Managed Care Program Annual Report (MCPAR) for Massachusetts: Senior Care Options

Due date	Last edited	Edited by	Status
06/29/2023	06/29/2023	Alison Kirchgasser	Submitted

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

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Massachusetts
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Alison Kirchgasser
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	alison.kirchgasser@mass.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Alison Kirchgasser
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	alison.kirchgasser@mass.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	06/29/2023

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2022
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2022
A6	**Program name** Auto-populated from report dashboard.	Senior Care Options

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	Wellsense Health Plan Commonwealth Care Alliance Fallon NaviCare Senior Whole Health Tufts Health Plan UnitedHealthCare

Add BSS entities (A.8)

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

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

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

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

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

Topic III. Encounter Data Report

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

Topic X: Program Integrity

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

		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. In addition, MassHealth has worked with SCO plans to enhance the process of receiving referrals of incidents of suspected PCA fraud involving their enrollees, and communicate such process to contracted PCM agencies and the Fiscal Intermediary. Additionally, MassHealth analyzed FFS payments where the members were enrolled in SCO, focusing on scenarios where retro-enrollment of members into SCO was causing MH to pay on services that were covered by SCO plans based on the updated eligibility. Any overpayments are pursued as appropriate.
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).	5.2.B.2.S
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	If the plan identifies an overpayment prior to MassHealth: 1) The plan shall recover the overpayment and may retain any overpayments collected. 2) The plan shall report the date of the identification and collection, if any, quarterly on the Fraud and Abuse report. 3) In the event no action toward collection of overpayments is taken by the plan one hundred and eighty (180) days after identification, EOHHS may begin collection activity and shall retain any overpayments collected.
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in	MassHealth reviews all overpayment reports for compliance, performance management, and best practices, including but not limited to the following: b. Report no later than five

	reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	business days to EOHHS, in accordance with all other Contract requirements, all overpayments (including capitation payments or other payments in excess of amounts specified in the Contract) identified and/or recovered, specifying those overpayments attributable to potential fraud. Report annually to EOHHS, in a form and format specified by EOHHS, on the Contractor's recoveries of overpayments in accordance with 42 CFR 438.608.
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).	SCO plans must report promptly to EOHHS when they receive information on a change in Enrollee circumstances which may impact their eligibility, 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	No

	must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	Yes
BX.9b	**Website posting of 5 percent or more ownership control: Link** What is the link to the website? Refer to 42 CFR 602(g)(3).	https://www.mass.gov/info-details/managed-care-entity-disclosure-of-ownership-and-control-addendum-information
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	MassHealth will begin audits in 2023.

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Senior Care Organization (SCO) Contract
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2016
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.mass.gov/lists/senior-care-organization-sco-contracts
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health 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 total number of individuals enrolled in the managed care program as of	74,683

	the first day of the last month of the reporting year.	
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	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 2.13 B

C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	Section 5.5.Q.2, Section 5.5.Q.1.P.
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	No barriers are present currently.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	A critical incident is defined as a sudden or progressive events that require 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.	For standard resolution of Internal Appeals and notice to the affected parties, no more than 30 calendar days from the date the Contractor received, either in writing or orally, whichever comes first, the Enrollee requests for an Internal Appeal, unless this timeframe is extended by up to 14 days under certain circumstances.
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.	For expedited resolution of Internal Appeals and notice to affected parties, no more than 72 hours after the Contractor received the expedited Internal Appeal, unless this timeframe is extended by up to 14 days under certain circumstances.
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	For the standard resolution of Grievances and notice to affected parties, no more than 30 calendar days from the date the Contractor received the Grievance, either orally or in writing, from a valid party, e.g., the Enrollee or the Enrollee's authorized Appeal Representative.

