Managed Care Program Annual Report (MCPAR) for Massachusetts: Managed Care Organization (MCO)

Due date	Last edited	Edited by	Status
09/27/2023	08/23/2024	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.	08/23/2024

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.	03/31/2023
A6	**Program name** Auto-populated from report dashboard.	Managed Care Organization (MCO)

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	BMC HealthNet Plan Tufts Health Together

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 Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

	Indicator	Response
	BSS entity name	Automated Health Systems (AHS)
		Maximus
		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	**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.	The MassHealth Program Integrity Unit and Compliance Unit met quarterly with MCOs 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 the MCOs annual Compliance Plan and Anti-Fraud, Waste and Abuse Plan, in order to ensure compliance with applicable contract requirements and to ensure MCOs have appropriate controls in place. In addition, in July 2022 MassHealth implemented new MCO Summary of Provider Overpayments Reporting. MassHealth published 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 now provide MassHealth with comprehensive information related to the impact of MCOs' controls, including the breadth of provider types reviewed and methodologies employed; the number and amount of overpayments identified and recovered by MCOs; 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 implementation of these new reports and ensuring compliance with the new requirements. Moving forward, the information contained in the new Summary of Provider Overpayments reports will enable MassHealth

		to share best practices across MCOs, monitor performance management, and enforce the relevant contract provisions related to overpayments that the plans fail to identify and/or recover. Further, in Contract Year 2022 MassHealth developed strengthened MCO contractual provisions related to enforcement of overpayment requirements, which will become effective April 2023. These new requirements will support MassHealth's ongoing expansion of MCO oversight, which will include direct audits of MCO providers and encounters beginning in Contract Year 2024 for dates of service in 2023.
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).	2.3.C.3.a.19

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 plans identify an overpayment prior to the state, the plan shall recover the overpayment and may retain the overpayment. If the state identifies an overpayment prior to the plan, the state may explore options, up to and including recovering the overpayment from the plan.
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 asking the state how it monitors that reporting.	MCOs are contractually required to submit the following overpayment reports: (1) Notification of Provider Overpayments (ad hoc within 5 days of overpayment identification; (2) Fraud and Abuse Notification (ad hoc within 5 days of identification); (3) Self-Reported Disclosures Report (ad hoc); (4) Summary of Provider Overpayments (quarterly); and (5) Fraud and Abuse Report (annual). Each of the ad hoc reports are screened by MassHealth on an ad hoc basis. The quarterly and annual reports are reviewed by MassHealth for compliance, performance management, and best practices.
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).	MCOs must report to EOHHS when they receive information on a change in Enrollee circumstances which may impact their eligibility primarily via a daily enrollment file exchange. The state and the MCOs use the daily enrollment files and other reporting to reconcile changes in Enrollee enrollment status, including but not limited to, a change in an Enrollee's residence, identification of TPL, or death of an Enrollee. MCOs must have member permission to report a change of residence.

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.	Plans must report no later than five business days when it receives information about a change in a provider's circumstances that may impact its ability to participate in the plan's network or the state.
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No

BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	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
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Managed Care Organization (MCO) Contract
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	03/01/2018
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.mass.gov/lists/managed-care-organization-mco-contracts
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 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 total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	117,110
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.	N/A

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data corrections Use of correct file formats Overall data accuracy (as determined through data validation)
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	2.14.B and Appendix E

	section references, not page numbers.	
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.	5.3.K.5
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	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	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 Enrollee request for an Internal Appeal, unless this timeframe is extended under applicable contract provisions.
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	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.

	MCO, PIHP or PAHP receives the appeal.	
C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	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.

