

Managed Care Program Annual Report (MCPAR) for Massachusetts: Behavioral Health Vendor (PIHP)

Due date	Last edited	Edited by	Status
06/29/2023	06/29/2023	Alison Kirchgasser	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.	Massachusetts
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.	Alison Kirchgasser
A2b	Contact email address Enter email address. Department or program-wide email addresses ok.	alison.kirchgasser@mass.gov
A3a	Submitter name CMS receives this data upon submission of this MCPAR report.	Alison Kirchgasser
A3b	Submitter email address CMS receives this data upon submission of this MCPAR report.	alison.kirchgasser@mass.gov
A4	Date of report submission CMS receives this date upon submission of this MCPAR report.	06/29/2023

Reporting Period

Number	Indicator	Response
A5a	Reporting period start date Auto-populated from report dashboard.	01/01/2022
A5b	Reporting period end date Auto-populated from report dashboard.	12/31/2022
A6	Program name Auto-populated from report dashboard.	Behavioral Health Vendor (PIHP)

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	Massachusetts Behavioral Health Partnership

Add BSS entities (A.8)

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

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

Indicator	Response
BSS entity name	Maximus
	Automated Health Systems (AHS)
	My Ombudsman (MYO)

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	Statewide Medicaid enrollment Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled.	2,324,510
BI.2	Statewide Medicaid managed care enrollment Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or more than one managed care plan.	1,643,380

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

Topic X: Program Integrity

Number	Indicator	Response
BX.1	<p>Payment risks between the state and plans</p> <p>Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program.</p> <p>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.</p>	<p>The MassHealth Program Integrity Unit and Compliance Unit met quarterly with MBHP to discuss contract management and topics related to controls against fraud, waste and abuse, including but not limited to recent trends, audits, overpayment issues, reporting, and best practices for program integrity controls. In addition, MassHealth reviewed MBHP's fraud and abuse reporting, in order to ensure compliance with applicable contract requirements and to ensure MBHP has appropriate controls in place. In addition, in Contract Year 2022 MassHealth developed strengthened MBHP contractual provisions related to controls against fraud, waste and abuse, program integrity reporting, and enforcement of overpayment requirements, which will become effective in 2023. These new provisions will establish consistency in program integrity requirements across all of MassHealth's managed care entities. The contractual requirements will support MassHealth's ongoing expansion of MBHP oversight, which may include direct audits of MBHP providers and encounters beginning in Contract Year 2024 for dates of service in 2023. Further, MassHealth is launching new MBHP Summary of Provider Overpayments Reporting in July 2023. MassHealth is publishing new, extremely detailed reporting requirements along with a new reporting template. This is a semi-annual report that includes all overpayments identified during the prior Contract Year through present, including all investigatory and recovery activity related to such overpayments. These reports will provide MassHealth with comprehensive information related to the impact of MBHP's controls, including the breadth of provider types reviewed and methodologies employed; the number and amount of overpayments identified and recovered by MBHP; the reasons for overpayments; next steps and actions taken; and claim-level detail to enable validation of recovery activity in the encounter data and financial reporting. In Contract Year 2022, MassHealth's primary focus was on development of these new reporting requirements. Moving forward, the information contained in the new Summary of Provider</p>

Overpayments reports will enable MassHealth to share best practices, monitor performance management, and enforce the relevant contract provisions related to overpayments that the plans fail to identify and/or recover.

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).	3.7.H.3.s
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 Contractor identifies an overpayment prior to EOHHS, The Contractor shall recover the overpayment and may retain any overpayments collected. The Contractor shall report the date of identification and collection, if any, quarterly on the Fraud and Abuse report. In the event no action toward collection of overpayments is taken by the Contractor one hundred and eighty (180) days after identification, EOHHS may begin collection activity and shall retain any overpayments collected. If EOHHS identifies an overpayment prior to the Contractor EOHHS may explore options up to and including recovering the overpayment from the Contractor.
BX.5	State overpayment reporting monitoring Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is	MassHealth reviews all overpayment reports for compliance, performance management, and best practices, including but not limited to the Semi-Annual Fraud and Abuse Activity report and the Fraud Referrals and Response reports.

asking the state how it monitors that reporting.

