, the OAG, or any other agent or contractor of the Department within the timeframe requested

Sanction details

D3.VIII.5 Instances of non-compliance

15

D3.VIII.6 Sanction amount

$21,000

D3.VIII.7 Date assessed

02/21/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

Appendix A; 79: Failure to provide a required report or deliverable set forth in Appendix C, Reporting Requirements and Reporting Deliverables" in the required timeframe; for which submission is incomplete or incorrect; or failure to resolve identified reporting or deliverable errors within five (5) Business Days or other required timelines upon notification by the Department.

Sanction details

D3.VIII.5 Instances of non-compliance

15

D3.VIII.6 Sanction amount

$250

D3.VIII.7 Date assessed

01/26/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Intervention topic

Subcontractor Oversight

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

4.3 Delegations of Authority: If the Contractor delegates responsibilities to a Subcontractor, the Contractor shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6. The Contractor shall ensure that the Subcontractor is in compliance with all Medicaid laws and regulations including applicable sub regulatory guidance and contract provisions and 15.1 Contractor MIS: "The Contractor shall meet all system requirements, including, but not limited to, required testing, as directed by the Department. Upon request by the Department, the Contractor shall participate in Joint Application Development sessions for system or policy changes."

Sanction details

D3.VIII.5 Instances of non-compliance

15

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

04/06/2023

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

Yes, remediated 05/06/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

D3.VIII.2 Intervention topic

Escrow release

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

37.4 Penalties for Failure to Correct (B) Other Penalties, "Should the Contractor have repeated contractual violations for a similar deficiency, the Department may impose additional penalties as follows: 1. First (1st) Offense: $5,000 per determination."

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

09/07/2023

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

Yes, remediated 10/06/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

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D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

26.13 Monitoring Compliance with Network Adequacy and Access Requirements and 26.4 Provider Network Access and Adequacy

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/07/2023

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

Yes, remediated 10/06/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

21 / 71

D3.VIII.2 Intervention topic

Late payment posting

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

Department of Medicaid Services Managed Care Organization Contract 29.0 Pharmacy Benefits and MedImpact HealthCare Systems, Inc. (“MedImpact”) Contract 4.4 Failure of Client to Pay Timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

10/24/2023

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

Yes, remediated 11/24/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

22 / 71

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

Appendices 78; Failure to provide a required report or deliverable set fourth in Appendix C, Reporting Requirements and Reporting Deliverables in the required timeframe; for which submission is incomplete or incorrect; or failure to resolve identified reporting or deliverable errors within five (5) Business days or other required timelines upon notification by the Department

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/07/2023

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

Yes, remediated 11/07/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

23 / 71

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

34.0 Program Integrity F. Responding to informational or reporting requests timely;

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

10/31/2023

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

Yes, remediated 01/01/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

24 / 71

D3.VIII.2 Intervention topic

Failure to resolve enrollee appeals and grievance within the required timeframe.

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

Appendix C: 46; Failure to resolve Enrollee appeals and grievances within required timeframes as set fourth in Section 24.0 “Enrollee Grievances and Appeals”

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

10/24/2023

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

Yes, remediated 12/01/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

25 / 71

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name

Provider Complaints | Humana Healthy Horizons

D3.VIII.4 Reason for intervention

16.1 Encounter Data Submission In accordance with the terms of this Contract and all applicable state and federal laws, the Contractor shall submit complete, accurate, and timely Encounter Data to the Department within thirty (30) Days of Claim adjudication. This includes all paid and denied Claims, corrected Claims, adjusted Claims, voided Claims, and zero dollars ($0) paid Claims processed by the Contractor or by its Subcontractors and 15.1 Contractor MIS The Contractor shall maintain a Management Information System (MIS) that will provide support for all aspects of a managed care operation to include the following subsystems: Enrollee, Third Party Liability, provider, reference, Encounter/Claims processing, financial, utilization data/ Quality Improvement and Surveillance Utilization Review Subsystem

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/14/2023

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

Yes, remediated 02/23/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

26 / 71

D3.VIII.2 Intervention topic

Provider suspension escrow

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

34.0 (E) Program Integrity Plan, “Effective lines of communication between the Compliance Officer and the Contractor’s employees; 34.0 (H) Program Integrity Plan, “Ensuring formal case tracking and case management of provider and Enrollee cases; 34.0 (J) Program Integrity Plan, “Meeting the requirements of Appendix K Program Integrity Requirements.”

