

Managed Care Program Annual Report (MCPAR) for Massachusetts: One Care

Due date	Last edited	Edited by	Status
06/29/2026	06/29/2026	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
Did you submit or do you plan on submitting a Network Adequacy and Access Assurances (NAAAR) Report for this program for this reporting period through the MDCT online tool? If "No", please complete the following questions under each plan.	Yes, I submitted it in MDCT

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.	06/29/2026

Reporting Period

Number	Indicator	Response
A5a	Reporting period start date Auto-populated from report dashboard.	01/01/2025
A5b	Reporting period end date Auto-populated from report dashboard.	12/31/2025
A6	Program name Auto-populated from report dashboard.	One Care

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	Commonwealth Care Alliance One Care Tufts One Care UnitedHealthcare Connected for One Care

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	Serving the Health Insurance Needs for Everyone (SHINE)
	My Ombudsman
	Automated Health Systems (AHS)

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

This section must be completed if any in lieu of services or settings (ILOSs) *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** (See 42 CFR 438.3(e)(2) and 438.16).

Indicator	Response
ILOS name	Not answered

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	Statewide Medicaid enrollment Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	1,989,905
BI.2	Statewide Medicaid risk-based managed care enrollment Enter the average number of individuals enrolled in risk-based Medicaid managed care per month during the reporting year (i.e., average member months). Include all MCOs and at-risk PIHPs and PAHPs only, and count each person only once, even if they are enrolled in multiple managed care programs or plans.	1,366,727

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. If no PI activities were performed, enter "No PI activities were performed during the reporting period" as your response. "N/A" is not an acceptable response.	The MassHealth Program Integrity Unit and Compliance Unit met regularly with One Care plans 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 One Care plans' fraud and abuse reporting and One Care plans' annual Compliance Plan and Anti-Fraud, Waste and Abuse Plan, in order to ensure compliance with applicable contract requirements and to ensure One Care plans have appropriate controls in place. In addition, strengthened One Care contractual provisions related to controls against fraud, waste and abuse, program integrity reporting, and enforcement of overpayment requirements took effect on 1/1/23. These provisions established consistency in program integrity requirements across all of MassHealth's managed care entities. The contractual requirements supported MassHealth's ongoing One Care plan oversight, which included direct audits of One Care providers and encounters beginning in Contract Year 2024 for dates of service in 2023. In 2024, MassHealth performed direct audits and encounter analyses to identify One Care provider overpayments. These audit findings and overpayments identified through encounter analysis were shared with One Care plans for collection in 2025. Further, MassHealth continued to collect One Care plans' Summary of Provider Overpayments Reporting originally initiated in 2023. This semi-annual report includes all overpayments identified during the prior Contract Year through present, including all investigatory and recovery activity related to such overpayments. These reports provide MassHealth with comprehensive information related to the impact of One Care plans' controls, including the breadth and depth of provider types reviewed and methodologies employed; the number and amount of overpayments identified and recovered by One Care plans; 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

2025, MassHealth continued to focus on ensuring information contained in the new Summary of Provider Overpayments reports was comprehensive. The information contained in the new Summary of Provider Overpayments reports enabled MassHealth to share best practices across managed care entities, monitor performance management, and enforce the relevant contract provisions related to overpayments that the plans fail to identify and/or recover. In addition, MassHealth has worked with One Care plans to enhance the process of receiving referrals of incidents of suspected PCA fraud involving their enrollees and communicate such process to contracted PCM agencies and the Fiscal Intermediary.

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).	2.1.5.2
BX.4	Description of overpayment contract standard Briefly describe the overpayment standard selected in indicator B.X.2.	If a plan identifies an overpayment prior to the state, the plan shall recover the overpayment and may retain the overpayment. If no collection action is taken by the plan within 180 days, the plan must report that no action was taken and provide a justification for failure to recover. 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?	MassHealth reviews all overpayment reports for compliance, performance management, and best practices, including but not limited to the Ad Hoc Fraud, Waste, and Abuse, Overpayments as a result of Fraud report.

The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.

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).	Plans 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 plans 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. Plans 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.	The Contractor must notify EOHHS of any Provider Network changes that impact Enrollee access to Covered Services within five 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	No

or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.

BX.9a	Website posting of 5 percent or more ownership control	No
BX.10	Periodic audits If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter "No such audits were conducted during the reporting year" as your response. "N/A" is not an acceptable response.	An audit on One Care plans is underway and we anticipate posting the results in the summer of 2026.

Topic XIII. Prior Authorization



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

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

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.	One Care Three-Way Contract
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2023
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/one-care-contracts
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.	Managed Care Organization (MCO)
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 Long-term services and supports (LTSS) Dental Transportation
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 average number of individuals enrolled in this managed care program per	38,936

month during the reporting year (i.e., average member months).