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.	MassHealth MCOs face similar challenges to those faced by all other plans (including those in the commercial insurance space) with the availability of providers for certain specialties and behavioral health services in underserved areas.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	MassHealth uses its contract to enforce standards that protect access to care. When issues arise, we connect with MCP key contacts to identify the issue, develop a long term plan to correct the issue, and a plan to preserve member access to services while the underlying issue is being addressed. When appropriate MassHealth also engages with our clinical staff to speak with the MCP. MassHealth has included many tools in its contracts to address non-compliance including, corrective workplan, formal corrective action plan, sanctions, or contract termination

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: 21

Complete

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

1 / 21

C2.V.2 Measure standard

Two open PCP panels within 15 miles or 30 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide except for Oak Bluffs and Nantucket Services Areas	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually and Ad hoc

Complete

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

2 / 21

C2.V.2 Measure standard

Two open PCP panels within 40 miles or 40 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider

Primary care

C2.V.5 Region

Oak Bluffs and Nantucket Service Areas

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually and Ad hoc

Complete

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

3 / 21

C2.V.2 Measure standard

One adult PCP for every 200 adult Enrollees

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider

Primary care

C2.V.5 Region

Statewide

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

plan reported calculations

C2.V.8 Frequency of oversight methods

Annually and Ad hoc

Complete

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

4 / 21

C2.V.2 Measure standard

One pediatric PCP for every 200 pediatric Enrollees

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Pediatric

C2.V.7 Monitoring Methods

plan reported calculations

C2.V.8 Frequency of oversight methods

Annually and Ad hoc

Complete

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

5 / 21

C2.V.2 Measure standard

20 miles or 40 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Acute Inpatient Hospital	Statewide except for Oak Bluffs and Nantucket Service Areas	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually and Ad hoc

Complete

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

6 / 21

C2.V.2 Measure standard

20 miles or 40 minutes, or the closest acute inpatient hospital located outside these Service Areas

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Acute Inpatient Hospital	Oak Bluffs and Nantucket Service Areas	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually and Ad hoc

Complete

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

7 / 21

C2.V.2 Measure standard

15 miles or 30 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urgent Care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually and Ad hoc

Complete

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

8 / 21

C2.V.2 Measure standard

30 miles or 60 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Rehabilitation Hospital	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually and Ad hoc

Complete

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

9 / 21

C2.V.2 Measure standard

One provider within 15 miles or 30 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OBGYN	Statewide	female enrollees aged 10 and older

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually and Ad hoc

Complete

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

10 / 21

C2.V.2 Measure standard

One OBGYN for every 500 Enrollees

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OBGYN	Statewide	female enrollees aged 10 and older

C2.V.7 Monitoring Methods

plan reported calculations

C2.V.8 Frequency of oversight methods

Annually and Ad hoc

Complete

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

11 / 21

C2.V.2 Measure standard

15 miles or 30 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacy	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually and Ad hoc

Complete

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

12 / 21

C2.V.2 Measure standard

20 miles or 40 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Allergy, Anesthesiology, Audiology, Cardiology, Chiropractic, Dermatology, Emergency Medicine, Endocrinology, Gastroenterology, General Surgery, Hematology, Infectious Disease, Medical Oncology, Nephrology, Neurology, Neurosurgery, Nuclear Medicine, Ophthalmology, Oral surgery, Orthopedic Surgery, Otolaryngology, Pathology, Physiatry, Plastic Surgery, Podiatry, Psychiatric Advanced Practice Nurse (Psychiatric Clinical Nurse Specialist or Certified Nurse Practitioner), Psychiatry, Psychology, Pulmonology, Radiation Oncology, Radiology, Rheumatology, Thoracic Surgery,	Statewide except for Oak Bluffs and Nantucket Service Areas	Adult and pediatric

Urology, Vascular Surgery

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually and Ad hoc

Complete

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

13 / 21

C2.V.2 Measure standard

40 miles or 40 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Allergy, Anesthesiology, Audiology, Cardiology, Chiropractic, Dermatology, Emergency Medicine, Endocrinology, Gastroenterology, General Surgery, Hematology, Infectious Disease, Medical Oncology, Nephrology, Neurology,	Oak Bluffs and Nantucket Service Areas	Adult and pediatric

