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

Due date	Last edited	Edited by	Status
06/28/2024	06/27/2024	Alison Kirchgasser	Submitted

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Selected

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Massachusetts
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Alison Kirchgasser
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	alison.kirchgasser@mass.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Alison Kirchgasser
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	alison.kirchgasser@mass.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	06/27/2024

Reporting Period

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

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 Health Plan Unify United Healthcare 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 438.71See Glossary in Excel Workbook for the definition of BSS entities.

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

	Indicator	Response
	BSS entity name	Serving the Health Insurance Needs for Everyone (SHINE) My Ombudsman (MYO) Automated Health Systems (AHS) Maximus

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.	2,374,433
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	1,574,873

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 quarterly 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, 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 plans' 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 new provisions established consistency in program integrity requirements across all of MassHealth's managed care entities. The contractual requirements will support MassHealth's ongoing expansion of One Care plans' oversight, which may include direct audits of One Care plans' providers and encounters beginning in Contract Year 2024 for dates of service in 2023. In 2023, MassHealth began preparing for performing direct audits and encounter analyses to identify One Care plans' provider overpayments. These activities will include audits of Applied Behavior Analysis (ABA) providers to be conducted in the summer of 2024. Further, MassHealth launched new One Care plans Summary of Provider Overpayments Reporting in July 2023. MassHealth published new, extremely detailed reporting requirements along with a new reporting template. This is a semi-annual report that includes all overpayments identified during the prior Contract Year through present, including all investigatory and recovery activity related to such overpayments. These reports provide MassHealth with comprehensive information related to the impact of One Care plans' controls, including the breadth 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 2023, MassHealth primary focus was on ensuring compliance with these new reporting requirements. Moving forward, the information contained in the new Summary of Provider Overpayments reports will enable MassHealth to share best practices, monitor performance management, and enforce the relevant contract provisions related to overpayments that the plans fail to identify and/or recover.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	2.8.3.1.1.6.4; 4.6.2.2
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	One Care: 2.8.3.1.1.6.4. Consistent with 42 C.F.R. §438.608(d), plans shall develop and maintain policies and procedures that support a process for the recoupment of overpayments to providers including those providers identified as excluded by appearing on any exclusion or debarment database. Plans must maintain documentation to support the date and activities by which recoupment efforts are established for claims paid after the date indicated in the exclusion database. At a minimum, the Contractor must document recoupment efforts include outreach to the Provider, voiding claims, and establishing a recoupment account.
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).	One Care plans must report promptly to EOHHS when they receive information on a change in Enrollee circumstances which may impact their elgibility, including but not limited to a change in an Enrollee's residence or death of an Enrollee.
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 or PCCM entity, any subcontractor, as well as any	No

	person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	Yes
BX.9b	**Website posting of 5 percent or more ownership control: Link** What is the link to the website? Refer to 42 CFR 602(g)(3).	https://www.mass.gov/managed-care-entity-disclosure-requirements
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.	Audits to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans are underway and being conducted in two sets. The first set of audits covering ACO/MCO/MBHP are in the final stages of completion and we expect to post audit results in late 2024. The second set of audits covering SCO and One Care are underway and expected to be completed in 2025.

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	One Care Three-Way Contract
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2022
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.mass.gov/info-details/one-care-three-way-contract-and-memorandum-of-understanding-mou
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Long-term services and supports (LTSS) Dental Transportation
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per	41,434

	month during the reporting year (i.e., average member months).	
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter 'There were no major changes to the population or benefits during the reporting year' as your response. 'N/A' is not an acceptable response.	N/A

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data corrections Use of correct file formats Overall data accuracy (as determined through data validation)
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Section 2.17 Encounter Reporting
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	5.3.15.1, 5.3.15.1.11

	standards. Use contract section references, not page numbers.	
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting 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.	No barriers are present currently.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	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.	Appeal resolution time frames - All service Appeals must be resolved (at each level) within thirty (30) days of their submission for standard Appeals in accordance with Section 2.12.2.3 and within seventy-two (72) hours of their submission for expedited Appeals in accordance with Section 2.12.2.4.
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.	Appeal resolution time frames - All service Appeals must be resolved (at each level) within thirty (30) days of their submission for standard Appeals in accordance with Section 2.12.2.3 and within seventy-two (72) hours of their submission for expedited Appeals in accordance with Section 2.12.2.4.
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	Response, electronically, orally or in writing, to each Enrollee Grievance within a reasonable time, but no later than thirty (30) days after the Contractor receives the Grievance.