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

N/A

2

D3.VIII.7 Date assessed

11/21/2023

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

Yes, remediated 01/23/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

27 / 71

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

34.0 Program Integrity F. Responding to informational or reporting requests timely; J. Meeting the requirements of Appendix K "Program Integrity Requirements"

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/11/2023

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

Yes, remediated 03/01/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

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D3.VIII.2 Intervention topic

Provider termination

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

Appendix A; 76: Failure to submit or comply with the requirements of the Department-approved Program Integrity Plan specific program integrity reporting

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$1,000

D3.VIII.7 Date assessed

11/21/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

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D3.VIII.2 Intervention topic

Provider Termination

D3.VIII.3 Plan name

Humana Healthy Horizons

D3.VIII.4 Reason for intervention

34.0 Program Integrity Appendix K. IV Complaint System (i) If the OIG investigation results in a referral to the MFCU and/or the U.S. Attorney, the OIG will notify the Department and the PIU of the referral. The Department and the PIU shall only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

11/21/2023

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

Yes, remediated 02/12/2024

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

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D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

WellCare of KY

D3.VIII.4 Reason for intervention

21.4 EQR Performance If during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding or deficiency is identified, the Contractor shall respond to and correct the finding or deficiency in a timely manner in accordance with guidelines established by the Department and EQRO

Sanction details

D3.VIII.5 Instances of non-compliance

14

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/10/2023

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

Yes, remediated 02/10/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

31 / 71

D3.VIII.2 Intervention topic

Subcontractor oversight

D3.VIII.3 Plan name

WellCare of KY

D3.VIII.4 Reason for intervention

4.3 Delegations of Authority: If the Contractor delegates responsibilities to a Subcontractor, the Contractor shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6. The Contractor shall ensure that the Subcontractor is in compliance with all Medicaid laws and regulations including applicable sub regulatory guidance and contract provisions. 15.1 Contractor MIS: "The Contractor shall meet all system requirements, including, but not limited to, required testing, as directed by the Department. Upon request by the Department, the Contractor shall participate in Joint Application Development sessions for system or policy changes

Sanction details

D3.VIII.5 Instances of non-compliance

14

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

04/06/2023

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

Yes, remediated 05/30/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

32 / 71

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

WellCare of KY

D3.VIII.4 Reason for intervention

Section 26.13 Monitoring Compliance with Network Adequacy and Access Requirements and Section 26.4 Provider Network Access and Adequacy

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/07/2023

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

Yes, remediated 12/15/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

33 / 71

D3.VIII.2 Intervention topic

Contract requirement

D3.VIII.3 Plan name

WellCare of KY

D3.VIII.4 Reason for intervention

under Appendix A; 69: Failure of the Contractor’s PIU to conduct a minimum of three (3) site visits per calendar quarter.

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$20,000

D3.VIII.7 Date assessed

07/18/2023

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

Yes, remediated 10/01/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

34 / 71

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

WellCare of KY

D3.VIII.4 Reason for intervention

Appendices 78; Failure to provide a required report or deliverable set fourth in Appendix C, Reporting Requirements and Reporting Deliverables in the required timeframe; for which submission is incomplete or incorrect; or failure to resolve identified reporting or deliverable errors within five (5) Business days or other required timelines upon notification by the Department

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/19/2023

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

Yes, remediated 12/31/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

35 / 71

D3.VIII.2 Intervention topic

Stand down orders

D3.VIII.3 Plan name

WellCare of KY

D3.VIII.4 Reason for intervention

37.0 Program Integrity, and 37.1 Program Integrity Plan

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

10/24/2023

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

Yes, remediated 12/23/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

36 / 71

D3.VIII.2 Intervention topic

Provider Escrow Suspension

D3.VIII.3 Plan name

WellCare of KY

D3.VIII.4 Reason for intervention

34.0 € Program Integrity Plan, "Effective lines of communication between the Compliance Officer and the Contractor's employees; 34.0 (H) Program Integrity Plan, "Ensuring formal case tracking and case management of provider and Enrollee cases; 34.0 (J) Program Integrity Plan, "Meeting the requirements of Appendix K Program Integrity Requirements."