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).	EOHHS performs a monthly reconciliation of the Estimated Monthly BH Covered Services Capitation Payment Amount against the actual number of Covered Individual months by RC, as determined by EOHHS using the methodology described in Section 4.3.A.
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.	Yes
BX.7c	Changes in provider circumstances: Describe metric Describe the metric or indicator that the state uses.	When the Contractor terminates or suspends a Network Provider from its Network, or rejects a potential provider’s application to join the Network, based on such Provider’s termination or suspension with MassHealth, Medicare, or another state’s Medicaid program, a state or federal licensing action, or based on any other independent action, the Contractor shall notify EOHHS of the Network Provider termination, suspension or rejection, and the reason thereof, within three business days.
BX.8a	Federal database checks: Excluded person or entities During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any	No

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).	Yes
BX.9b	Website posting of 5 percent or more ownership control: Link What is the link to the website? Refer to 42 CFR 602(g)(3).	https://www.mass.gov/info-details/managed-care-entity-disclosure-of-ownership-and-control-addendum-information
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, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	MassHealth will begin audits in 2023.

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C11.1	Program contract Enter the title of the contract between the state and plans participating in the managed care program.	Contract for The MassHealth PCC Plan's Comprehensive Behavioral Health Program and Management Support Services, and Behavioral Health Specialty Programs
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	10/01/2012
C11.2	Contract URL Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.mass.gov/lists/masshealth-behavioral-health-carve-out-vendor-bh-vendor-contract
C11.3	Program type What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Prepaid Inpatient Health Plan (PIHP)
C11.4a	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
C11.4b	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
C11.5	Program enrollment Enter the total number of individuals enrolled in the managed care program as of	688,383

the first day of the last month
of the reporting year.

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.

There were no changes to the population or
benefits in Calendar Year 2022.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	<p>Uses of encounter data</p> <p>For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more.</p> <p>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)).</p>	<p>Rate setting</p> <p>Quality/performance measurement</p> <p>Monitoring and reporting</p> <p>Contract oversight</p> <p>Program integrity</p> <p>Policy making and decision support</p>
C1III.2	<p>Criteria/measures to evaluate MCP performance</p> <p>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.</p> <p>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).</p>	<p>Timeliness of initial data submissions</p> <p>Timeliness of data corrections</p> <p>Use of correct file formats</p> <p>Overall data accuracy (as determined through data validation)</p>
C1III.3	<p>Encounter data performance criteria contract language</p> <p>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.</p>	<p>Section 9.5</p>

C1III.4	Financial penalties contract language Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	Sections 11.1.D & 11.2.C
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 managed care plan encounter data that the state has experienced during the reporting period.	No barriers are present currently.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	<p>State's definition of "critical incident," as used for reporting purposes in its MLTSS program</p> <p>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.</p>	N/A
C1IV.2	<p>State definition of "timely" resolution for standard appeals</p> <p>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.</p>	For standard resolution of Internal Appeals and notice to the affected parties, no more than 30 calendar days from the date the Contractor received either in writing or orally, whichever comes first, the Covered Individual request for an Internal Appeal unless the timeframe is extended under applicable contract provisions.
C1IV.3	<p>State definition of "timely" resolution for expedited appeals</p> <p>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.</p>	For expedited resolution of Internal Appeals and notice to affected parties, no more than 72 hours from the date the Contractor received the expedited Internal Appeal unless this timeframe is extended under applicable contract provisions.

C1IV.4	State definition of "timely" resolution for grievances Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	For the standard resolution of Grievances and notice to affected parties, no more than 30 calendar days from the date the Contractor received the Grievance, either orally or in writing, from a valid party, e.g., the Covered Individual or the Covered Individual's authorized Appeal Representative
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Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	Gaps/challenges in network adequacy What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	There is limited numbers of providers for certain services in certain regions of the Commonwealth including the west and southeast regions.
C1V.2	State response to gaps in network adequacy How does the state work with MCPs to address gaps in network adequacy?	The state is engaging in multi-pronged efforts to increase the numbers of providers of behavioral health services, including through loan repayment, provider training and professional development opportunities and other workforce initiatives.

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.