		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 standards.	Challenges currently facing SCO 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; and (3) lack of certain provider types (including dermatologists and dentists) to contract to provide services.
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: 26

Complete

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

1 / 26

C2.V.2 Measure standard

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
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 / 26

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 / 26

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 / 26

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: LTSS-related standard: enrollee travels to the provider

5 / 26

C2.V.2 Measure standard

30 minutes and/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 - Other	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 / 26

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 / 26

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 / 26

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 / 26

C2.V.2 Measure standard

2 Providers within 30 Minutes or 15 Miles Adult Day Health

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS - Adult Day 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: LTSS-related standard: provider travels to the enrollee 10 / 26

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 Foster Care and 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: General quantitative availability and accessibility standard 11 / 26

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
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

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/Otolaryngology, 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

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 Medicine	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

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, Psych inpatient, Psychiatric	Statewide	Adult

Day Treatment, Recovery Coaching, Recovery Support Navigators, Residential Rehabilitation Services for Substance Use Disorders (Level 3.1), Speech Therapy, Structured Outpatient Addiction Program

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 / 26

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

16 / 26

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

17 / 26

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

18 / 26

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

19 / 26

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,	Metro	Adult

Plastic Surgery,
Vascular Surgery

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 / 26

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

21 / 26

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 - Group 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: LTSS-related standard: provider travels to the enrollee

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

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 24 / 26

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	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: LTSS-related standard: enrollee travels to the provider 25 / 26

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	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: enrollee travels to the provider 26 / 26

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	Micro	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 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)
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.
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying,	My Ombudsman (MYO) tracks information about every member they assist, including cases involving access to LTSS, by topic in a

	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).	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. 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** What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	**Wellsense Health Plan** 2,088 **Commonwealth Care Alliance** 14,301 **Fallon NaviCare** 10,165 **Senior Whole Health** 13,260 **Tufts Health Plan** 10,495 **UnitedHealthCare** 24,374
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)	**Wellsense Health Plan** 0.1% **Commonwealth Care Alliance** 0.6% **Fallon NaviCare** 0.4% **Senior Whole Health** 0.6% **Tufts Health Plan** 0.5% **UnitedHealthCare** 1%

D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Wellsense Health Plan** 0.1% **Commonwealth Care Alliance** 0.9% **Fallon NaviCare** 0.6% **Senior Whole Health** 0.8% **Tufts Health Plan** 0.6% **UnitedHealthCare** 1.5%

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.	**Wellsense Health Plan** 93% **Commonwealth Care Alliance** 97% **Fallon NaviCare** 97% **Senior Whole Health** 89% **Tufts Health Plan** 94% **UnitedHealthCare** 93%
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.	**Wellsense Health Plan** Program-specific statewide **Commonwealth Care Alliance** Program-specific statewide **Fallon NaviCare** Program-specific statewide **Senior Whole Health** Program-specific statewide **Tufts Health Plan** Program-specific statewide **UnitedHealthCare** 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.	**Wellsense Health Plan** N/A **Commonwealth Care Alliance** N/A **Fallon NaviCare** N/A **Senior Whole Health** N/A **Tufts Health Plan** N/A **UnitedHealthCare** 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?	**Wellsense Health Plan** Yes **Commonwealth Care Alliance** Yes **Fallon NaviCare** Yes **Senior Whole Health** Yes **Tufts Health Plan** Yes **UnitedHealthCare** Yes
N/A	Enter the start date.	**Wellsense Health Plan** 01/01/2021

		Commonwealth Care Alliance 01/01/2021 **Fallon NaviCare** 01/01/2021 **Senior Whole Health** 01/01/2021 **Tufts Health Plan** 01/01/2021 **UnitedHealthCare** 01/01/2021
N/A	Enter the end date.	**Wellsense Health Plan** 12/31/2021 **Commonwealth Care Alliance** 12/31/2021 **Fallon NaviCare** 12/31/2021 **Senior Whole Health** 12/31/2021 **Tufts Health Plan** 12/31/2021 **UnitedHealthCare** 12/31/2021