C11.6

Changes to enrollment or benefits

Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter "There were no major changes to the population or benefits during the reporting year" as your response. "N/A" is not an acceptable response.

There were no major changes to the population or benefits during the reporting year.

Topic II: Medical Loss Ratio (MLR) Reporting

Number	Indicator	Response
C1II.1	Submission Date of Most Recent MLR Report When is the last date the state submitted the MLR Summary Report in the Medicaid Data Collection Tool (MDCT) MLR Portal for this program?	01/01/1900
C1II.2	Most Recent MLR Reporting Period Please report the beginning date of that MLR reporting period.	01/01/1900
N/A	Please report the end date of that MLR reporting period.	01/01/1900
C1II.3	MLR Validation Completion Has the state completed the validation of plan MLR data for the current MCPAR reporting period by the submission date of this report for all plans? (See detailed reporting in Section D1.II by plan.)	No
C1II.3a	Anticipated Validation Date When does the state anticipate doing so?	08/2026

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 section references, not page numbers.	2.17

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.	5.3.14.1, 5.3.14.1.11
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 program does not use incentives to reward 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 year. If there were no barriers, please enter "The state did not experience any barriers to collecting or validating encounter data during the reporting year" as your response. "N/A" is not an acceptable response.	The state did not experience any barriers to collecting or validating encounter data during the reporting year.

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.	A critical incident is defined as a sudden or progressive event that requires immediate attention and action to prevent/minimize a negative impact on the health and welfare of a member. Critical incidents may include, but are not limited to: death of a member due to unnatural causes, exposure to hazardous material, medication error, unauthorized restraints, natural disaster, serious physical injuries, criminal activity impacting the participant, serious neglect, missing persons, and significant property damage.
C1IV.2	State definition of “timely” resolution for standard appeals Provide the state’s definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	The plan must notify the Enrollee of a standard appeal decision as expeditiously as the Enrollee’s health requires, but no later than thirty (30) calendar days after the plan's receipt of the appeal.
C1IV.3	State definition of “timely” resolution for expedited appeals Provide the state’s definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), 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.	The plan must notify the Enrollee of an expedited appeal decision as expeditiously as the Enrollee’s health requires, but no later than seventy two (72) hours after the plan’s receipt of 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	The plan must respond, electronically, orally or in writing, to each Enrollee Grievance within a reasonable time, but no later than thirty (30) days after the plan receives the Grievance.

day the MCO, PIHP or PAHP
receives the grievance.

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	BSS website List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	member-issues@masshealthquestions.com, www.mass.gov/info-details/contact-masshealth-information-for-members, www.mass.gov/info-details/serving-the-health-insurance-needs-of-everyone-shine-program, ADAAccommodations@mass.gov, info@myombudsman.org, www.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.	SHINE refers to 88 bilingual counselors, uses a translation line, TTY, and has ASL counselor resources. CMS and the SHIPTA Center also prints materials in Braille, many languages, and on CD. Each SHINE regional office provides access to in-person counseling sessions. My Ombudsman: • 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. AHS - Contract complies with the 42 CFR 438.71(b)(2) 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. 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.

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). If the program does not offer LTSS, enter "N/A".

My Ombudsman tracks information about every member they assist, including cases involving access to LTSS, by topic in a database; they report case data on One Care monthly to the State, CMS and the Administration for Community Living (ACL) by topic, plan, and program type, which includes any grievances and appeals they assist on. The State also meets with MYO leadership weekly to review cases and discuss any emerging trends or systemic concerns. MYO and the State also share One Care data and work directly with managed care plans as needed to resolve individual and/or systemic concerns.

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?

SHINE - The Administration on Community Living evaluates SHINE based on data that they input into the STARS database on client contacts, group work, and media work. 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). 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

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	Does this program include MCOs? If “Yes”, please complete the following questions.	Yes
C1XII.5	Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system? (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	Yes
C1XII.6	Did the State or MCOs complete the most recent parity analysis(es)?	MCO
C1XII.7a	Have there been any events in the reporting period that necessitated an update to the parity analysis(es)? (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	Yes
C1XII.7b	Describe the event(s) that necessitated an update to the parity analysis(es). Select all that apply.	Other, specify – Required for annual legislative report
C1XII.8	When was the last parity analysis(es) for this program completed? States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may	10/31/2025

have multiple reports, one for each MCO).