Complete

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

1 / 7

C2.V.2 Measure standard

The plan must provide at least 90% of covered individual with two providers within 60 miles or 60 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider

Adult Inpatient
mental health
facilities

C2.V.5 Region

Statewide

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

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

2 / 7

C2.V.2 Measure standard

The plan must provide at least 90% of Covered Individuals with two providers within 60 miles or 60 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider

Adolescent inpatient
mental health
facilities

C2.V.5 Region

Statewide

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

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

3 / 7

C2.V.2 Measure standard

The plan must provide at least 90% of Covered Individuals with two providers within 60 miles or 60 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider

Child Inpatient
mental health
facilities

C2.V.5 Region

Statewide

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

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

4 / 7

C2.V.2 Measure standard

The plan must provide at least 90% of Covered Individuals with two providers within 60 miles or 60 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider

Adult and adolescent
inpatient SUD (ASAM
4.0)

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods



Complete

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

5 / 7

C2.V.2 Measure standard

The plan must provide at least 90% of Covered Individuals with two providers within 30 miles or 30 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider

ABA (Applied Behavioral Analysis),
ATS (Level 3.7) (Acute Treatment Services for SUD), BH
Psychiatry, CSS Level 3.5 (Clinical Support Services for SUD),
CBAT-ICBAT-TCU (Community-based Acute Treatment - Intensive
Community-based Treatment - Transitional Care Unit), CSP
(Community Support Program, IHBS (In Home Behavioral Health Services), IHT (In-Home Therapy),
IOP (Intensive Outpatient Program),
OTP (Opioid Treatment Program),
PHP (Partial Hospitalization), PDT (Psychiatric Day Treatment), RC (Recovery Coach),
RSN (Recovery Support Navigator),
RRS Level 3.1

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

(Residential
Rehabilitation
Services for SUD),
SOAP Structured
Outpatient Addiction
Program, TM
(Therapeutic
Mentoring)

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

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

6 / 7

C2.V.2 Measure standard

The plan must provide at least 90% of Covered Individuals with two providers within 30 miles or 30 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider

ESP (Emergency
Services Program)

C2.V.5 Region

Catchment Area

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

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

7 / 7

C2.V.2 Measure standard

For non-specified behavioral health services, ensure access to at least one Network Provider, except ESPs, of each BH Covered Service in every geographic region of the state with more than 2.5 percent of Covered

Individuals or, as determined by EOHHS, to the extent that qualified, interested Providers are available.

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider

Other Behavioral
Health

C2.V.5 Region

Region

C2.V.6 Population

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	<p>BSS website</p> <p>List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.</p>	<p>member-issues@masshealthquestions.com, info@myombudsman.org</p>
C1IX.2	<p>BSS auxiliary aids and services</p> <p>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)?</p> <p>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.</p>	<p>AHS - Contract has accessibility requirements to accommodate members with disabilities. AHS is required to comply with the ADA and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 USC §794) and ensure that beneficiaries with disabilities are provided with reasonable accommodations, which include but are not limited to: 1. Providing assistance to customers with visual impairments (e.g., large print versions of all written materials); 2. Providing auxiliary aids and services; 3. Ensuring that all written materials are available in formats compatible with optical recognition software; 4. Reading notices and other written materials to individuals upon request; 5. Assisting Customers to complete forms; 6. Ensuring effective communication with individuals with disabilities through email, telephone, and other electronic means; 7. Ensuring the Contractor's website complies with all ADA and Section 504 requirements, as well as ITD requirements for accessibility and other Commonwealth and EOHHS requirements; 8. Providing TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the deaf; and 9. Providing individualized assistance, as necessary. Maximus - Contract has accessibility requirements to accommodate members with disabilities. Maximus is required to comply with the ADA and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 USC §794) and ensure that ensure that beneficiaries with disabilities are provided with reasonable accommodations, which include but are not limited to: 1. Providing assistance to customers with visual impairments (e.g., large print versions of all written materials); 2. Providing auxiliary aids and services; 3. Ensuring that all written materials are available in formats compatible with optical recognition software; 4.</p>