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.	**Wellsense Health Plan** As specified in Contract section 2.13.b.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. **Commonwealth Care Alliance** As specified in Contract section 2.13.b.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. **Fallon NaviCare** As specified in Contract section 2.13.b.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. **Senior Whole Health** As specified in Contract section 2.13.b.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** As specified in Contract section 2.13.b.5 all Health Plans are expected to submit encounters by end of month, for remit dates thru end of previous month. This includes corrections based on automated submission feedback. **UnitedHealthCare** As specified in Contract section 2.13.b.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 period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	**Wellsense Health Plan** 100% **Commonwealth Care Alliance** 100% **Fallon NaviCare** 100% **Senior Whole Health** 100% **Tufts Health Plan** 100% **UnitedHealthCare** 100%

D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	**Wellsense Health Plan** 100% **Commonwealth Care Alliance** 100% **Fallon NaviCare** 100% **Senior Whole Health** 100% **Tufts Health Plan** 100% **UnitedHealthCare** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved as of the first day of the last month of the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Wellsense Health Plan** 29 **Commonwealth Care Alliance** 998 **Fallon NaviCare** 212 **Senior Whole Health** 7 **Tufts Health Plan** 325 **UnitedHealthCare** 728
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Wellsense Health Plan** 4 **Commonwealth Care Alliance** 78 **Fallon NaviCare** 13 **Senior Whole Health** 1 **Tufts Health Plan** 21 **UnitedHealthCare** 86

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).	**Wellsense Health Plan** 10 **Commonwealth Care Alliance** 686 **Fallon NaviCare** 181 **Senior Whole Health** 6 **Tufts Health Plan** 263 **UnitedHealthCare** 280
D1IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”. Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”. The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the	**Wellsense Health Plan** 3 **Commonwealth Care Alliance** 0 **Fallon NaviCare** 2 **Senior Whole Health** 0 **Tufts Health Plan** 1 **UnitedHealthCare** 0

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

D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Wellsense Health Plan** 12 **Commonwealth Care Alliance** 861 **Fallon NaviCare** 156 **Senior Whole Health** 6 **Tufts Health Plan** 241 **UnitedHealthCare** 530
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Wellsense Health Plan** 21 **Commonwealth Care Alliance** 200 **Fallon NaviCare** 54

Senior Whole Health

2

Tufts Health Plan

80

UnitedHealthCare

188

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).

Wellsense Health Plan

29

Commonwealth Care Alliance

1,104

Fallon NaviCare

109

Senior Whole Health

7

Tufts Health Plan

42

UnitedHealthCare

476

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.

Wellsense Health Plan

0

Commonwealth Care Alliance

70

Fallon NaviCare

0

Senior Whole Health

0

Tufts Health Plan

0

UnitedHealthCare

232

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.

Wellsense Health Plan

4

Commonwealth Care Alliance

2

Fallon NaviCare

31

Senior Whole Health

1

Tufts Health Plan

113

UnitedHealthCare

20

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).

Wellsense Health Plan

1

Commonwealth Care Alliance

0

Fallon NaviCare

0

Senior Whole Health

0

Tufts Health Plan

11

UnitedHealthCare

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.

Wellsense Health Plan

0

Commonwealth Care Alliance

0

Fallon NaviCare

2

Senior Whole Health

0

Tufts Health Plan

155

UnitedHealthCare

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).

Wellsense Health Plan

0

Commonwealth Care Alliance

0

Fallon NaviCare

0

Senior Whole Health

0

Tufts Health Plan

9

UnitedHealthCare

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.

Wellsense Health Plan

4

Commonwealth Care Alliance

2

Fallon NaviCare

0

Senior Whole Health

0

Tufts Health Plan

40

UnitedHealthCare

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".	**Wellsense Health Plan** 1 **Commonwealth Care Alliance** 0 **Fallon NaviCare** 5 **Senior Whole Health** 1 **Tufts Health Plan** 3 **UnitedHealthCare** 6
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".	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 86 **Fallon NaviCare** 68 **Senior Whole Health** 4 **Tufts Health Plan** 2 **UnitedHealthCare** 95

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".	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 0 **Fallon NaviCare** 0 **Senior Whole Health** 0 **Tufts Health Plan** 0 **UnitedHealthCare** 0
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 0 **Fallon NaviCare** 0 **Senior Whole Health** 0 **Tufts Health Plan** 0 **UnitedHealthCare** 0
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs**	**Wellsense Health Plan** 9