C1XII.9	When was the last parity analysis(es) for this program submitted to CMS? States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	01/23/2026
C1XII.10a	In the last analysis(es) conducted, were any deficiencies identified?	No
C1XII.12a	Has the state posted the current parity analysis(es) covering this program on its website? The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.	Yes
C1XII.12b	Provide the URL link(s). Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.	https://www.mass.gov/doc/masshealth-2025-mental-health-parity-report/download

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	Plan enrollment Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	Commonwealth Care Alliance One Care 27,779
		Tufts One Care 6,811
		UnitedHealthcare Connected for One Care 4,346
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)	Commonwealth Care Alliance One Care 1.4%
		Tufts One Care 0.3%
		UnitedHealthcare Connected for One Care 0.2%
D1I.3	Plan share of risk-based Medicaid managed care What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in risk-based managed care?Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid risk-based managed care enrollment (B.I.2)	Commonwealth Care Alliance One Care 2%
		Tufts One Care 0.5%
		UnitedHealthcare Connected for One Care 0.3%

D1I.4: Parent	Organization: The name of the parent entity that controls the Medicaid Managed Care Plan. If the managed care plan is owned or controlled by a separate entity (parent), report the name of that entity. If the managed care plan is not controlled by a separate entity, please report the managed care plan name in this field.	Commonwealth Care Alliance One Care CareSource Tufts One Care Point32Health, Inc. UnitedHealthcare Connected for One Care United Healthcare
----------------------	--	--

Topic II: Medical Loss Ratio (MLR) Reporting

Number	Indicator	Response
D1II.1	MLR Data Received Has the state received the MLR data specified at 42 CFR 438.8(k) from this plan for the current MCPAR reporting period as of the submission date of this MCPAR report?	Commonwealth Care Alliance One Care No Tufts One Care No UnitedHealthcare Connected for One Care No
D1II.1c	Projected Date for Receipt of MLR Data for This Reporting Period When does the state anticipate receiving MLR data for this reporting period from this plan?	Commonwealth Care Alliance One Care 08/2026 Tufts One Care 082026 UnitedHealthcare Connected for One Care 08/2026

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.	Commonwealth Care Alliance One Care As specified in Contract section 2.17.2.1.5 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 One Care As specified in Contract section 2.17.2.1.5 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.
		UnitedHealthcare Connected for One Care As specified in Contract section 2.17.2.1.5 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 year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	Commonwealth Care Alliance One Care 100%
		Tufts One Care 100%
		UnitedHealthcare Connected for One Care 100%
D1III.3	Share of encounter data submissions that were HIPAA compliant What percent of the plan's encounter data submissions	Commonwealth Care Alliance One Care 100%
		Tufts One Care

(submitted during the reporting year) met state requirements for HIPAA compliance?

If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.

100%

UnitedHealthcare Connected for One Care

100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	Appeals resolved (at the plan level) Enter the total number of appeals resolved during the reporting year. An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.	Commonwealth Care Alliance One Care 1,635 Tufts One Care 150 UnitedHealthcare Connected for One Care 288
D1IV.1a	Appeals denied Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.	Commonwealth Care Alliance One Care 1,025 Tufts One Care 81 UnitedHealthcare Connected for One Care 149
D1IV.1b	Appeals resolved in partial favor of enrollee Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.	Commonwealth Care Alliance One Care 144 Tufts One Care 2 UnitedHealthcare Connected for One Care 4
D1IV.1c	Appeals resolved in favor of enrollee Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.	Commonwealth Care Alliance One Care 466 Tufts One Care 67 UnitedHealthcare Connected for One Care 135

D1IV.2	Active appeals Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	Commonwealth Care Alliance One Care 0 Tufts One Care 108 UnitedHealthcare Connected for One Care 3
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).	Commonwealth Care Alliance One Care 796 Tufts One Care 103 UnitedHealthcare Connected for One Care 9
D1IV.4	Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal	Commonwealth Care Alliance One Care 15 Tufts One Care 3 UnitedHealthcare Connected for One Care 1

need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

D1IV.5a	Standard appeals for which timely resolution was provided Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	Commonwealth Care Alliance One Care 1,526
		Tufts One Care 125
		UnitedHealthcare Connected for One Care 178
D1IV.5b	Expedited appeals for which timely resolution was provided Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	Commonwealth Care Alliance One Care 100
		Tufts One Care 23
		UnitedHealthcare Connected for One Care 109
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).	Commonwealth Care Alliance One Care 1,087
		Tufts One Care 130
		UnitedHealthcare Connected for One Care 250