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

10/24/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

37 / 71

D3.VIII.2 Intervention topic

RFI issue

D3.VIII.3 Plan name

WellCare of KY

D3.VIII.4 Reason for intervention

34.0 Program Integrity (F) and (J); F: Responding to informational or reporting requests timely; J: Meeting the requirements of Appendix K: Program Integrity Requirements"

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

10/24/2023

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

Yes, remediated 12/23/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

D3.VIII.2 Intervention topic

Grievances and Appeals

D3.VIII.3 Plan name

WellCare of KY

D3.VIII.4 Reason for intervention

Appendix A; 46: Failure to comply with all orders and final decisions relating to claim disputes, grievances, appeals and or State Fair Hearings as issued or as directed by the Department and set forth in Section 22.0 "Enrollee Grievances and Appeals"

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

11/07/2023

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

Yes, remediated 12/23/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Intervention topic

Grievance and Appeals

D3.VIII.3 Plan name

WellCare of KY

D3.VIII.4 Reason for intervention

25.10 Provider Grievances and Appeals; A Provider who has exhausted the Contractor's internal appeal process shall have a right to a final Denial, in whole or in part, by the Contractor to an external independent third party in accordance with applicable state laws and regulations, including Denials, in whole or in part, involving Emergency Services. The Contractor shall provide written notification to the Provider of its rights to file an appeal. A Provider shall have a right to Appeal a final decision by an external independent third party to the Cabinet for Health and Family Services Division of Administrative Hearings for a hearing in accordance with applicable state laws and regulations. If the Provider prevails, in whole or in part, the Contractor shall comply with any Final Order within sixty (60) days unless the Final Order designates a different timeframe

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/11/2023

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

Yes, remediated 03/01/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Anthem Blue Cross/Blue Shield

D3.VIII.4 Reason for intervention

21.4 EQR Performance - Partially Met metrics

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

1

N/A

D3.VIII.7 Date assessed

02/08/2023

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

Yes, remediated 02/23/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

41 / 71

D3.VIII.2 Intervention topic

Failure to respond timely to the Department request.

D3.VIII.3 Plan name

Anthem Blue Cross/Blue Shield

D3.VIII.4 Reason for intervention

37.4 Penalties for Failure to Correct and Appendix A (11)

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$5,500

D3.VIII.7 Date assessed

02/14/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

42 / 71

D3.VIII.2 Intervention topic

Credentialing timelines

D3.VIII.3 Plan name

Anthem Blue Cross/Blue Shield

D3.VIII.4 Reason for intervention

27.7 Provider credentialing & recredentialing. MCO went through a system configuration, which resulted in a backlog of provider applications, and processing of the applications fell outside of the required credentialing timeframes

Sanction details

D3.VIII.5 Instances of non-compliance

362

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/14/2023

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

Yes, remediated 06/01/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

43 / 71

D3.VIII.2 Intervention topic

Program Integrity

D3.VIII.3 Plan name

Anthem Blue Cross/Blue Shield

D3.VIII.4 Reason for intervention

37.4 penalties for failure to correct. PI requested records regarding for OIG regarding a MFCU provider and response was late.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

02/23/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

44 / 71

D3.VIII.2 Intervention topic

Program Integrity

D3.VIII.3 Plan name

Anthem Blue Cross/Blue Shield

D3.VIII.4 Reason for intervention

37.4 penalties for failure to correct. PI requested records regarding for OIG regarding a MFCU provider and response was late.