		day the MCO, PIHP or PAHP receives the grievance.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter 'No challenges were encountered' as your response. 'N/A' is not an acceptable response.	Challenges currently facing One Care plans include: (1) limited numbers of providers of certain services in certain geographic areas, including the islands; (2) reluctance from certain large hospital providers to contract to provide services, including specialty physicians; and (3) lack of certain provider types (including dermatologists and dentists) to contract to provide services, particularly in rural areas.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	MassHealth uses its contract to enforce standards that protect access to care. When issues arise, we connect with MCP key contacts to identify the issue, develop a long-term plan to correct the issue, and a plan to preserve member access to services while the underlying issue is being addressed. MassHealth has tools in its contracts to address non-compliance including corrective workplan, formal corrective action plan, sanctions, or contract termination.

Access Measures

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

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

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

Access measure total count: 25

Complete

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

1 / 25

C2.V.2 Measure standard

30 minutes or 15 miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

2 / 25

C2.V.2 Measure standard

25 minutes and 10 miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Large metro	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

3 / 25

C2.V.2 Measure standard

45 minutes and 30 miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Metro	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

4 / 25

C2.V.2 Measure standard

80 minutes and 60 miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Micro	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

5 / 25

C2.V.2 Measure standard

30 minutes or 15 miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS	Statewide	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

6 / 25

C2.V.2 Measure standard

2 Providers within 25 Minutes and 10 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Acute Inpatient Hospital	Large Metro	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

7 / 25

C2.V.2 Measure standard

2 Providers within 45 Minutes and 30 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Acute Inpatient Hospital	Metro	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

8 / 25

C2.V.2 Measure standard

2 Providers within 80 Minutes and 60 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Acute Inpatient Hospital	Micro	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: LTSS-related standard: enrollee travels to the provider

9 / 25

C2.V.2 Measure standard

2 Providers within 30 Minutes or 15 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Adult Day Health, Adult Foster Care	Statewide	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 10 / 25

C2.V.2 Measure standard

2 Providers within 30 Minutes and 15 Miles

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 11 / 25

C2.V.2 Measure standard

1 Provider within 53 Minutes and 35 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Allergy and Immunology, Nephrology, Physiatry, Rehabilitative Medicaine	Metro	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

12 / 25

C2.V.2 Measure standard

1 Provider within 30 Minutes and 15 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Allergy and Immunology, Cardiothoracic Surgery, Chiropractor, Endocrinology, ENT/Otolaryngolog, Infectious Diseases, Nephrology, Neurosurgery, OB/GYN, Oncology - Radiation/Radiation Oncology, Physiatry/ Rehabilitative Medicine, Plastic Surgery, Rheumatology, Vascular Surgery	Large Metro	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

13 / 25

C2.V.2 Measure standard

2 Providers within 30 Minutes or 15 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
BH Outpatient, Clinical Support Services for Substance Use Disorders (Level 3.5), Community Crisis Stabilization, Community Support Program, Emergency Support Services, Intensive Outpatient Program, Monitored inpatient Level 3.7, Occupational Therapy, Orthotics and Prosthetics, Oxygen and Respiratory Equipment,Partial Hospitalization Program, Physical Therapy, Program of Assertive Community Treatment, Psychiatric Day Treatment, Recovery Coaching, Recovery Support Navigators, Residential Rehabilitation Services for Substance Use Disorders (Level 3.1), Speech Therapy, Structured Outpatient Addiction Program	Statewide	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

14 / 25

C2.V.2 Measure standard

1 Provider within 20 Minutes and 10 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Cardiology, Dermatology, Gastroenterology, General Surgery, Neurology, Oncology - Medical, Surgical, Ophthalmology, Orthopedic Surgery, Podiatry, Psychiatry, Pulmonology, Urology	Large Metro	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

15 / 25

C2.V.2 Measure standard

1 Provider within 38 Minutes and 25 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Cardiology, Ophthalmology, Orthopedic Surgery	Metro	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

16 / 25

C2.V.2 Measure standard

1 Provider within 60 Minutes and 40 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Cardiothoracic Surgery, Neurosurgery, Oncology - Radiation/Radiation Oncology, Rheumatology	Metro	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