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.	Commonwealth Care Alliance One Care 484 Tufts One Care 0 UnitedHealthcare Connected for One Care 37
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.	Commonwealth Care Alliance One Care 51 Tufts One Care 14 UnitedHealthcare Connected for One Care 1
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).	Commonwealth Care Alliance One Care 0 Tufts One Care 4 UnitedHealthcare Connected for One Care 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 failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	Commonwealth Care Alliance One Care 0 Tufts One Care 2 UnitedHealthcare Connected for One Care 0
D1IV.6f	Resolved appeals related to plan denial of an enrollee's right to request out-of-network care	Commonwealth Care Alliance One Care N/A Tufts One 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). If not applicable, enter "N/A."	0	UnitedHealthcare Connected for One Care	N/A
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.		Commonwealth Care Alliance One Care	13
			Tufts One Care	0
			UnitedHealthcare Connected for One Care	0

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	Resolved appeals related to general inpatient services Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter “N/A”.	Commonwealth Care Alliance One Care 0 Tufts One Care 0 UnitedHealthcare Connected for One Care 1
D1IV.7b	Resolved appeals related to general outpatient services Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter “N/A”.	Commonwealth Care Alliance One Care 0 Tufts One Care 0 UnitedHealthcare Connected for One Care 19
D1IV.7c	Resolved appeals related to inpatient behavioral health services Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter “N/A”.	Commonwealth Care Alliance One Care 3 Tufts One Care 0 UnitedHealthcare Connected for One Care 1
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	Commonwealth Care Alliance One Care 54 Tufts One Care 0

	substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	UnitedHealthcare Connected for One Care 0
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".	Commonwealth Care Alliance One Care 2,943 Tufts One Care 50 UnitedHealthcare Connected for One Care 241
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".	Commonwealth Care Alliance One Care 0 Tufts One Care 0 UnitedHealthcare Connected for One Care 0
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".(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	Commonwealth Care Alliance One Care 377 Tufts One Care 43 UnitedHealthcare Connected for One Care 9

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".	Commonwealth Care Alliance One Care 523 Tufts One Care 46 UnitedHealthcare Connected for One Care 11
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".	Commonwealth Care Alliance One Care 161 Tufts One Care 11 UnitedHealthcare Connected for One Care 1
D1IV.7k:	Resolved appeals related to durable medical equipment (DME) & supplies Enter the total number of appeals resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".	Commonwealth Care Alliance One Care 168 Tufts One Care 0 UnitedHealthcare Connected for One Care 5
D1IV.7l:	Resolved appeals related to home health / hospice Enter the total number of appeals resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".	Commonwealth Care Alliance One Care 210 Tufts One Care 0 UnitedHealthcare Connected for One Care 0
D1IV.7m:	Resolved appeals related to emergency services / emergency department Enter the total number of appeals resolved by the plan	Commonwealth Care Alliance One Care 0 Tufts One Care

during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include appeals related to emergency outpatient behavioral health – those should be included in indicator D1.IV.7d. If the managed care plan does not cover this type of service, enter “N/A”.

0

UnitedHealthcare Connected for One Care

0

D1IV.7n: Resolved appeals related to therapies

Enter the total number of appeals resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter “N/A”.

Commonwealth Care Alliance One Care

19

Tufts One Care

0

UnitedHealthcare Connected for One Care

0

D1IV.7o 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-n paid primarily by Medicaid, enter “N/A”.

Commonwealth Care Alliance One Care

0

Tufts One Care

0

UnitedHealthcare Connected for One Care

0

State Fair Hearings

Number	Indicator	Response
D1IV.8a	State Fair Hearing requests Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.	Commonwealth Care Alliance One Care
		30
		Tufts One Care
		0
		UnitedHealthcare Connected for One Care
		2
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.	Commonwealth Care Alliance One Care
		3
		Tufts One Care
		0
		UnitedHealthcare Connected for One Care
		1
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.	Commonwealth Care Alliance One Care
		27
		Tufts One Care
		0
		UnitedHealthcare Connected for One Care
		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) during the reporting year prior to reaching a decision.	Commonwealth Care Alliance One Care
		0
		Tufts One Care
		0
		UnitedHealthcare Connected for One Care
		1
D1IV.9a	External Medical Reviews resulting in a favorable decision for the enrollee	Commonwealth Care Alliance One Care
		0

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 One Care

0

UnitedHealthcare Connected for One Care

0

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).