	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** 325 **Fallon NaviCare** 97 **Senior Whole Health** 1 **Tufts Health Plan** 126 **UnitedHealthCare** 192
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".	**Wellsense Health Plan** 1 **Commonwealth Care Alliance** 4 **Fallon NaviCare** 12 **Senior Whole Health** 0 **Tufts Health Plan** 1 **UnitedHealthCare** 7
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	**Wellsense Health Plan** 1 **Commonwealth Care Alliance**

	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".	326 **Fallon NaviCare** 13 **Senior Whole Health** 1 **Tufts Health Plan** 2 **UnitedHealthCare** 271
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**Wellsense Health Plan** 3 **Commonwealth Care Alliance** 150 **Fallon NaviCare** 16 **Senior Whole Health** 2 **Tufts Health Plan** 78 **UnitedHealthCare** 146
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".	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 0 **Fallon NaviCare**

		0 **Senior Whole Health** 0 **Tufts Health Plan** 8 **UnitedHealthCare** 1
D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".	**Wellsense Health Plan** 18 **Commonwealth Care Alliance** 185 **Fallon NaviCare** 14 **Senior Whole Health** 1 **Tufts Health Plan** 56 **UnitedHealthCare** 10

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	**Wellsense Health Plan** 1 **Commonwealth Care Alliance** 111 **Fallon NaviCare** 0 **Senior Whole Health** 4 **Tufts Health Plan** 11 **UnitedHealthCare** 19
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.	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 4 **Fallon NaviCare** 0 **Senior Whole Health** 0 **Tufts Health Plan** 0 **UnitedHealthCare** 3

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.	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 13 **Fallon NaviCare** 0 **Senior Whole Health** 0 **Tufts Health Plan** 2 **UnitedHealthCare** 4
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) prior to reaching a decision.	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 62 **Fallon NaviCare** 0 **Senior Whole Health** 1 **Tufts Health Plan** 2 **UnitedHealthCare** 5
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee**	**Wellsense Health Plan** N/A

	If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Commonwealth Care Alliance** N/A **Fallon NaviCare** N/A **Senior Whole Health** N/A **Tufts Health Plan** N/A **UnitedHealthCare** 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).	**Wellsense Health Plan** N/A **Commonwealth Care Alliance** N/A **Fallon NaviCare** N/A **Senior Whole Health** N/A **Tufts Health Plan** N/A **UnitedHealthCare** 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.	**Wellsense Health Plan** 210 **Commonwealth Care Alliance** 1,773 **Fallon NaviCare** 451 **Senior Whole Health** 43 **Tufts Health Plan** 1,239 **UnitedHealthCare** 992
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Wellsense Health Plan** 30 **Commonwealth Care Alliance** 192 **Fallon NaviCare** 48 **Senior Whole Health** 4 **Tufts Health Plan** 208 **UnitedHealthCare** 147

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.	**Wellsense Health Plan** 34 **Commonwealth Care Alliance** 1,448 **Fallon NaviCare** 423 **Senior Whole Health** 21 **Tufts Health Plan** 1,107 **UnitedHealthCare** 14
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the 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	**Wellsense Health Plan** 1 **Commonwealth Care Alliance** 0 **Fallon NaviCare** 17 **Senior Whole Health** 0 **Tufts Health Plan** 33 **UnitedHealthCare** 0

	enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Wellsense Health Plan** 240 **Commonwealth Care Alliance** 1,925 **Fallon NaviCare** 453 **Senior Whole Health** 42 **Tufts Health Plan** 1,088 **UnitedHealthCare** 911

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".	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 0 **Fallon NaviCare** 19 **Senior Whole Health** 0 **Tufts Health Plan** 1 **UnitedHealthCare** 2
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".	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 4 **Fallon NaviCare** 49 **Senior Whole Health** 1 **Tufts Health Plan** 5 **UnitedHealthCare** 250