17 / 25

C2.V.2 Measure standard

1 Provider within 45 Minutes and 30 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Chiropractor, Dermatology,	Metro	Adult

ENT/Otolaryngology,
Gastroenterology,
Neurology, Ob/Gyn,
Oncology - Medical,
Surgical, Podiatry,
Psychiatry,
Pulmonology,
Urology

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: LTSS-related standard: enrollee travels to the provider 18 / 25

C2.V.2 Measure standard

2 Providers within 30 Minutes or 15 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Day Habilitation	Statewide	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: LTSS-related standard: enrollee travels to the provider 19 / 25

C2.V.2 Measure standard

2 Providers within 30 Minutes or 15 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-adult day care	Statewide	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

20 / 25

C2.V.2 Measure standard

1 Provider within 75 Minutes and 50 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Endocrinology, Infectious Diseases, Plastic Surgery, Vascular Surgery	Metro	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

21 / 25

C2.V.2 Measure standard

1 Provider within 30 Minutes and 20 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
General Surgery	Metro	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: LTSS-related standard: provider travels to the enrollee

22 / 25

C2.V.2 Measure standard

2 Providers within 30 Minutes or 15 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Group Adult Foster Care, Hospice	Statewide	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: LTSS-related standard: provider travels to the enrollee

23 / 25

C2.V.2 Measure standard

2 Providers within 30 Minutes or 15 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-personal care assistant	Statewide	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

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

24 / 25

C2.V.2 Measure standard

1 Provider within 30 Minutes or 15 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Rehabilitation hospital	Statewide	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: LTSS-related standard: enrollee travels to the provider

25 / 25

C2.V.2 Measure standard

2 Providers within 30 Minutes and 15 Miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-SNF	Statewide	Adult

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Annually

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://www.mass.gov/health-insurance-counseling; info@myombudsman.org (email); www.myombudsman.org (general information); member-issues@masshealthquestions.com
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 (MYO): • Can be reached by phone (855-781-9898); videophone (for Deaf and Hard of Hearing members: 339-224-6831); via email (info@myombudsman.org) and in person (drop in or by appointment) on certain days. They also have virtual resources on their website: www.myombudsman.org • Have a fully accessible physical location that members may go to for drop in or in-person assistance on certain days • Maintains Vlogs (Video Blog) that provide information about My Ombudsman in ASL (all currently on YouTube) and other MH topics for Deaf and Hard of Hearing members. • Provides My Ombudsman information in large print. • Their website has an application that allows users with specific disabilities to adjust the website's design to their personal needs to ensure accessibility. • Uses technology such as QR codes to help make materials more accessible to those with vision disabilities. • has in-house staff who can provide services to One Care enrollees in American Sign Language (ASL), Hindi, Spanish, and Haitian-Creole. • can provide additional interpreters for all its services and activities in over 165 different languages (upon request). • provides My Ombudsman informational materials in English, Chinese, Haitian-Creole, Portuguese, Russian, Spanish, and Vietnamese. • Provides additional language translation services as needed. • Also does in-person and virtual outreach with community based organizations and at community events. AHS - Contract has accessibility requirements to accommodate members with disabilities. AHS is required to comply with the ADA and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 USC

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

		and 9. Providing individualized assistance, as necessary.
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).	My Ombudsman (MYO) 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). Maximus - The State evaluates Maximus's quality, effectiveness, and efficiency

through various contract management, internal controls, and reporting requirements. For example, Section 4.8 of Maximus's contract requires that Maximus engage in weekly and ad hoc meetings with EOHHS to address project plans, operational issues, progress toward annual goals, and the status of any quality improvement projects. Maximus is further required to conduct an independent annual compliance audit, cooperate and participate in program or financial audits and maintain and submit to EOHHS fraud, waste, and abuse protocols (see Section 4.9). Maximus is also required to use principles of continuous quality improvement to satisfy its obligations under its contract, which include analyzing data measuring contractor performance, training staff, recommending operational improvements, and identifying and implementing Quality Improvement Projects and related reports (see Section 4.10). Lastly, the Maximus contract contains general reporting requirements (see Section 4.13), which include weekly, monthly, quarterly, and ad hoc reports detailing, e.g., member transactions and customer encounters. My Ombudsman (MYO) – The State evaluates My Ombudsman's quality, effectiveness and efficiency through various contract management, internal controls and reporting requirements; through routine review of satisfaction survey data (My Ombudsman asks each member they work with to complete a survey to evaluate their satisfaction with services once a case has been closed); and through weekly case meetings.