Commonwealth Care Alliance One Care

0

Tufts One Care

0

UnitedHealthcare Connected for One Care

19

Grievances Overview

Number	Indicator	Response
D1IV.10	Grievances resolved Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. A grievance is “resolved” when it has reached completion and been closed by the plan.	Commonwealth Care Alliance One Care 6,969 Tufts One Care 851 UnitedHealthcare Connected for One Care 125
D1IV.11	Active grievances Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	Commonwealth Care Alliance One Care 0 Tufts One Care 148 UnitedHealthcare Connected for One Care 7
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.	Commonwealth Care Alliance One Care 393 Tufts One Care 667 UnitedHealthcare Connected for One Care 3
D1IV.13	Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been “related” to the same issue -	Commonwealth Care Alliance One Care 0 Tufts One Care 46 UnitedHealthcare Connected for One Care 2

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 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	Commonwealth Care Alliance One Care 6,937
	Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	Tufts One Care 847
		UnitedHealthcare Connected for One Care 119

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”.	Commonwealth Care Alliance One Care 9 Tufts One Care 1 UnitedHealthcare Connected for One Care 1
D1IV.15b	Resolved grievances related to general outpatient services Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Do not include grievances related to outpatient behavioral health services - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter “N/A”.	Commonwealth Care Alliance One Care 0 Tufts One Care 215 UnitedHealthcare Connected for One Care 31
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”.	Commonwealth Care Alliance One Care 0 Tufts One Care 0 UnitedHealthcare Connected for One Care 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	Commonwealth Care Alliance One Care 0 Tufts One Care

	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".	8 UnitedHealthcare Connected for One Care 2
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".	Commonwealth Care Alliance One Care 863 Tufts One Care 77 UnitedHealthcare Connected for One Care 4
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".	Commonwealth Care Alliance One Care 6 Tufts One Care 12 UnitedHealthcare Connected for One Care 0
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".	Commonwealth Care Alliance One Care 393 Tufts One Care 79 UnitedHealthcare Connected for One Care 1
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".	Commonwealth Care Alliance One Care 198 Tufts One Care 50 UnitedHealthcare Connected for One Care

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".	Commonwealth Care Alliance One Care 1,841 Tufts One Care 141 UnitedHealthcare Connected for One Care 72
D1IV.15k	Resolved grievances related to durable medical equipment (DME) & supplies Enter the total number of grievances resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".	Commonwealth Care Alliance One Care 251 Tufts One Care 10 UnitedHealthcare Connected for One Care 1
D1IV.15l	Resolved grievances related to home health / hospice Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".	Commonwealth Care Alliance One Care 0 Tufts One Care 0 UnitedHealthcare Connected for One Care 2
D1IV.15m	Resolved grievances related to emergency services / emergency department Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	Commonwealth Care Alliance One Care 0 Tufts One Care 0 UnitedHealthcare Connected for One Care 0

D1IV.15n	Resolved grievances related to therapies Enter the total number of grievances resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter "N/A".	Commonwealth Care Alliance One Care 0 Tufts One Care 4 UnitedHealthcare Connected for One Care 0
D1IV.15o	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-n paid primarily by Medicaid, enter "N/A".	Commonwealth Care Alliance One Care 0 Tufts One Care 24 UnitedHealthcare Connected for One Care 0

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.	Commonwealth Care Alliance One Care 1,228 Tufts One Care 75 UnitedHealthcare Connected for One Care 0
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.	Commonwealth Care Alliance One Care 898 Tufts One Care 79 UnitedHealthcare Connected for One Care 1
D1IV.16c	Resolved grievances related to network adequacy or access to care/services from plan or provider Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	Commonwealth Care Alliance One Care 77 Tufts One Care 60 UnitedHealthcare Connected for One Care 0
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.	Commonwealth Care Alliance One Care 104 Tufts One Care 181 UnitedHealthcare Connected for One Care 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.	Commonwealth Care Alliance One Care 35 Tufts One Care 8 UnitedHealthcare Connected for One Care 0
D1IV.16f	Resolved grievances related to payment or billing issues Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	Commonwealth Care Alliance One Care 489 Tufts One Care 29 UnitedHealthcare Connected for One Care 5
D1IV.16g	Resolved grievances related to suspected fraud Enter the total number of grievances resolved by the plan 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.	Commonwealth Care Alliance One Care 25 Tufts One Care 1 UnitedHealthcare Connected for One Care 0
D1IV.16h	Resolved grievances related to abuse, neglect or exploitation Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	Commonwealth Care Alliance One Care 0 Tufts One Care 0 UnitedHealthcare Connected for One Care 0

D1IV.16i	Resolved grievances related to lack of timely plan response to a prior authorization/service authorization or appeal (including requests to expedite or extend appeals) Enter the total number of grievances resolved by the plan 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).	Commonwealth Care Alliance One Care 13 Tufts One Care 0 UnitedHealthcare Connected for One Care 0
D1IV.16j	Resolved grievances related to plan denial of expedited appeal Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	Commonwealth Care Alliance One Care 0 Tufts One Care 4 UnitedHealthcare Connected for One Care 0
D1IV.16k	Resolved grievances filed for other reasons Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	Commonwealth Care Alliance One Care 0 Tufts One Care 414 UnitedHealthcare Connected for One Care 101