Reading notices and other written materials to individuals upon request; 5. Assisting Customers to complete forms; 6. Ensuring effective communication with individuals with disabilities through email, telephone, and other electronic means; 7. Ensuring the Contractor's website complies with all ADA and Section 504 requirements, as well as ITD requirements for accessibility and other Commonwealth and EOHHS requirements; 8. Providing TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the deaf; and 9. Providing individualized assistance, as necessary. My Ombudsman (MYO): • Can be reached by phone (855-781-9898); videophone (for Deaf and Hard of Hearing members: 339-224-6831); via email (info@myombudsman.org) and in person (drop in or by appointment) on certain days. They also have virtual resources on their website: www.myombudsman.org • Have a fully accessible physical location that members may go to for drop in or in-person assistance on certain days • Maintains Vlogs (Video Blog) that provide information about My Ombudsman in ASL (all currently on YouTube) and other MH topics for Deaf and Hard of Hearing members. • Provides My Ombudsman information in large print. • Their website has an application that allows users with specific disabilities to adjust the website's design to their personal needs to ensure accessibility. • Uses technology such as QR codes to help make materials more accessible to those with vision disabilities. • has in-house staff who can provide services to One Care enrollees in American Sign Language (ASL), Hindi, Spanish, and Haitian-Creole. • can provide additional interpreters for all its services and activities in over 165 different languages (upon request). • provides My Ombudsman informational materials in English, Chinese, Haitian-Creole, Portuguese, Russian, Spanish, and Vietnamese. • Provides additional language translation services as needed. • Also does in-person and virtual outreach with community based organizations and at community events.

C1IX.3

BSS LTSS program data

N/A

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).

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?

AHS - The State evaluates AHS's quality, effectiveness, and efficiency through various contract management, internal controls, and reporting requirements. For example, Section 2.10 of AHS's contract requires that AHS participate in contract management meetings on an ad hoc quarterly basis to address project plans, operational issues, progress toward annual goals, and the status of any Quality Improvement Projects. Upon the State's request, AHS is also required to work with EOHHS and designated vendors to enhance program and operational efficiency. AHS is further required to conduct an independent annual compliance audit, cooperate and participate in program or financial audits and maintain and submit to EOHHS fraud, waste, and abuse protocols (see Section 2.9). AHS is also required to submit standard reports on a weekly, monthly, quarterly and ad hoc basis (see Section 2.5). AHS is further required to use principles of continuous quality improvement to satisfy its obligations under its contract, which include analyzing data measuring contractor performance, training staff, recommending operational improvements, and identifying and implementing Quality Improvement Projects and related reports (see Section 2.6).

Maximus - The State evaluates Maximus's quality, effectiveness, and efficiency through various contract management, internal controls, and reporting requirements. For example, Section 4.8 of Maximus's contract requires that Maximus engage in weekly and ad hoc meetings with EOHHS to address project plans, operational issues, progress toward annual goals, and the status of any quality improvement projects. Maximus is further required to conduct an independent annual compliance audit, cooperate and participate in program or financial audits and maintain and submit to EOHHS fraud, waste, and abuse protocols (see Section 4.9). Maximus is also required to use principles of continuous quality improvement to satisfy its obligations under its contract, which include analyzing data

measuring contractor performance, training staff, recommending operational improvements, and identifying and implementing Quality Improvement Projects and related reports (see Section 4.10). Lastly, the Maximus contract contains general reporting requirements (see Section 4.13), which include weekly, monthly, quarterly, and ad hoc reports detailing, e.g., member transactions and customer encounters. My Ombudsman - The State evaluates My Ombudsman's quality, effectiveness and efficiency through various contract management, internal controls and reporting requirements; through routine review of satisfaction survey data (My Ombudsman asks each member they work with to complete a survey to evaluate their satisfaction with services once a case has been closed); and through weekly case meetings

Topic X: Program Integrity

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

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	Plan enrollment What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	Massachusetts Behavioral Health Partnership 688,383
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? <ul style="list-style-type: none"> • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1) 	Massachusetts Behavioral Health Partnership 29.6%
D1I.3	Plan share of any Medicaid managed care What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? <ul style="list-style-type: none"> • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2) 	Massachusetts Behavioral Health Partnership 41.9%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	Medical Loss Ratio (MLR) What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	Massachusetts Behavioral Health Partnership 100%
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.	Massachusetts Behavioral Health Partnership Statewide all programs & populations
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.	Massachusetts Behavioral Health Partnership 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?	Massachusetts Behavioral Health Partnership Yes
N/A	Enter the start date.	Massachusetts Behavioral Health Partnership 01/01/2021

N/A

Enter the end date.