Neurosurgery, Nuclear Medicine, Ophthalmology, Oral surgery, Orthopedic Surgery, Otolaryngology, Pathology, Physiatry, Plastic Surgery, Podiatry, Psychiatric Advanced Practice Nurse (Psychiatric Clinical Nurse Specialist or Certified Nurse Practitioner), Psychiatry, Psychology, Pulmonology, Radiation Oncology, Radiology, Rheumatology, Thoracic Surgery, Urology, Vascular Surgery

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually and Ad hoc

Complete

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

14 / 21

C2.V.2 Measure standard

Primary care: within 48 hours of the Enrollee's request for Urgent Care

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Through narrative from the plans on their monitoring of this requirement

C2.V.8 Frequency of oversight methods

Annually

Complete

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

15 / 21

C2.V.2 Measure standard

Primary care: within 10 calendar days of the Enrollee's request for Symptomatic Care

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Through narrative from the plans on their monitoring of this requirement

C2.V.8 Frequency of oversight methods

Annually

Complete

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

16 / 21

C2.V.2 Measure standard

Primary care: within 45 calendar days of the Enrollee's request for Non-Symptomatic Care

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Through narrative from the plans on their monitoring of this requirement

C2.V.8 Frequency of oversight methods

Annually

Complete

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

17 / 21

C2.V.2 Measure standard

Assure the provision of screenings in accordance with the schedule established by the EPSDT Periodicity Schedule

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	statewide	Pediatric

C2.V.7 Monitoring Methods

Through narrative from the plans on their monitoring of this requirement

C2.V.8 Frequency of oversight methods

Annually

Complete

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

18 / 21

C2.V.2 Measure standard

Two within 60 miles or 60 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Inpatient mental health	Statewide	Adult, Adolescent and Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually and Ad hoc

Complete

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

19 / 21

C2.V.2 Measure standard

Two within 60 miles or 60 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider

Inpatient SUD

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and Adolescent

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually and Ad hoc

Complete

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

20 / 21

C2.V.2 Measure standard

Two within 30 miles or 30 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider

ATS (Level 3.7) (Acute Treatment Services for SUD)

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

Annually and Ad hoc

Complete

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

C2.V.2 Measure standard

30 miles or 30 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
ABA (Applied Behavioral Analysis), CPS (Certified Peer Specialist), CSS (Clinical Stabilization Services) level 3.5, CBAT-ACBAT-TCU (Community-Based Acute Treatment - Intensive Community-Based Acute Treatment - Transitional Care Unit), CSP (Community Support Program), IHBS (In-Home Behavioral Services), IHT (In-Home Therapy), IOP (Intensive Outpatient Program), OTP (Opioid Treatment Program), PHP (Partial Hospitalization Program), PDT (Psychiatric Day	Statewide	Adult and pediatric

Treatment), RRS (Residential Rehabilitation Services) level 3.1, Recovery Coach, RSN (Recovery Support Navigator), SOAP (Structured Outpatient Addictions Program), TM (Therapeutic Mentoring)

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually and Ad hoc

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	member-issues@masshealthquestions.com and info@myombudsman.org
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.	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 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. 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** 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?	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?	**BMC HealthNet Plan** 70,856 **Tufts Health Together** 46,254
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)	**BMC HealthNet Plan** 3% **Tufts Health Together** 2%
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)	**BMC HealthNet Plan** 4.3% **Tufts Health Together** 2.8%

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.	**BMC HealthNet Plan** 92% **Tufts Health Together** 92%
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.	**BMC HealthNet Plan** Program-specific statewide **Tufts Health Together** 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.	**BMC HealthNet Plan** N/A **Tufts Health Together** 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?	**BMC HealthNet Plan** Yes **Tufts Health Together** Yes
N/A	Enter the start date.	**BMC HealthNet Plan** 01/01/2022 **Tufts Health Together** 01/01/2022
N/A	Enter the end date.	**BMC HealthNet Plan** 12/31/2022 **Tufts Health Together** 12/31/2022