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: Controlling High Blood Pressure

1 / 21

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

HEDIS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

HEDIS measure

Measure results

Commonwealth Care Alliance One Care

85.6%

Tufts One Care

78%

UnitedHealthcare Connected for One Care

81.3%



Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness - 7 Days (Total)

2 / 21

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

HEDIS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

HEDIS measure

Measure results

Commonwealth Care Alliance One Care

40%

Tufts One Care

56.4%

UnitedHealthcare Connected for One Care

36.4%



Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness - 30 Days (Total)

3 / 21

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

HEDIS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

HEDIS measure

Measure results

Commonwealth Care Alliance One Care

58.4%

Tufts One Care

79.4%

UnitedHealthcare Connected for One Care

61.2%



Complete

D2.VII.1 Measure Name: Initiation of Substance Use Disorder Treatment (Total)

4 / 21

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

HEDIS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

HEDIS measure

Measure results

Commonwealth Care Alliance One Care

42.5%

Tufts One Care

37.7%

UnitedHealthcare Connected for One Care

32.7%



Complete

D2.VII.1 Measure Name: Engagement of Substance Use Disorder Treatment (Total)

5 / 21

D2.VII.2 Measure Domain

Behavioral health care

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

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

Program-specific rate

0004

D2.VII.6 Measure Set
HEDIS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

HEDIS measure

Measure results

Commonwealth Care Alliance One Care

11.9%

Tufts One Care

10%

UnitedHealthcare Connected for One Care

8.5%



Complete

D2.VII.1 Measure Name: Plan All-Cause Readmission - 30 day readmits (Total <65) (O/E ratio) 6 / 21

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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
HEDIS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

HEDIS measure

Measure results

Commonwealth Care Alliance One Care

1.3715

Tufts One Care

1.3516

UnitedHealthcare Connected for One Care

1.2785



Complete

D2.VII.1 Measure Name: Access to LTSS Coordinator

7 / 21

D2.VII.2 Measure Domain

Long-term services and supports

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, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Percent of members with LTSS needs who have a referral to an LTSS Coordinator within 90 days of enrollment

Measure results

Commonwealth Care Alliance One Care

99.6%

Tufts One Care

93.3%

UnitedHealthcare Connected for One Care

59%



Complete

D2.VII.1 Measure Name: Tracking Demographic Data

8 / 21

D2.VII.2 Measure Domain

Population Health Management

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, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Percent of members whose demographic data are collected and maintained in the MMP Centralized Enrollee Record

Measure results

Commonwealth Care Alliance One Care

90.7%

Tufts One Care

77.2%

UnitedHealthcare Connected for One Care

84.5%



Complete

D2.VII.1 Measure Name: Documentation of Care Plan Goals

9 / 21

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, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

Percent of members with documented discussions of care goals

Measure results

Commonwealth Care Alliance One Care

100%

Tufts One Care

99.3%

UnitedHealthcare Connected for One Care

96.9%



Complete

D2.VII.1 Measure Name: Timely Assessment of New Members

10 / 21

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

CMS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

CMS measure

Measure results

Commonwealth Care Alliance One Care

93.2%

Tufts One Care

99.1%

UnitedHealthcare Connected for One Care

82%



Complete

D2.VII.1 Measure Name: Breast Cancer Screening

11 / 21

D2.VII.2 Measure Domain

Primary care access and preventative care

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

2372

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

HEDIS measure

Measure results

Commonwealth Care Alliance One Care

72.2%

Tufts One Care

70.3%

UnitedHealthcare Connected for One Care

65.6%



Complete

D2.VII.1 Measure Name: Glycemic Status Assessment for Patients with Diabetes – Poor Control (above 9%) 12 / 21

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

HEDIS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

HEDIS measure

Measure results

Commonwealth Care Alliance One Care

19.9%

Tufts One Care

24.8%

UnitedHealthcare Connected for One Care

21.4%



Complete

D2.VII.1 Measure Name: Transitions of Care - Patient Engagement After Inpatient Discharge (18-64) 13 / 21

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

HEDIS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

HEDIS measure

Measure results

Commonwealth Care Alliance One Care

91.3%

Tufts One Care

79.7%

UnitedHealthcare Connected for One Care

89.6%



Complete

D2.VII.1 Measure Name: Transitions of Care - Notification of Inpatient Admission (Ages 18-64) 14 / 21

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

HEDIS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

HEDIS measure

Measure results

Commonwealth Care Alliance One Care

91.8%

Tufts One Care

16%

UnitedHealthcare Connected for One Care

21.1%



Complete

D2.VII.1 Measure Name: Transitions of Care - Medication Reconciliation Post-Discharge (Ages 18-64) 5 / 21