Topic X: Program Integrity

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

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** 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** 30,668 **Tufts Health Plan Unify** 6,822 **United Healthcare Connected for One Care** 4,155
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** 1.3% **Tufts Health Plan Unify** 0.3% **United Healthcare Connected for One Care** 0.2%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Commonwealth Care Alliance One Care** 1.9% **Tufts Health Plan Unify** 0.4% **United Healthcare Connected for One Care** 0.3%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Commonwealth Care Alliance One Care** 92% **Tufts Health Plan Unify** 93% **United Healthcare Connected for One Care** 91%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Commonwealth Care Alliance One Care** Program-specific statewide **Tufts Health Plan Unify** Program-specific statewide **United Healthcare Connected for One Care** Program-specific statewide
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**Commonwealth Care Alliance One Care** N/A **Tufts Health Plan Unify** N/A **United Healthcare Connected for One Care** N/A
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Commonwealth Care Alliance One Care** Yes **Tufts Health Plan Unify**

		Yes **United Healthcare Connected for One Care** Yes
N/A	Enter the start date.	**Commonwealth Care Alliance One Care** 01/01/2021 **Tufts Health Plan Unify** 01/01/2021 **United Healthcare Connected for One Care** 01/01/2022
N/A	Enter the end date.	**Commonwealth Care Alliance One Care** 12/31/2021 **Tufts Health Plan Unify** 12/31/2021 **United Healthcare Connected for One Care** 12/31/2022

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**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 Health Plan Unify** 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. **United Healthcare 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** 25% **Tufts Health Plan Unify** 100% **United Healthcare Connected for One Care** 100%
D1III.3	**Share of encounter data submissions that were HIPAA compliant**	**Commonwealth Care Alliance One Care** 100%

What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	**Tufts Health Plan Unify** 100% **United Healthcare 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** 2,070 **Tufts Health Plan Unify** 577 **United Healthcare Connected for One Care** 204
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 Health Plan Unify** 39 **United Healthcare Connected for One Care** 2
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** 111 **Tufts Health Plan Unify** 366 **United Healthcare Connected for One Care** 3
D1IV.4	**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal**	**Commonwealth Care Alliance One Care** 0 **Tufts Health Plan Unify**

	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 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.	10 **United Healthcare Connected for One Care** 0
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** 1,493 **Tufts Health Plan Unify** 351 **United Healthcare Connected for One Care** 105
D1IV.5b	**Expedited appeals for which timely resolution was**	**Commonwealth Care Alliance One Care**

	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.	567 **Tufts Health Plan Unify** 173 **United Healthcare Connected for One Care** 98
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** 0 **Tufts Health Plan Unify** 186 **United Healthcare Connected for One Care** 200
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** 111 **Tufts Health Plan Unify** 0 **United Healthcare Connected for One Care** 0
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Commonwealth Care Alliance One Care** 8 **Tufts Health Plan Unify** 158 **United Healthcare Connected for One Care** 4

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 Health Plan Unify** 53 **United Healthcare 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 Health Plan Unify** 374 **United Healthcare Connected for One Care** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of 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).	**Commonwealth Care Alliance One Care** 0 **Tufts Health Plan Unify** 186 **United Healthcare Connected for One Care** 0
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Commonwealth Care Alliance One Care** 1 **Tufts Health Plan Unify** 9 **United Healthcare 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 Health Plan Unify** 1 **United Healthcare Connected for One Care** 0
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Commonwealth Care Alliance One Care** 120 **Tufts Health Plan Unify** 9 **United Healthcare Connected for One Care** 25
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** 2 **Tufts Health Plan Unify** 7 **United Healthcare Connected for One Care** 0
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan	**Commonwealth Care Alliance One Care** 0 **Tufts Health Plan Unify**

	during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	6 **United Healthcare 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** 1,350 **Tufts Health Plan Unify** 195 **United Healthcare Connected for One Care** 164
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 Health Plan Unify** 0 **United Healthcare 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".	**Commonwealth Care Alliance One Care** 111 **Tufts Health Plan Unify** 11 **United Healthcare Connected for One Care** 0
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that	**Commonwealth Care Alliance One Care** 337 **Tufts Health Plan Unify**