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$10,000

D3.VIII.7 Date assessed

03/15/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

45 / 71

D3.VIII.2 Intervention topic

Third Party Liability or Other Health Insurance

D3.VIII.3 Plan name

Anthem Blue Cross/Blue Shield

D3.VIII.4 Reason for intervention

37.4 Penalties for failure to correct. TPL submitted a dire need request to MCO. MCO response was late.

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$20,000

D3.VIII.7 Date assessed

05/01/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

46 / 71

D3.VIII.2 Intervention topic

D3.VIII.3 Plan name

Timely access | Anthem Blue Cross/Blue Shield

D3.VIII.4 Reason for intervention

26.13 Monitoring Compliance with Network Adequacy & Access Requirements; 26.4 Provider Network Access & Availability

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

06/15/2023

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

Yes, remediated 11/01/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

47 / 71

D3.VIII.2 Intervention topic

Program Integrity

D3.VIII.3 Plan name

Anthem Blue Cross/Blue Shield

D3.VIII.4 Reason for intervention

34.0 Program Integrity (H) and (E) Escrow Funds Release

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

08/03/2023

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

Yes, remediated 10/16/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

48 / 71

D3.VIII.2 Intervention topic
External Independent Third Party Review

D3.VIII.3 Plan name
Anthem Blue Cross/Blue Shield

D3.VIII.4 Reason for intervention

907 KAR 17:035 Section 2 (3&7). EIR not submitted within designated timeframe

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
11/13/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 01/22/2024

D3.VIII.9 Corrective action plan
No

D3.VIII.1 Intervention type: Civil monetary penalty

D3.VIII.2 Intervention topic
Program Integrity

D3.VIII.3 Plan name
Anthem Blue Cross/Blue Shield

D3.VIII.4 Reason for intervention

37.4 Repeat Violation (1st)

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$5,000

D3.VIII.7 Date assessed
09/18/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 05/10/2024

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Intervention topic
Performance improvement

D3.VIII.3 Plan name
Passport by Molina

D3.VIII.4 Reason for intervention

21.4 EQR Performance

Sanction details

D3.VIII.5 Instances of non-compliance
10

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
02/08/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 03/13/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Intervention topic
Performance improvement

D3.VIII.3 Plan name
Passport by Molina

D3.VIII.4 Reason for intervention

21.4 EQR Performance

Sanction details

D3.VIII.5 Instances of non-compliance
10

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
02/08/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 03/13/2023

D3.VIII.9 Corrective action plan
Yes

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Intervention topic

Subcontractor

D3.VIII.3 Plan name

Passport by Molina

D3.VIII.4 Reason for intervention

4.3 Delegations of Authority / 15.1 Contractor MIS

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/09/2023

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

Yes, remediated 05/09/2023

D3.VIII.9 Corrective action plan

No

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Intervention topic

Third Party Liability or Other Health Insurance

D3.VIII.3 Plan name

Passport by Molina

D3.VIII.4 Reason for intervention

14.2 Third Party Liability

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/13/2023

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

Yes, remediated 05/17/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Intervention topic

Program Integrity

D3.VIII.3 Plan name

Passport by Molina

D3.VIII.4 Reason for intervention

34.1 Program Integrity and Appendix K

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/01/2023

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

Yes, remediated 09/29/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Passport by Molina

D3.VIII.4 Reason for intervention

26.13 Monitoring Compliance with Network Adequacy & Access Requirements / 26.4 Provider Network Access & Availability

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

06/15/2023

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

Yes, remediated 08/17/2023

D3.VIII.9 Corrective action plan

Yes

D3.VIII.1 Intervention type: Corrective action plan

56 / 71

D3.VIII.2 Intervention topic

Program Integrity

D3.VIII.3 Plan name

Passport by Molina

D3.VIII.4 Reason for intervention

Appendix K. IV Complaint System (i)