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".	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 0 **Fallon NaviCare** 1 **Senior Whole Health** 0 **Tufts Health Plan** 1 **UnitedHealthCare** 0
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 0 **Fallon NaviCare** 1 **Senior Whole Health** 1 **Tufts Health Plan** 2 **UnitedHealthCare** 2
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs**	**Wellsense Health Plan** 9

	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** 27 **Fallon NaviCare** 5 **Senior Whole Health** 2 **Tufts Health Plan** 51 **UnitedHealthCare** 4
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 0 **Fallon NaviCare** 8 **Senior Whole Health** 0 **Tufts Health Plan** 1 **UnitedHealthCare** 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	**Wellsense Health Plan** 10 **Commonwealth Care Alliance**

	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".	36 **Fallon NaviCare** 3 **Senior Whole Health** 0 **Tufts Health Plan** 20 **UnitedHealthCare** 12
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**Wellsense Health Plan** 4 **Commonwealth Care Alliance** 49 **Fallon NaviCare** 11 **Senior Whole Health** 0 **Tufts Health Plan** 74 **UnitedHealthCare** 33

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".	**Wellsense Health Plan** 156 **Commonwealth Care Alliance** 658 **Fallon NaviCare** 161 **Senior Whole Health** 13 **Tufts Health Plan** 391 **UnitedHealthCare** 610
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	**Wellsense Health Plan** 61 **Commonwealth Care Alliance** 1,191 **Fallon NaviCare** 214 **Senior Whole Health** 27 **Tufts Health Plan** 12 **UnitedHealthCare** 9

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.	**Wellsense Health Plan** 228 **Commonwealth Care Alliance** 188 **Fallon NaviCare** 271 **Senior Whole Health** 26 **Tufts Health Plan** 89 **UnitedHealthCare** 34
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.	**Wellsense Health Plan** 11 **Commonwealth Care Alliance** 244 **Fallon NaviCare** 48 **Senior Whole Health** 1 **Tufts Health Plan** 116 **UnitedHealthCare** 61

D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 291 **Fallon NaviCare** 53 **Senior Whole Health** 14 **Tufts Health Plan** 16 **UnitedHealthCare** 3
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.	**Wellsense Health Plan** 11 **Commonwealth Care Alliance** 63 **Fallon NaviCare** 48 **Senior Whole Health** 1 **Tufts Health Plan** 117 **UnitedHealthCare** 179
D1IV.16e	**Resolved grievances related to plan communications**	**Wellsense Health Plan** 0

	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** 6 **Fallon NaviCare** 3 **Senior Whole Health** 0 **Tufts Health Plan** 8 **UnitedHealthCare** 32
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 12 **Fallon NaviCare** 16 **Senior Whole Health** 2 **Tufts Health Plan** 20 **UnitedHealthCare** 14
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved during the reporting year that were related to suspected fraud.	**Wellsense Health Plan** 0 **Commonwealth Care Alliance**

	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.	11 **Fallon NaviCare** 2 **Senior Whole Health** 0 **Tufts Health Plan** 3 **UnitedHealthCare** 3
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 0 **Fallon NaviCare** 48 **Senior Whole Health** 0 **Tufts Health Plan** 0 **UnitedHealthCare** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved during the reporting year that were filed	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 6 **Fallon NaviCare**

	due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	11 **Senior Whole Health** 0 **Tufts Health Plan** 0 **UnitedHealthCare** 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 1 **Fallon NaviCare** 0 **Senior Whole Health** 0 **Tufts Health Plan** 1 **UnitedHealthCare** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	**Wellsense Health Plan** 0 **Commonwealth Care Alliance** 1,143 **Fallon NaviCare** 47 **Senior Whole Health**

0

Tufts Health Plan

303

UnitedHealthCare

596

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: 21

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

0105

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

71.4%

Commonwealth Care Alliance

81.2%

Fallon NaviCare

80.7%

Senior Whole Health

81.4%

Tufts Health Plan

79.5%

UnitedHealthCare

77.9%

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

0105

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

54.3%

Commonwealth Care Alliance

76.1%

Fallon NaviCare

66.8%

Senior Whole Health

69.2%

Tufts Health Plan

61.0%

UnitedHealthCare

64.4%

Complete

D2.VII.1 Measure Name: Care for Older Adults (Advance Care Plan)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0326