	were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	44 **United Healthcare Connected for One Care** 15
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** 0 **Tufts Health Plan Unify** 1 **United Healthcare Connected for One Care** 0
D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i paid primarily by Medicaid, enter "N/A".	**Commonwealth Care Alliance One Care** 150 **Tufts Health Plan Unify** 303 **United Healthcare 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 filed during the reporting year with the plan that issued an adverse benefit determination.	**Commonwealth Care Alliance One Care** 26 **Tufts Health Plan Unify** 5 **United Healthcare Connected for One Care** 1
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** 4 **Tufts Health Plan Unify** 3 **United Healthcare Connected for One Care** 0
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Commonwealth Care Alliance One Care** 22 **Tufts Health Plan Unify** 1 **United Healthcare 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** 47 **Tufts Health Plan Unify** 1 **United Healthcare Connected for One Care** 1

D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Commonwealth Care Alliance One Care** N/A **Tufts Health Plan Unify** N/A **United Healthcare Connected for One Care** N/A
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Commonwealth Care Alliance One Care** N/A **Tufts Health Plan Unify** N/A **United Healthcare Connected for One Care** N/A

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Commonwealth Care Alliance One Care** 5,488 **Tufts Health Plan Unify** 519 **United Healthcare Connected for One Care** 211
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 Health Plan Unify** 42 **United Healthcare Connected for One Care** 9
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** 122 **Tufts Health Plan Unify** 376 **United Healthcare 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	**Commonwealth Care Alliance One Care** 0 **Tufts Health Plan Unify** 16

	the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should 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.	**United Healthcare Connected for One Care** 0
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year.	**Commonwealth Care Alliance One Care** 5,488 **Tufts Health Plan Unify** 400

See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**United Healthcare Connected for One Care** 211

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** 0 **Tufts Health Plan Unify** 0 **United Healthcare 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, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Commonwealth Care Alliance One Care** 0 **Tufts Health Plan Unify** 3 **United Healthcare Connected for One Care** 32
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 Health Plan Unify** 0 **United Healthcare 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 were related to outpatient	**Commonwealth Care Alliance One Care** 0 **Tufts Health Plan Unify**

	mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	5 **United Healthcare Connected for One Care** 1
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** 141 **Tufts Health Plan Unify** 66 **United Healthcare Connected for One Care** 3
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** 3 **Tufts Health Plan Unify** 0 **United Healthcare 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** 122 **Tufts Health Plan Unify** 112 **United Healthcare Connected for One Care** 14
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	**Commonwealth Care Alliance One Care** 182 **Tufts Health Plan Unify** 17

	not cover this type of service, enter "N/A".	**United Healthcare Connected for One Care** 7
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** 2,209 **Tufts Health Plan Unify** 67 **United Healthcare Connected for One Care** 150
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i paid primarily by Medicaid, enter "N/A".	**Commonwealth Care Alliance One Care** 0 **Tufts Health Plan Unify** 316 **United Healthcare Connected for One Care** 3

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** 194 **Tufts Health Plan Unify** 21 **United Healthcare Connected for One Care** 4
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** 146 **Tufts Health Plan Unify** 74 **United Healthcare Connected for One Care** 11
D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.	**Commonwealth Care Alliance One Care** 695 **Tufts Health Plan Unify** 21 **United Healthcare Connected for One Care** 3

Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.

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** 187 **Tufts Health Plan Unify** 58 **United Healthcare Connected for One Care** 35
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** 4 **Tufts Health Plan Unify** 12 **United Healthcare Connected for One Care** 6
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** 109 **Tufts Health Plan Unify** 50 **United Healthcare 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 perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Commonwealth Care Alliance One Care** 38 **Tufts Health Plan Unify** 3 **United Healthcare 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** 11 **Tufts Health Plan Unify** 0 **United Healthcare Connected for One Care** 1
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved by the plan during the reporting year that 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** 0 **Tufts Health Plan Unify** 0 **United Healthcare Connected for One Care** 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal**	**Commonwealth Care Alliance One Care** 5

	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.	**Tufts Health Plan Unify** 5 **United Healthcare 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** 4,099 **Tufts Health Plan Unify** 275 **United Healthcare Connected for One Care** 146

Topic VII: Quality & Performance Measures

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

Quality & performance measure total count: 12

Complete

D2.VII.1 Measure Name: Influenza Vaccination

1 / 12

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0039

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

Program-specific rate

D2.VII.6 Measure Set

CAHPS

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

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

D2.VII.8 Measure Description

N/A

Measure results

Commonwealth Care Alliance One Care

69%

Tufts Health Plan Unify

67%

United Healthcare Connected for One Care

67%

Complete

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

2 / 12

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0018

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Commonwealth Care Alliance One Care