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

10/03/2023

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

Yes, remediated 11/09/2023

D3.VIII.9 Corrective action plan

Yes

D3.VIII.1 Intervention type: Corrective action plan

57 / 71

D3.VIII.2 Intervention topic

Pharmacy Benefit Manager - MedImpact

D3.VIII.3 Plan name

Passport by Molina

D3.VIII.4 Reason for intervention

29.0 Pharmacy Benefits and 4.4 Failure to Client to Pay Timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

08/03/2023

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

Yes, remediated 11/30/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Intervention topic
Subcontractor

D3.VIII.3 Plan name
Passport by Molina

D3.VIII.4 Reason for intervention

4.3 Delegations of Authority

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
10/03/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 10/05/2023

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Intervention topic
Program Integrity

D3.VIII.3 Plan name
Passport by Molina

D3.VIII.4 Reason for intervention

36.1 Program Integrity (h)

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
07/17/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 08/17/2023

D3.VIII.9 Corrective action plan
No

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

United Healthcare Community Plan

D3.VIII.4 Reason for intervention

21.4 EQR Performance / partially met items

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/08/2023

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

Yes, remediated 03/13/2023

D3.VIII.9 Corrective action plan

Yes

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

United Healthcare Community Plan

D3.VIII.4 Reason for intervention

21.4 EQR Performance / Non-Met Items

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/08/2023

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

Yes, remediated 03/13/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

D3.VIII.2 Intervention topic
Program Integrity

D3.VIII.3 Plan name
United Healthcare Community Plan

D3.VIII.4 Reason for intervention

37.4 penalties for failure to correct; repeat violation (1st)

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
$5,000

D3.VIII.7 Date assessed
03/15/2023

D3.VIII.8 Remediation date non-compliance was corrected
No, no remediation

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
United Healthcare Community Plan

D3.VIII.4 Reason for intervention

15.1 Contractor MIS

Sanction details

D3.VIII.5 Instances of non-compliance
2

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
03/21/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 06/27/2023

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
United Healthcare Community Plan

D3.VIII.4 Reason for intervention

37.4 Penalties for failure to correct; repeat violation (2nd & 3rd)

Sanction details

D3.VIII.5 Instances of non-compliance
3

D3.VIII.6 Sanction amount
$20,000

D3.VIII.7 Date assessed
05/01/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 08/01/2023

D3.VIII.9 Corrective action plan
Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Intervention topic
Performance improvement

D3.VIII.3 Plan name
United Healthcare Community Plan

D3.VIII.4 Reason for intervention

26.13 Monitoring Compliance with Network adequacy and access requirements; 26.4 provider network access & availability

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
06/15/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 08/17/2023

D3.VIII.9 Corrective action plan
No

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Intervention topic

Program Integrity

D3.VIII.3 Plan name

United Healthcare Community Plan

D3.VIII.4 Reason for intervention

Appendix K. II. Program Integrity Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

10/03/2023

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

Yes, remediated 04/26/2024

D3.VIII.9 Corrective action plan

Yes

D3.VIII.1 Intervention type: Civil monetary penalty

D3.VIII.2 Intervention topic

Missed deadline reporting

D3.VIII.3 Plan name

United Healthcare Community Plan

D3.VIII.4 Reason for intervention

Appendix A. Remedies for Violations, Breach, Non-Performance (11)

Sanction details

D3.VIII.5 Instances of non-compliance

7

D3.VIII.6 Sanction amount

$4,500

D3.VIII.7 Date assessed

10/10/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

Yes

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Intervention topic

Program Integrity

D3.VIII.3 Plan name

United Healthcare Community Plan

D3.VIII.4 Reason for intervention

34.0 Program Integrity Plan (h) and 34.1 Program Integrity Plan (e): Release of escrow funds

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/17/2023

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

Yes, remediated 11/09/2023

D3.VIII.9 Corrective action plan

No

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Intervention topic

Pharmacy Benefit Manager - MedImpact

D3.VIII.3 Plan name

United Healthcare Community Plan

D3.VIII.4 Reason for intervention

29.0 Pharmacy Benefits and 4.4 Failure of Client to Pay Timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

08/03/2023

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

Yes, remediated 11/09/2023

D3.VIII.9 Corrective action plan

No

D3.VIII.1 Intervention type: Civil monetary penalty

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

United Healthcare Community Plan

D3.VIII.4 Reason for intervention

Appendix A. Remedies for Violations, Breach, Non-Performance (77)