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

HEDIS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

HEDIS measure

Measure results

Commonwealth Care Alliance One Care

75%

Tufts One Care

33.5%

UnitedHealthcare Connected for One Care

77.4%



Complete

D2.VII.1 Measure Name: Transitions of Care – Receipt of Discharge Information (Ages 18-64)

16 / 21

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

HEDIS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

HEDIS measure

Measure results

Commonwealth Care Alliance One Care

66.8%

Tufts One Care

10.6%

UnitedHealthcare Connected for One Care

16.4%



Complete

D2.VII.1 Measure Name: Minimizing Facility Length of Stay

17 / 21

D2.VII.2 Measure Domain

Long-term services and supports

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

CMS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

CMS measure

Measure results

Commonwealth Care Alliance One Care

1.79

Tufts One Care

1.87

UnitedHealthcare Connected for One Care

1.03



Complete

D2.VII.1 Measure Name: Getting Needed Care

18 / 21

D2.VII.2 Measure Domain

Health plan enrollee experience of 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

CMS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

CMS measure

Measure results

Commonwealth Care Alliance One Care

81%

Tufts One Care

78%

UnitedHealthcare Connected for One Care

N/A



Complete

D2.VII.1 Measure Name: Rating of Health Care Quality

19 / 21

D2.VII.2 Measure Domain

Health plan enrollee experience of 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

CMS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

CMS measure

Measure results

Commonwealth Care Alliance One Care

88%

Tufts One Care

87%

UnitedHealthcare Connected for One Care

N/A



Complete

D2.VII.1 Measure Name: Rating of Health Plan

20 / 21

D2.VII.2 Measure Domain

Health plan enrollee experience of 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

CMS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

CMS measure

Measure results

Commonwealth Care Alliance One Care

91%

Tufts One Care

86%

UnitedHealthcare Connected for One Care

84%



Complete

D2.VII.1 Measure Name: Care Coordination

21 / 21

D2.VII.2 Measure Domain

Health plan enrollee experience of 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

CMS

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

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

CMS measure

Measure results

Commonwealth Care Alliance One Care

85%

Tufts One Care

86%

UnitedHealthcare Connected for One Care

N/A

Topic VIII. Sanctions

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

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



Complete

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

1 / 5

D3.VIII.2 Plan performance issue

Prescription drug event

D3.VIII.3 Plan name

Commonwealth Care Alliance One Care

D3.VIII.4 Reason for intervention

Payment of pharmacy claims to disenrolled members

Sanction details**D3.VIII.5 Instances of non-compliance**

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/16/2025

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

Yes, remediated 01/16/2025

D3.VIII.9 Corrective action plan

Yes



Complete

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

2 / 5

D3.VIII.2 Plan performance issue

Timeliness Study

D3.VIII.3 Plan name

Commonwealth Care Alliance One Care

D3.VIII.4 Reason for intervention

2025 Call Center Monitoring Q1

Sanction details**D3.VIII.5 Instances of non-compliance**

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/10/2025

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

Yes, remediated 09/10/2025

D3.VIII.9 Corrective action plan

Yes



Complete

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

3 / 5

D3.VIII.2 Plan performance issue

Benefit Administration

D3.VIII.3 Plan name

Commonwealth Care Alliance One Care

D3.VIII.4 Reason for intervention

Direct member reimbursements were not processed timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

06/30/2025

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

Yes, remediated 06/30/2025

D3.VIII.9 Corrective action plan

Yes



Complete

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

4 / 5

D3.VIII.2 Plan performance issue

Care Coordination

D3.VIII.3 Plan name

UnitedHealthcare Connected for One Care

D3.VIII.4 Reason for intervention

Care Coordination and Transition of Care

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

08/12/2025

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

Yes, remediated 08/12/2025

D3.VIII.9 Corrective action plan

Yes



Complete

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

5 / 5

D3.VIII.2 Plan performance issue

Claims Processing

D3.VIII.3 Plan name

UnitedHealthcare Connected for One Care

D3.VIII.4 Reason for intervention

Incorrect Claims Processing for a Subset of Out-of-Network Providers

Sanction details**D3.VIII.5 Instances of non-compliance**

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

06/24/2025

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

Yes, remediated 06/24/2025

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).	Commonwealth Care Alliance One Care
		4
		Tufts One Care
		19
		UnitedHealthcare Connected for One Care
		2
D1X.2	Count of opened program integrity investigations How many program integrity investigations were opened by the plan during the reporting year?	Commonwealth Care Alliance One Care
		293
		Tufts One Care
		68
		UnitedHealthcare Connected for One Care
		11
D1X.4	Count of resolved program integrity investigations How many program integrity investigations were resolved by the plan during the reporting year?	Commonwealth Care Alliance One Care
		138
		Tufts One Care
		39
		UnitedHealthcare Connected for One Care
		24
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.	Commonwealth Care Alliance One Care
		Makes referrals to the State Medicaid Agency (SMA) only
		Tufts One Care
		Makes referrals to the State Medicaid Agency (SMA) only
		UnitedHealthcare Connected for One Care
		Makes referrals to the State Medicaid Agency (SMA) only