73.22%

Tufts Health Plan Unify

67.25

United Healthcare Connected for One Care

N/A

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Commonwealth Care Alliance One Care

41.23%

Tufts Health Plan Unify

54.40%

United Healthcare Connected for One Care

29.07%

Complete

D2.VII.1 Measure Name: Follow-up After Hospitalization for Mental Illness (30 days)

4 / 12

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Commonwealth Care Alliance One Care

62.15%

Tufts Health Plan Unify

69.95%

United Healthcare Connected for One Care

45.35%

Complete

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

5 / 12

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

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Commonwealth Care Alliance One Care

38.90%

Tufts Health Plan Unify

38.16%

United Healthcare Connected for One Care

N/A

Complete

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

6 / 12

D2.VII.2 Measure Domain

Behavioral health care

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

0004

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Commonwealth Care Alliance One Care

10.64%

Tufts Health Plan Unify

11.05%

United Healthcare Connected for One Care

N/A

Complete

D2.VII.1 Measure Name: HBD: Hemoglobin A1c Control: >9%

7 / 12

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0059

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Commonwealth Care Alliance One Care

N/A

Tufts Health Plan Unify

29.2%

United Healthcare Connected for One Care

N/A

Complete

D2.VII.1 Measure Name: Plan All-Cause Readmission (Observed/Expected Ratio) (18–64 years)

8 / 12

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

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Commonwealth Care Alliance One Care

1.3778

Tufts Health Plan Unify

0.9360

United Healthcare Connected for One Care

N/A

Complete

D2.VII.1 Measure Name: Access to LTS Coordinator: Percent of members with LTSS needs who have a referral to an LTS Coordinator within 90 days of enrollment

9 / 12

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 Quality Withold Measure

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

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

D2.VII.8 Measure Description

Denominator: The total number of members identified with LTSS needs within 90 days of enrollment, excluding the total number of members with LTSS needs who refused an LTS Coordinator within 90 days of enrollment (Data Element B – Data Element C) summed over four quarters. Numerator: The total number of members with LTSS needs who have a referral to an

LTS Coordinator within 90 days of enrollment (Data Element D) summed over four quarters.

Measure results

Commonwealth Care Alliance One Care

99.90%

Tufts Health Plan Unify

71.40%

United Healthcare Connected for One Care

33.70%

Complete

10 / 12

D2.VII.1 Measure Name: Tracking of Demographic Information: Percent of members whose demographic data are collected and maintained in the Centralized Enrollee Record (race/ethnicity/ primary language/homelessness/disability type/LGBTQ identity).

D2.VII.2 Measure Domain

Health plan administration

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 Quality Withold Measure

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

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

D2.VII.8 Measure Description

Denominator: The total number of members enrolled at the end of the reporting period multiplied by six (six is the number of data elements included in the measure). Numerator: The total number of members whose race/ethnicity/primary language/homelessness/disability type/LGBTQ identity data are collected and maintained in the MMP Centralized Enrollee Record (Data Element A + Data Element B + Data Element C + Data Element D + Data Element E + Data Element F)

Measure results

Commonwealth Care Alliance One Care

75.50%

Tufts Health Plan Unify

69.9%

United Healthcare Connected for One Care

61%

Complete

D2.VII.1 Measure Name: Documentation of Care Plan Goals: Percent of members with documented discussions of care goals.

D2.VII.2 Measure Domain

Care 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

CMS Quality Withold Measure

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

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

D2.VII.8 Measure Description

Denominator: The total number of members with an initial care plan completed during the reporting period plus the total number of existing care plans revised during the reporting period (Data Element A + Data Element C) summed over four quarters. Numerator: The total number of members with at least one documented discussion of care goals in the initial care plan plus the total number of revised care plans with at least one documented discussion of new or existing care goals (Data Element B + Data Element D) summed over four quarters

Measure results

Commonwealth Care Alliance One Care

100%

Tufts Health Plan Unify

97.6%

United Healthcare Connected for One Care

98.3%

Complete

D2.VII.1 Measure Name: Timely Assessment: Percent of members with an initial assessment completed within 90 days of enrollment