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.	**BMC HealthNet Plan** In accordance with Section 214(b) of the Contract, all Health Plans are expected to submit encounters by end of month, for remit dates thru end of previous month. This includes corrections based on automated submission feedback. **Tufts Health Together** In accordance with Section 214(b) of the Contract, all Health Plans are expected to submit encounters by end of month, for remit dates thru end of previous month. This includes corrections based on automated submission feedback.
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 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.	**BMC HealthNet Plan** 100% **Tufts Health Together** 100%

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.	**BMC HealthNet Plan** 100% **Tufts Health Together** 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 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.	**BMC HealthNet Plan** 165 **Tufts Health Together** 409
D1IV.2	**Active appeals** 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.	**BMC HealthNet Plan** 21 **Tufts Health Together** 33
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).	**BMC HealthNet Plan** N/A **Tufts Health Together** N/A

D1IV.4	**Number of critical incidents filed during the reporting period 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 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 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	**BMC HealthNet Plan** N/A **Tufts Health Together** N/A

	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 during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**BMC HealthNet Plan** 85 **Tufts Health Together** 171
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 during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**BMC HealthNet Plan** 79 **Tufts Health Together** 198
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).	**BMC HealthNet Plan** 161 **Tufts Health Together** 69

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.	**BMC HealthNet Plan** 0 **Tufts Health Together** 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.	**BMC HealthNet Plan** 0 **Tufts Health Together** 44
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).	**BMC HealthNet Plan** 0 **Tufts Health Together** 3
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	**BMC HealthNet Plan** 0 **Tufts Health Together** 57

	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).	**BMC HealthNet Plan** 2 **Tufts Health Together** 39
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.	**BMC HealthNet Plan** 3 **Tufts Health Together** 29

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".	**BMC HealthNet Plan** 3 **Tufts Health Together** 10
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".	**BMC HealthNet Plan** 118 **Tufts Health Together** 50
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan	**BMC HealthNet Plan** 0 **Tufts Health Together**

	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".	6
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".	**BMC HealthNet Plan** 0 **Tufts Health Together** 2
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".	**BMC HealthNet Plan** 141 **Tufts Health Together** 226
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".	**BMC HealthNet Plan** N/A **Tufts Health Together** 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".	**BMC HealthNet Plan** N/A **Tufts Health Together** 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".	**BMC HealthNet Plan** N/A **Tufts Health Together** 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".	**BMC HealthNet Plan** 0 **Tufts Health Together** 0
D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do	**BMC HealthNet Plan** 13 **Tufts Health Together**

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".	23	

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.	**BMC HealthNet Plan** 2 **Tufts Health Together** 6
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.	**BMC HealthNet Plan** 0 **Tufts Health Together** 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.	**BMC HealthNet Plan** 1 **Tufts Health Together** 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.	**BMC HealthNet Plan** 1 **Tufts Health Together** 5
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee**	**BMC HealthNet Plan** 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 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).	**Tufts Health Together** N/A
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).	**BMC HealthNet Plan** N/A **Tufts Health Together** N/A

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.	**BMC HealthNet Plan** 58 **Tufts Health Together** 143
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.	**BMC HealthNet Plan** 2 **Tufts Health Together** 34
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.	**BMC HealthNet Plan** N/A **Tufts Health Together** N/A
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an**	**BMC HealthNet Plan** N/A

LTSS user who previously filed a grievance	Tufts Health Together
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 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	N/A

	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 period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**BMC HealthNet Plan** 58 **Tufts Health Together** 103

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".	**BMC HealthNet Plan** 0 **Tufts Health Together** 0
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**BMC HealthNet Plan** 37 **Tufts Health Together** 1

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".	**BMC HealthNet Plan** 0 **Tufts Health Together** 4
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".	**BMC HealthNet Plan** 2 **Tufts Health Together** 4
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".	**BMC HealthNet Plan** 2 **Tufts Health Together** 8
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services**	**BMC HealthNet Plan** N/A