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$25,000

D3.VIII.7 Date assessed

07/24/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

D3.VIII.1 Intervention type: Civil monetary penalty

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

United Healthcare Community Plan

D3.VIII.4 Reason for intervention

37.4 Repeat Violation (4th, 5th, and 6th offense)

Sanction details

D3.VIII.5 Instances of non-compliance

6

D3.VIII.6 Sanction amount

$60,000

D3.VIII.7 Date assessed

08/10/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

Yes

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Aetna Better Health** 3 **Anthem Blue Cross/Blue Shield** 3 **Humana Healthy Horizons** 2 **Passport by Molina** 5 **United Healthcare Community Plan** 3 **WellCare of KY** 3
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Aetna Better Health** 2 **Anthem Blue Cross/Blue Shield** 1 **Humana Healthy Horizons** 6 **Passport by Molina** 4 **United Healthcare Community Plan** 1 **WellCare of KY** 0

D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Aetna Better Health** 0.0084:1,000 **Anthem Blue Cross/Blue Shield** 0.0053975:1,000 **Humana Healthy Horizons** 0.037:1,000 **Passport by Molina** 0.01:1,000 **United Healthcare Community Plan** 0.01077586:1,000 **WellCare of KY** 0:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Aetna Better Health** 3 **Anthem Blue Cross/Blue Shield** 1 **Humana Healthy Horizons** 2 **Passport by Molina** 0 **United Healthcare Community Plan** 1 **WellCare of KY** 0
D1X.5	**Ratio of resolved program integrity investigations to enrollees**	**Aetna Better Health** 0.011:1,000

	What is the ratio of program integrity investigations resolved by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Anthem Blue Cross/Blue Shield** 0.0053975:1,000 **Humana Healthy Horizons** 0.011:1,000 **Passport by Molina** 0:1,000 **United Healthcare Community Plan** 0.01077586:1,000 **WellCare of KY** 0:1,000
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Aetna Better Health** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Anthem Blue Cross/Blue Shield** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Humana Healthy Horizons** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Passport by Molina** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **United Healthcare Community Plan** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **WellCare of KY** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals made during the reporting year.	**Aetna Better Health** 1 **Anthem Blue Cross/Blue Shield** 1 **Humana Healthy Horizons** 0 **Passport by Molina** 0 **United Healthcare Community Plan** 0 **WellCare of KY** 0
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.	**Aetna Better Health** 0.0042:1,000 **Anthem Blue Cross/Blue Shield** 0.0053975:1,000 **Humana Healthy Horizons** 0:1,000 **Passport by Molina** 0:1,000 **United Healthcare Community Plan** 0:1,000 **WellCare of KY** 0:1,000
D1X.9	**Plan overpayment reporting to the state**	**Aetna Better Health** 151,872.48

	Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, at minimum, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 42 CFR 438.8(f)(2).	**Anthem Blue Cross/Blue Shield** 283,727.05 **Humana Healthy Horizons** 29,436,022.17 **Passport by Molina** 473,208.52 **United Healthcare Community Plan** 7,371,943.78 **WellCare of KY** 860,257.05
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Aetna Better Health** Monthly **Anthem Blue Cross/Blue Shield** Monthly **Humana Healthy Horizons** Promptly when plan receives information about the change **Passport by Molina** Monthly **United Healthcare Community Plan** Monthly **WellCare of KY** Weekly

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).	**MMIS** State Government Entity **Department for Community Based Services** State Government Entity **Integrated Enrollment and Eligibility System (IEES)** State Government Entity
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).	**MMIS** Other, specify – MMIS is the Medicaid Information System that contains members eligibility, claims, and provider data. **Department for Community Based Services** Other, specify – Determines member eligible for Medicaid Programs. **Integrated Enrollment and Eligibility System (IEES)** Other, specify – Integrated enrollment and eligibility system that communicates to DMS' KY MMIS system for source of truth.