12 / 12

D2.VII.2 Measure Domain

Care 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

CMS Quality Withold Measure

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

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

D2.VII.8 Measure Description

Denominator: The total number of members whose 90th day of enrollment occurred within the reporting period, excluding the total number of members who were documented as unwilling to participate in the assessment within 90 days of enrollment and the total number of members the MMP was unable to reach within 90 days of enrollment (Data Element A – Data Element B – Data Element C) summed over four quarters.
Numerator: The total number of members with an assessment completed within 90 days of enrollment (Data Element D) summed over four quarters

Measure results

Commonwealth Care Alliance One Care

91.1%

Tufts Health Plan Unify

96.2%

United Healthcare Connected for One Care

51.1%

Topic VIII. Sanctions

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

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

Sanction total count: 13

Complete

D3.VIII.1 Intervention type: Compliance letter

1 / 13

D3.VIII.2 Plan performance issue

Appeals and Grievances, Including Coverage/Organization Determination

D3.VIII.3 Plan name

Commonwealth Care Alliance One Care

D3.VIII.4 Reason for intervention

Delay or denial of Part C medical services and Part D medications.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

11/20/2023

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

Yes, remediated 11/20/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

2 / 13

D3.VIII.2 Plan performance issue

Accuracy & Accessibility Study

D3.VIII.3 Plan name

Commonwealth Care Alliance One Care

D3.VIII.4 Reason for intervention

2023 ACC NONC

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

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

10/25/2023

Yes, remediated 10/25/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Plan performance issue

Marketing Materials--Advertising and Enrollment

D3.VIII.3 Plan name

Commonwealth Care Alliance One Care

D3.VIII.4 Reason for intervention

due to accuracy issues (e.g., inaccurate cost share and prior authorization requirements) with MA-PD marketing materials, CCA had removed all SB materials from their websites and halted in-person and telephonic enrollment.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/06/2023

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

Yes, remediated 09/06/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Plan performance issue

Appeals and Grievances, Including Coverage/Organization Determination

D3.VIII.3 Plan name

Commonwealth Care Alliance One Care

D3.VIII.4 Reason for intervention

failed to effectuate or report as effectuated a total of 50 Part C and D appeals.

Sanction details

D3.VIII.5 Instances of non-compliance

50

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

04/13/2023

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

Yes, remediated 04/13/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

5 / 13

D3.VIII.2 Plan performance issue

Appeals and Grievances, Including Coverage/Organization Determination

D3.VIII.3 Plan name

Commonwealth Care Alliance One Care

D3.VIII.4 Reason for intervention

the organization had mailed 11,193 organization determinations and grievance dispositions with incomplete address information from June 24, 2022 through August 20, 2022, resulting in the return of notifications as undeliverable.

Sanction details

D3.VIII.5 Instances of non-compliance

11,193

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

04/13/2023

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

Yes, remediated 04/13/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

6 / 13

D3.VIII.2 Plan performance issue

Marketing Material

D3.VIII.3 Plan name

Commonwealth Care Alliance One Care

D3.VIII.4 Reason for intervention

ANOC Errata Timeliness

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/29/2023

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

Yes, remediated 03/29/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

7 / 13

D3.VIII.2 Plan performance issue

Access to Services--Pharmacies/Prescription Drug

D3.VIII.3 Plan name

Commonwealth Care Alliance One Care

D3.VIII.4 Reason for intervention

On January 5, 2022, CCA began receiving complaints that members were not able to access pharmacy benefits and/or were ineligible for plan benefits such as contracted provider visits and payment of claims for covered services. 524 members were impacted.

Sanction details

D3.VIII.5 Instances of non-compliance

524

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/23/2023

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

Yes, remediated 01/23/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

8 / 13

D3.VIII.2 Plan performance issue

Timeliness Study

D3.VIII.3 Plan name

Tufts Health Plan Unify

D3.VIII.4 Reason for intervention

2023 Timeliness S1Q1 NONC

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

06/28/2023

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

Yes, remediated 06/28/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

9 / 13

D3.VIII.2 Plan performance issue

Access to Services--Health Care Providers/Medical Services

D3.VIII.3 Plan name

Tufts Health Plan Unify

D3.VIII.4 Reason for intervention

Between August - November 2022, 68 organization determinations were denied because the plan did not have adequate staff to process the service requests during the initial review timeframe.