**Massachusetts Behavioral Health
Partnership**

12/31/2021

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	<p>Definition of timely encounter data submissions</p> <p>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.</p>	<p>Massachusetts Behavioral Health Partnership</p> <p>As specified in Contract sections 9.5.4-6 MBHP provides Encounter Data to EOHHS on a monthly basis or within time frames specified by EOHHS in consultation with MBHP, including at a frequency determined necessary by EOHHS to comply with any and all applicable statutes, rules, regulations and guidance. MBHP shall submit Encounter Data by the last calendar day of the month following the month of the claim payment.</p>
D1III.2	<p>Share of encounter data submissions that met state's timely submission requirements</p> <p>What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.</p>	<p>Massachusetts Behavioral Health Partnership</p> <p>100%</p>

D1III.3	Share of encounter data submissions that were HIPAA compliant What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	Massachusetts Behavioral Health Partnership 100%
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Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	<p>Appeals resolved (at the plan level)</p> <p>Enter the total number of appeals resolved as of the first day of the last month of the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.</p>	<p>Massachusetts Behavioral Health Partnership</p> <p>0</p>
D1IV.2	<p>Active appeals</p> <p>Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.</p>	<p>Massachusetts Behavioral Health Partnership</p> <p>0</p>
D1IV.3	<p>Appeals filed on behalf of LTSS users</p> <p>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).</p>	<p>Massachusetts Behavioral Health Partnership</p> <p>N/A</p>
D1IV.4	<p>Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal</p> <p>For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the</p>	<p>Massachusetts Behavioral Health Partnership</p> <p>N/A</p>

reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A".

The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.

To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

D1IV.5a	Standard appeals for which timely resolution was provided	Massachusetts Behavioral Health Partnership 0
	Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	
D1IV.5b	Expedited appeals for which timely resolution was provided	Massachusetts Behavioral Health Partnership 0
	Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	

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).	Massachusetts Behavioral Health Partnership 0
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.	Massachusetts Behavioral Health Partnership 0
D1IV.6c	Resolved appeals related to payment denial Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	Massachusetts Behavioral Health Partnership 0
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).	Massachusetts Behavioral Health Partnership 0
D1IV.6e	Resolved appeals related to lack of timely plan response to an appeal or grievance Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's	Massachusetts Behavioral Health Partnership 0

failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

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).	Massachusetts Behavioral Health Partnership 0
D1IV.6g	Resolved appeals related to denial of an enrollee's request to dispute financial liability Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	Massachusetts Behavioral Health Partnership 0

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	<p>Resolved appeals related to general inpatient services</p> <p>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.</p> <p>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".</p>	<p>Massachusetts Behavioral Health Partnership</p> <p>N/A</p>
D1IV.7b	<p>Resolved appeals related to general outpatient services</p> <p>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".</p>	<p>Massachusetts Behavioral Health Partnership</p> <p>N/A</p>
D1IV.7c	<p>Resolved appeals related to inpatient behavioral health services</p> <p>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".</p>	<p>Massachusetts Behavioral Health Partnership</p> <p>0</p>
D1IV.7d	<p>Resolved appeals related to outpatient behavioral health services</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that</p>	<p>Massachusetts Behavioral Health Partnership</p> <p>0</p>

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".

D1IV.7e	Resolved appeals related to covered outpatient prescription drugs Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	Massachusetts Behavioral Health Partnership N/A
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".	Massachusetts Behavioral Health Partnership 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 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".	Massachusetts Behavioral Health Partnership 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".	Massachusetts Behavioral Health Partnership N/A

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".	Massachusetts Behavioral Health Partnership N/A
D1IV.7j	Resolved appeals related to other service types Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".	Massachusetts Behavioral Health Partnership N/A

State Fair Hearings

Number	Indicator	Response
D1IV.8a	State Fair Hearing requests Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	Massachusetts Behavioral Health Partnership 0
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.	Massachusetts Behavioral Health Partnership 0
D1IV.8c	State Fair Hearings resulting in an adverse decision for the enrollee Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	Massachusetts Behavioral Health Partnership 0
D1IV.8d	State Fair Hearings retracted prior to reaching a decision Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) prior to reaching a decision.	Massachusetts Behavioral Health Partnership 0
D1IV.9a	External Medical Reviews resulting in a favorable decision for the enrollee If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	Massachusetts Behavioral Health Partnership N/A

D1IV.9b

**External Medical Reviews
resulting in an adverse
decision for the enrollee**

**Massachusetts Behavioral Health
Partnership**

N/A

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).