	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".	**Tufts Health Together** 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".	**BMC HealthNet Plan** N/A **Tufts Health Together** 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".	**BMC HealthNet Plan** N/A **Tufts Health Together** N/A
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".	**BMC HealthNet Plan** 0 **Tufts Health Together** 0

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".	**BMC HealthNet Plan** 7 **Tufts Health Together** 38

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.	**BMC HealthNet Plan** 28 **Tufts Health Together** 19
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.	**BMC HealthNet Plan** 0 **Tufts Health Together** 1

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.	**BMC HealthNet Plan** 1 **Tufts Health Together** 1
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.	**BMC HealthNet Plan** 19 **Tufts Health Together** 59
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	**BMC HealthNet Plan** 0 **Tufts Health Together** 5

	enrollee's access to or the accessibility of enrollee materials or plan communications.	
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.	**BMC HealthNet Plan** 0 **Tufts Health Together** 3
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 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.	**BMC HealthNet Plan** 0 **Tufts Health Together** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved during the reporting year that were	**BMC HealthNet Plan** 0 **Tufts Health Together** 0

	related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	
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 (including requests to expedite or extend appeals).	**BMC HealthNet Plan** 0 **Tufts Health Together** 1
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	**BMC HealthNet Plan** 0 **Tufts Health Together** 0

	representative have the right to file a grievance.	
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.	**BMC HealthNet Plan** 0 **Tufts Health Together** 38

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: 18

Complete

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

1 / 18

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

1800

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult and Child Core Sets

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

BMC HealthNet Plan

61.4%

Tufts Health Together

50.9%

Complete

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

2 / 18

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

BMC HealthNet Plan

49.0%

Tufts Health Together

54.5%

Complete

D2.VII.1 Measure Name: Behavioral Health Community Partner Engagement

3 / 18

D2.VII.2 Measure Domain

Care Coordination

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

Percentage of members 18 to 64 years of age who engaged with a BH Community Partner and received a treatment plan within 3 months (122 days) of Community Partner assignment

Measure results

BMC HealthNet Plan

4.3%

Tufts Health Together

3.7%

Complete

D2.VII.1 Measure Name: Controlling High Blood Pressure

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0018

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

BMC HealthNet Plan

67.4%

Tufts Health Together

58.0%

Complete

D2.VII.1 Measure Name: Comprehensive Diabetes Care: A1c Poor Control

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0059

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

BMC HealthNet Plan

32.5%

Tufts Health Together

37.5%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status (Combination 10)

6 / 18

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

BMC HealthNet Plan

32.6%

Tufts Health Together

32.8%

Complete

D2.VII.1 Measure Name: Community Tenure: Members with Diagnosis of Bipolar, Schizophrenia, or Psychotic Disorder (BSP) – Observed to Expected Ratio

7 / 18

D2.VII.2 Measure Domain

Care Coordination

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

"The percentage of eligible days that ACO members 18-64 with bipolar disorder, schizophrenia, or psychosis (BSP) diagnoses who reside in their home or in a community setting without utilizing acute, chronic, or post-acute institutional health care services during the measurement year"

Measure results

BMC HealthNet Plan

1.1289

Tufts Health Together

.5280

Complete

D2.VII.1 Measure Name: Community Tenure: LTSS Population (and not in BSP population) – Observed to Expected Ratio

8 / 18

D2.VII.2 Measure Domain

Care Coordination

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

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

State-specific

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

"The percentage of eligible days that ACO members 18-64 who have at least 3 consecutive months of LTSS utilization reside in their home or in a community setting without utilizing acute, chronic, or post-acute institutional health care services during the measurement year"

Measure results

BMC HealthNet Plan

1.0101

Tufts Health Together

.8174

Complete

D2.VII.1 Measure Name: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7-day total)

9 / 18

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

BMC HealthNet Plan

72.7%

Tufts Health Together

74.4%

Complete

D2.VII.1 Measure Name: Follow-up After Hospitalization for Mental Illness (7-day total)