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

41.6%

Commonwealth Care Alliance

80.7%

Fallon NaviCare

76.4%

Senior Whole Health

95.9%

Tufts Health Plan

98.8%

UnitedHealthCare

69.8%

Complete

D2.VII.1 Measure Name: Colorectal Cancer Screening

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0034

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

71.2%

Commonwealth Care Alliance

78.5%

Fallon NaviCare

61.2%

Senior Whole Health

84.9%

Tufts Health Plan

66.1%

UnitedHealthCare

85.4%

Complete

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

5 / 21

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0018

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

65.8%

Commonwealth Care Alliance

66.1%

Fallon NaviCare

59.8%

Senior Whole Health

61.4%

Tufts Health Plan

74.6%

UnitedHealthCare

74.5%

Complete

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

6 / 21

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Program-specific rate

D2.VII.6 Measure Set

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

Medicaid Adult and Child Core Sets

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

N/A

Commonwealth Care Alliance

44.2%

Fallon NaviCare

25.0%

Senior Whole Health

N/A

Tufts Health Plan

58.3%

UnitedHealthCare

25.8%

Complete

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

7 / 21

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult and Child Core Sets

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

N/A

Commonwealth Care Alliance

70.1%

Fallon NaviCare

61.1%

Senior Whole Health

N/A

Tufts Health Plan

77.8%

UnitedHealthCare

67.7%

Complete

D2.VII.1 Measure Name: Transitions of Care: Medication Reconciliation Post-Discharge

8 / 21

D2.VII.2 Measure Domain

Primary care access and preventative care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

75.9%

Commonwealth Care Alliance

68.1%

Fallon NaviCare

88.1%

Senior Whole Health

43.3%

Tufts Health Plan

58.6%

UnitedHealthCare

55.7%

Complete

D2.VII.1 Measure Name: Osteoporosis Management in Women Who Had a Fracture

9 / 21

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0053

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

N/A

Commonwealth Care Alliance

34.0%

Fallon NaviCare

30.8%

Senior Whole Health

55.3%

Tufts Health Plan

N/A

UnitedHealthCare

38.7%

Complete

D2.VII.1 Measure Name: Persistence of Beta-Blocker Treatment After Heart Attack

10 / 21

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0071

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

N/A

Commonwealth Care Alliance

N/A

Fallon NaviCare

N/A

Senior Whole Health

N/A

Tufts Health Plan

N/A

UnitedHealthCare

N/A

Complete

D2.VII.1 Measure Name: Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0549

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

88.9%

Commonwealth Care Alliance

77.7%

Fallon NaviCare

79.2%

Senior Whole Health

74.2%

Tufts Health Plan

76.0%

UnitedHealthCare

73.3%

Complete

D2.VII.1 Measure Name: Pharmacotherapy Management of COPD Exacerbation - Bronchodilator

12 / 21

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0549

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

94.4%

Commonwealth Care Alliance

90.6%

Fallon NaviCare

92.9%

Senior Whole Health

89.4%

Tufts Health Plan

90.7%

UnitedHealthCare

90.1%

Complete

D2.VII.1 Measure Name: Potentially Harmful Drug Disease Interactions in the Elderly (Total)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

2993

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

26.9%

Commonwealth Care Alliance

32.6%

Fallon NaviCare

35.8%

Senior Whole Health

31.5%

Tufts Health Plan

33.6%

UnitedHealthCare

31.5%

Complete

D2.VII.1 Measure Name: Use of High-Risk Medications in the Elderly – 2+ High Risk Medications (Total)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0022

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

17.2%

Commonwealth Care Alliance

25.6%

Fallon NaviCare

25.3%

Senior Whole Health

19.9%

Tufts Health Plan

19.5%

UnitedHealthCare

21.7%

Complete

D2.VII.1 Measure Name: Use of Spirometry Testing in the Assessment and Diagnosis of COPD