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.	Massachusetts Behavioral Health Partnership 24
D1IV.11	Active grievances Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	Massachusetts Behavioral Health Partnership 1
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.	Massachusetts Behavioral Health Partnership N/A
D1IV.13	Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the	Massachusetts Behavioral Health Partnership N/A

same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user.

If the managed care plan does not cover LTSS, the state should enter "N/A" in this field.

Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field.

To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.

D1IV.14**Number of grievances for which timely resolution was provided****Massachusetts Behavioral Health Partnership**

24

Enter the number of grievances for which timely resolution was provided by plan during the reporting period.

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

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".	Massachusetts Behavioral Health Partnership N/A
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".	Massachusetts Behavioral Health Partnership N/A
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".	Massachusetts Behavioral Health Partnership 0
D1IV.15d	Resolved grievances related to outpatient behavioral health services Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or	Massachusetts Behavioral Health Partnership 0

substance use services. If the managed care plan does not cover this type of service, enter "N/A".

D1IV.15e	Resolved grievances related to coverage of outpatient prescription drugs Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	Massachusetts Behavioral Health Partnership N/A
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".	Massachusetts Behavioral Health Partnership 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 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".	Massachusetts Behavioral Health Partnership 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".	Massachusetts Behavioral Health Partnership N/A
D1IV.15i	Resolved grievances related to non-emergency medical transportation (NEMT)	Massachusetts Behavioral Health Partnership

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".

N/A

D1IV.15j

Resolved grievances related to other service types

Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".

Massachusetts Behavioral Health Partnership

N/A

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	<p>Resolved grievances related to plan or provider customer service</p> <p>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.</p>	<p>Massachusetts Behavioral Health Partnership</p> <p>2</p>
D1IV.16b	<p>Resolved grievances related to plan or provider care management/case management</p> <p>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.</p>	<p>Massachusetts Behavioral Health Partnership</p> <p>0</p>

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.	Massachusetts Behavioral Health Partnership 4
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.	Massachusetts Behavioral Health Partnership 18
D1IV.16e	Resolved grievances related to plan communications Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	Massachusetts Behavioral Health Partnership 0

D1IV.16f	Resolved grievances related to payment or billing issues Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	Massachusetts Behavioral Health Partnership 2
D1IV.16g	Resolved grievances related to suspected fraud Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetrated 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.	Massachusetts Behavioral Health Partnership 0
D1IV.16h	Resolved grievances related to abuse, neglect or exploitation Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	Massachusetts Behavioral Health Partnership 0
D1IV.16i	Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals) Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request	Massachusetts Behavioral Health Partnership 0

(including requests to expedite or extend appeals).

D1IV.16j	Resolved grievances related to plan denial of expedited appeal Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	Massachusetts Behavioral Health Partnership 0
D1IV.16k	Resolved grievances filed for other reasons Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	Massachusetts Behavioral Health Partnership 0

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.



Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase 1 / 14

D2.VII.2 Measure Domain

Behavioral health care

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

0108

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

Massachusetts Behavioral Health Partnership

33.2%



Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase 2 / 14

D2.VII.2 Measure Domain

Behavioral health care

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

0108

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

Massachusetts Behavioral Health Partnership

36.0%



Complete

D2.VII.1 Measure Name: Antidepressant Medication Management - Effective Acute Phase

3 / 14

D2.VII.2 Measure Domain

Behavioral health care

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

0105

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

Massachusetts Behavioral Health Partnership

70.7%



Complete

D2.VII.1 Measure Name: Antidepressant Medication Management - Effective Continuation Phase