10 / 18

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

BMC HealthNet Plan

41.1%

Tufts Health Together

40.5%

Complete

D2.VII.1 Measure Name: Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (Total) 11 / 18

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

BMC HealthNet Plan

55.7%

Tufts Health Together

53.1%

Complete

D2.VII.1 Measure Name: Engagement of Alcohol and Other Drug Abuse or Dependence Treatment- (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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

BMC HealthNet Plan

23.5%

Tufts Health Together

22.7%

Complete

D2.VII.1 Measure Name: Immunization for Adolescents (Combination 2)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1407

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

BMC HealthNet Plan

21.6%

Tufts Health Together

39.0%

Complete

D2.VII.1 Measure Name: LTSS Community Partner Engagement

14 / 18

D2.VII.2 Measure Domain

Care Coordination

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

"Percentage of members 3 to 64 years of age who engaged with an LTSS Community Partner and received a care plan within 3 months (122 days) of Community Partner assignment"

Measure results

BMC HealthNet Plan

4.5%

Tufts Health Together

11.5%

Complete

D2.VII.1 Measure Name: Plan All-Cause Readmissions (Observed Readmission Rate)

15 / 18

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1768

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

BMC HealthNet Plan

12.5%

Tufts Health Together

10.8%

Complete

D2.VII.1 Measure Name: Timeliness of Prenatal Care

16 / 18

D2.VII.2 Measure Domain

Maternal and perinatal health

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

1517

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

BMC HealthNet Plan

84.6%

Tufts Health Together

90.2%

Complete

D2.VII.1 Measure Name: Risk adjusted ratio (obs/exp) of ED visits for members with SMI/SUD/co-occurring conditions

17 / 18

D2.VII.2 Measure Domain

Primary care access and preventative care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

"Risk-adjusted number of ED visits for members 18 to 64 years of age identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions"

Measure results

BMC HealthNet Plan

.7837

Tufts Health Together

.7529

Complete

D2.VII.1 Measure Name: Oral Health Evaluation

18 / 18

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

"Percentage of members under age 21 who received a comprehensive or periodic oral evaluation during the measurement year"

Measure results

BMC HealthNet Plan

48.4%

Tufts Health Together

50.9%

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:

0 - No sanctions entered

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).	**BMC HealthNet Plan** 10 **Tufts Health Together** 23
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**BMC HealthNet Plan** 90 **Tufts Health Together** 79
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?	**BMC HealthNet Plan** 1.27:1,000 **Tufts Health Together** 1.71:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations have been resolved by the plan in the past year?	**BMC HealthNet Plan** 56 **Tufts Health Together** 49
D1X.5	**Ratio of resolved program integrity investigations to**	**BMC HealthNet Plan**

	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?	0.79:1,000 **Tufts Health Together** 1.06:1,000
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.	**BMC HealthNet Plan** Makes some referrals to the SMA and others directly to the MFCU **Tufts Health Together** 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.	**BMC HealthNet Plan** 1 **Tufts Health Together** 79
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.	**BMC HealthNet Plan** 0.01:1,000 **Tufts Health Together** 1.71:1,000
D1X.9	**Plan overpayment reporting to the state**	**BMC HealthNet Plan**

	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: • 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).	"Date of report: 1/31/23 and 4/30/23 Dollar amount of overpayments recovered: $477,736.20 Ratio of premium revenue: 5.71%" **Tufts Health Together** "Date of reports: 1/31/23 and 4/30/23 Dollar amount of overpayments recovered: $1,900,315.53 Ratio of premium revenue: 4.96%"
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**BMC HealthNet Plan** Daily **Tufts Health Together** 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).	**Automated Health Systems (AHS)** Enrollment Broker **Maximus** 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).	**Automated Health Systems (AHS)** Enrollment Broker/Choice Counseling **Maximus** Enrollment Broker/Choice Counseling **My Ombudsman (MYO)** Beneficiary Outreach