D1X.7	Count of program integrity referrals to the state	Commonwealth Care Alliance One Care
	Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made.	27
		Tufts One Care
		68
		UnitedHealthcare Connected for One Care
		22
D1X.9a:	Plan overpayment reporting to the state: Start Date	Commonwealth Care Alliance One Care
	What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	01/01/2025
		Tufts One Care
		01/01/2025
		UnitedHealthcare Connected for One Care
		01/01/2025
D1X.9b:	Plan overpayment reporting to the state: End Date	Commonwealth Care Alliance One Care
	What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	12/31/2025
		Tufts One Care
		12/31/2025
		UnitedHealthcare Connected for One Care
		12/31/2025
D1X.9c:	Plan overpayment reporting to the state: Dollar amount	Commonwealth Care Alliance One Care
	From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	\$0
		Tufts One Care
		\$46,970.82
		UnitedHealthcare Connected for One Care
		\$271,503.78
D1X.9d:	Plan overpayment reporting to the state: Corresponding premium revenue	Commonwealth Care Alliance One Care
		\$791,383,509

What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))

Tufts One Care

\$296,926,989

UnitedHealthcare Connected for One Care

\$189,985,915

D1X.10

Changes in beneficiary circumstances

Select the frequency the plan reports changes in beneficiary circumstances to the state.

Commonwealth Care Alliance One Care

Promptly when plan receives information about the change

Tufts One Care

Promptly when plan receives information about the change

UnitedHealthcare Connected for One Care

Promptly when plan receives information about the change

Topic XI: ILOS

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

Number	Indicator	Response
D4XI.1	ILOSs offered by plan Indicate whether this plan offered any ILOS to their enrollees.	Commonwealth Care Alliance One Care No ILOSs were offered by this plan
		Tufts One Care No ILOSs were offered by this plan
		UnitedHealthcare Connected for One Care No ILOSs were offered by this plan

Topic XIII. Prior Authorization



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

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Commonwealth Care Alliance One Care Not answered
		Tufts One Care Not answered
		UnitedHealthcare Connected for One Care Not answered

Topic XIV. Patient Access API Usage



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

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Commonwealth Care Alliance One Care Not answered Tufts One Care Not answered UnitedHealthcare Connected for One Care Not answered

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

Number	Indicator	Response
EIX.1	BSS entity type What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	Serving the Health Insurance Needs for Everyone (SHINE) State Health Insurance Assistance Program (SHIP)
		My Ombudsman Ombudsman Program Other Community-Based Organization
		Automated Health Systems (AHS) Enrollment Broker
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).	Serving the Health Insurance Needs for Everyone (SHINE) Enrollment Broker/Choice Counseling
		My Ombudsman Beneficiary Outreach LTSS Complaint Access Point LTSS Grievance/Appeals Education Other, specify – Assistance with any issues or complaints accessing managed care benefits or services, Collection and review of data
		Automated Health Systems (AHS) Enrollment Broker/Choice Counseling

Section F: Notes

Notes

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

Number	Indicator	Response
F1	Notes (optional)	* We have indicated No for B.X.9a as we have temporary approval from CMS to not post this information due to safety concerns *We entered dummy dates of 1/1/1900 in response to C1.II.1-2 because One Care operated as a Medicare-Medicaid Plan Demonstration program pursuant to Section 1115A and a three-way contract between CMS, EOHHS, and the One Care plans during the reporting period. The three-way contract included MLR requirements specific to One Care, including specifying that the One Care MLR reflects a blend of Medicare and Medicaid data and also required that One Care plans’ MLR reporting be submitted to and reviewed by CMS and EOHHS jointly. * In response to D1.X.6, we chose Option 2 but the plans sometimes copy the MFCU when referring the provider to the SMA. * In response to D1.XIV.5, we have included the Patient Access API URL in the Provider Access and Payer-to-Payer API field in the report. Since the URLs for the Provider Access and Payer-to-Payer API go into effect on 1/1/27, we will be able to provide those URLs in our MCPAR reports for CY2026, submitted in June 2027.