15 / 21

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0577

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

N/A

Commonwealth Care Alliance

23.7%

Fallon NaviCare

26.6%

Senior Whole Health

15.9%

Tufts Health Plan

27.2%

UnitedHealthCare

31.1%

Complete

D2.VII.1 Measure Name: Plan All-Cause Readmission (obs/exp ratio) 1

16 / 21

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1768

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

0.9956

Commonwealth Care Alliance

1.3568

Fallon NaviCare

1.1528

Senior Whole Health

0.7696

Tufts Health Plan

1.1951

UnitedHealthCare

1.2819

Complete

D2.VII.1 Measure Name: Influenza Immunization

17 / 21

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0041

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

77.0%

Commonwealth Care Alliance

78.0%

Fallon NaviCare

79.0%

Senior Whole Health

79.0%

Tufts Health Plan

86.0%

UnitedHealthCare

81.0%

Complete

D2.VII.1 Measure Name: Getting Needed Care

18 / 21

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicare Advantage CAHPS

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

78%

Commonwealth Care Alliance

83%

Fallon NaviCare

79%

Senior Whole Health

75%

Tufts Health Plan

83%

UnitedHealthCare

77%

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicare Advantage CAHPS

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

N/A

Commonwealth Care Alliance

88%

Fallon NaviCare

88%

Senior Whole Health

84%

Tufts Health Plan

87%

UnitedHealthCare

85%

Complete

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

20 / 21

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicare Advantage CAHPS

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

88%

Commonwealth Care Alliance

90%

Fallon NaviCare

92%

Senior Whole Health

84%

Tufts Health Plan

90%

UnitedHealthCare

87%

Complete

D2.VII.1 Measure Name: Care Coordination

21 / 21

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicare Advantage CAHPS

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

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

D2.VII.8 Measure Description

N/A

Measure results

Wellsense Health Plan

86%

Commonwealth Care Alliance

85%

Fallon NaviCare

84%

Senior Whole Health

80%

Tufts Health Plan

86%

UnitedHealthCare

84%

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: 12

Complete

D3.VIII.1 Intervention type: Compliance letter

1 / 12

D3.VIII.2 Plan performance issue

Timely access

D3.VIII.3 Plan name

Commonwealth Care Alliance

D3.VIII.4 Reason for intervention

Call Center Monitoring Timeliness Study (Q1 2022): Pharmacy Hold Time: 3:42 (threshold 2 minutes)

Sanction details

D3.VIII.5 Instances of non-compliance

8

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

11/22/2022

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

Yes 11/22/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

2 / 12

D3.VIII.2 Plan performance issue

Timely access

D3.VIII.3 Plan name

Commonwealth Care Alliance

D3.VIII.4 Reason for intervention

CCA's service provider that connects CCA's data center to the internet and transfers the calls in and out, experienced a regional outage which impacted telecom, internet, and VPN services. This resulted in CCA's call center being unavailable between the hours of 12:22 p.m. and 4:39 p.m. CCA was therefore unable to maintain call center operations during usual business hours.

Sanction details

D3.VIII.5 Instances of non-compliance

8

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

11/22/2022

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

Yes 11/22/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

3 / 12

D3.VIII.2 Plan performance issue

Timely access

D3.VIII.3 Plan name

Commonwealth Care Alliance

D3.VIII.4 Reason for intervention

Call Center Monitoring Timeliness Study (Q2 2022): Part C Disconnect Percentage Rate: 5.56% (threshold 5%) Part D Disconnect Percentage Rate: 5.56% (threshold 5%)

Sanction details

D3.VIII.5 Instances of non-compliance

8

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/08/2022

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

Yes 12/08/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

4 / 12

D3.VIII.2 Plan performance issue

Timely access

D3.VIII.3 Plan name

Commonwealth Care Alliance

D3.VIII.4 Reason for intervention

On October 21, 2022, CCA identified that 25 marketing materials were not uploaded to the Health Plan Management System (HPMS), impacting more than 421,097 prospective members. In addition, on August 8, 2022, CCA

directly mailed one of these unsubmitted marketing materials to 59,910 prospective members.