Sanction details

D3.VIII.5 Instances of non-compliance

68

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

07/12/2023

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

Yes, remediated 07/12/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

10 / 13

D3.VIII.2 Plan performance issue

Cost Sharing

D3.VIII.3 Plan name

Tufts Health Plan Unify

D3.VIII.4 Reason for intervention

CMS and EOHHS issued a notice of non-compliance regarding the organization's failure to charge the appropriate prescription drug copayments for subsidy eligible individuals.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

10/16/2023

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

Yes, remediated 10/16/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

11 / 13

D3.VIII.2 Plan performance issue

Access to Services--Health Care

D3.VIII.3 Plan name

United Healthcare Connected for One Care

Providers/Medical Services

D3.VIII.4 Reason for intervention

Sponsor charged enrollees incorrect Part C and D cost sharing amounts.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/13/2023

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

Yes, remediated 02/13/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter

12 / 13

D3.VIII.2 Plan performance issue

Accuracy & Accessibility Study

D3.VIII.3 Plan name

United Healthcare Connected for One Care

D3.VIII.4 Reason for intervention

LEP WL 2023

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

10/25/2023

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

Yes, remediated 10/25/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Compliance letter 13 / 13

D3.VIII.2 Plan performance issue

Accuracy & Accessibility Study

D3.VIII.3 Plan name

United Healthcare Connected for One Care

D3.VIII.4 Reason for intervention

TTY WL 2023

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

10/25/2023

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

Yes, remediated 10/25/2023

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** 6 **Tufts Health Plan Unify** 23 **United Healthcare 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** 141 **Tufts Health Plan Unify** 17 **United Healthcare Connected for One Care** 13
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Commonwealth Care Alliance One Care** 4.6:1,000 **Tufts Health Plan Unify** 2.5:1,000 **United Healthcare Connected for One Care** 3.3:1,000
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** 75 **Tufts Health Plan Unify** 0 **United Healthcare Connected for One Care** 4

D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Commonwealth Care Alliance One Care** 2.45:1,000 **Tufts Health Plan Unify** 0:1,000 **United Healthcare Connected for One Care** 0.96:1,000
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Commonwealth Care Alliance One Care** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Tufts Health Plan Unify** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **United Healthcare Connected for One Care** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals made during the reporting year.	**Commonwealth Care Alliance One Care** 7 **Tufts Health Plan Unify** 17 **United Healthcare Connected for One Care** 10
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1).	**Commonwealth Care Alliance One Care** 0.23:1,000 **Tufts Health Plan Unify** 2.5:1,000 **United Healthcare Connected for One Care** 2.4:1,000

	Express this as a ratio per 1,000 beneficiaries.	
D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, at minimum, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 42 CFR 438.8(f)(2).	**Commonwealth Care Alliance One Care** The latest annual overpayment recovery report was the Q1 2024 Semi-Annual ""Summary of Provider Overpayments"" report, submitted on 01/30/2024. The report included overpayments identified or collected in CY 2023. The report identified $2,484.79 in overpayments collected. At this time, CCA is unable to provide the ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 42 CFR 438.8(f)(2), since CCA is still in the process of finalizing CY 2023 premium revenue data. **Tufts Health Plan Unify** Date: As of filing (1/19/24) (covering the time period January 1, 2023 through June 30, 2023), the most recent overpayment report was the 7/2023 PI-05 Dollar Amount: $384,519.11 Dollar Amount as Percent of Premium Revenue: 0.154% **United Healthcare Connected for One Care** Overpayment Recoveries Reporting Period 1: $ 89,722.96 Reporting Period 2: $103,646.50 Reporting Period 3: $193,369.46 Overpayment Ratios Reporting Period 1: .0013 Reporting Period 2: .0015 Reporting Period 3: .0029 * Reporting Period 1 (Jan. - June 2023) * Reporting Period 2 (July - Dec. 2023) * Reporting Period 3 (Jan. - Dec. 2023).
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 Health Plan Unify** Promptly when plan receives information about the change **United Healthcare Connected for One Care**

	Promptly when plan receives information about the change

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 Government Entity **My Ombudsman (MYO)** Ombudsman Program Other Community-Based Organization **Automated Health Systems (AHS)** Enrollment Broker **Maximus** 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 (MYO)** Beneficiary Outreach LTSS Complaint Access Point LTSS Grievance/Appeals Education Review/Oversight of LTSS Data **Automated Health Systems (AHS)** Enrollment Broker/Choice Counseling **Maximus** Enrollment Broker/Choice Counseling