4 / 14

D2.VII.2 Measure Domain

Behavioral health care

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

0105

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

Massachusetts Behavioral Health Partnership

56.9%



Complete

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

5 / 14

D2.VII.2 Measure Domain

Behavioral health care

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

2800

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

Massachusetts Behavioral Health Partnership

37.6%



Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness – 7 days

6 / 14

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult and Child Core Sets

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

No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

Massachusetts Behavioral Health Partnership

77.2%



Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness – 30 days 7 / 14

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult and Child
Core Sets

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

No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

Massachusetts Behavioral Health Partnership

83%



Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 days 8 / 14

D2.VII.2 Measure Domain

Behavioral health care

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

3489

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult and Child
Core Sets

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

No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

Massachusetts Behavioral Health Partnership

20.4%



Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 days 9 / 14

D2.VII.2 Measure Domain

Behavioral health care

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

3489

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult and Child
Core Sets

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

No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

Massachusetts Behavioral Health Partnership

28.7%



Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness – 7 days 10 / 14

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult and Child
Core Sets

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

No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

Massachusetts Behavioral Health Partnership

48.8%



Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness – 30 days

11 / 14

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult and Child Core Sets

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

No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

Massachusetts Behavioral Health Partnership

69.3%



Complete

D2.VII.1 Measure Name: Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment – Initiation Total

12 / 14

D2.VII.2 Measure Domain

Behavioral health care

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

0004

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

Massachusetts Behavioral Health Partnership

44.6%



Complete

**D2.VII.1 Measure Name: Initiation and Engagement of Alcohol, Opioid, 13 / 14
or Other Drug Abuse or Dependence Treatment – Engagement Total**

D2.VII.2 Measure Domain

Behavioral health care

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

0004

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

Massachusetts Behavioral Health Partnership

16%



Complete

**D2.VII.1 Measure Name: Diabetes Screening for People with
Schizophrenia or Bipolar Disorder who are using Antipsychotic
Medications**

14 / 14

D2.VII.2 Measure Domain

Behavioral health care

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

1932

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

Massachusetts Behavioral Health Partnership

78.8%

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.



Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 1

D3.VIII.2 Plan performance issue

Performance Improvement

D3.VIII.3 Plan name

Massachusetts Behavioral Health Partnership

D3.VIII.4 Reason for intervention

The National Committee for Quality Assurance (NCQA) revoked MBHP's accredited status as a Managed Behavioral Health Organization due to uncredentialed practitioners in MBHP's network and a lack of ongoing monitoring of sanctions.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

06/18/2021

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

Yes 02/08/2022

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).	Massachusetts Behavioral Health Partnership 3
D1X.2	Count of opened program integrity investigations How many program integrity investigations have been opened by the plan in the past year?	Massachusetts Behavioral Health Partnership 14
D1X.3	Ratio of opened program integrity investigations to enrollees What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	Massachusetts Behavioral Health Partnership 0.02:1,000
D1X.4	Count of resolved program integrity investigations How many program integrity investigations have been resolved by the plan in the past year?	Massachusetts Behavioral Health Partnership 19
D1X.5	Ratio of resolved program integrity investigations to enrollees What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	Massachusetts Behavioral Health Partnership 0.03:1,000
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.	Massachusetts Behavioral Health Partnership Makes some referrals to the SMA and others directly to the MFCU

D1X.7	Count of program integrity referrals to the state Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made to the SMA and the MFCU in aggregate.	Massachusetts Behavioral Health Partnership 1
D1X.8	Ratio of program integrity referral to the state What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.2) as the denominator.	Massachusetts Behavioral Health Partnership 0:1,000
D1X.9	Plan overpayment reporting to the state Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information: <ul style="list-style-type: none"> • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2). 	Massachusetts Behavioral Health Partnership \$21,654.60
D1X.10	Changes in beneficiary circumstances Select the frequency the plan reports changes in beneficiary circumstances to the state.	Massachusetts Behavioral Health Partnership Daily

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

Number	Indicator	Response
EIX.1	BSS entity type What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	Maximus Enrollment Broker
		Automated Health Systems (AHS) Enrollment Broker
		My Ombudsman (MYO) Ombudsman Program Other Community-Based Organization
EIX.2	BSS entity role What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	Maximus Enrollment Broker/Choice Counseling
		Automated Health Systems (AHS) Enrollment Broker/Choice Counseling
		My Ombudsman (MYO) Beneficiary Outreach