Sanction details

D3.VIII.5 Instances of non-compliance
8

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
12/20/2022

D3.VIII.8 Remediation date non-compliance was corrected
Yes 12/20/2022

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Compliance letter

5 / 12

D3.VIII.2 Plan performance issue
Reporting

D3.VIII.3 Plan name
UnitedHealthCare

D3.VIII.4 Reason for intervention

Missing protected class drug(s) during monthly formulary file submission window

Sanction details

D3.VIII.5 Instances of non-compliance
8

D3.VIII.6 Sanction amount
N/A

D3.VIII.7 Date assessed
06/07/2022

D3.VIII.8 Remediation date non-compliance was corrected
Yes 06/07/2022

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Compliance letter

6 / 12

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name
UnitedHealthCare

Reporting

D3.VIII.4 Reason for intervention

United was referred to the Division of Compliance Enforcement (DCE) in order to determine whether the results of UnitedHealth's 2022 Program Audit should result in an enforcement action. DCE completed their review and determined that UnitedHealth's non-compliance did not warrant an enforcement action.

Sanction details

D3.VIII.5 Instances of non-compliance

8

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/02/2022

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

Yes 09/02/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

7 / 12

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Tufts Health Plan

D3.VIII.4 Reason for intervention

Missing protected class drug(s) during monthly formulary file submission window.

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

06/07/2022

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

Yes 06/07/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Plan performance issue

Timely access

D3.VIII.3 Plan name

Senior Whole Health

D3.VIII.4 Reason for intervention

Failure to ensure timely receipt of Annual Notice of Change documents to enrollees for Contract Year (CY) 2022.

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/04/2022

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

Yes 03/04/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

D3.VIII.2 Plan performance issue

Timely access

D3.VIII.3 Plan name

Senior Whole Health

D3.VIII.4 Reason for intervention

SWH call centers were unable to meet regulatory requirements. Call center average hold times were consistently non-compliant throughout January 2022 and February 2022.

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/26/2022

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

Yes 05/26/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

10 / 12

D3.VIII.2 Plan performance issue

Timely access

D3.VIII.3 Plan name

Senior Whole Health

D3.VIII.4 Reason for intervention

Call Center Monitoring Timeliness Study (Q2 2022) Part C Disconnect Percentage Rate: 9.43% (threshold 5%) Part D Disconnect Percentage Rate: 9.43% (threshold 5%)

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/07/2022

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

Yes 12/07/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

11 / 12

D3.VIII.2 Plan performance issue

Timely access

D3.VIII.3 Plan name

Fallon NaviCare

D3.VIII.4 Reason for intervention

Failure to issue accurate Annual Notice of Change documents for Contract Year 2022.

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/09/2022

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

Yes 09/09/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

12 / 12

D3.VIII.2 Plan performance issue

Timely access

D3.VIII.3 Plan name

Wellsense Health Plan

D3.VIII.4 Reason for intervention

Call Center Monitoring Timeliness Study (Q4 2022) Pharmacy Disconnect Percentage Rate: 5.66% (threshold 5%)

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/07/2022

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

Yes 12/07/2022

D3.VIII.9 Corrective action plan

No

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).	**Wellsense Health Plan** 10 **Commonwealth Care Alliance** 6 **Fallon NaviCare** 5 **Senior Whole Health** 3 **Tufts Health Plan** 43 **UnitedHealthCare** 2
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**Wellsense Health Plan** 35 **Commonwealth Care Alliance** 130 **Fallon NaviCare** 0 **Senior Whole Health** 10 **Tufts Health Plan** 27 **UnitedHealthCare** 7

D1X.3

Ratio of opened program integrity investigations to enrollees

What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?

Wellsense Health Plan

16.82:1,000

Commonwealth Care Alliance

8.84:1,000

Fallon NaviCare

0:1,000

Senior Whole Health

0.75:1,000

Tufts Health Plan

2.58:1,000

UnitedHealthCare

0.29:1,000

D1X.4

Count of resolved program integrity investigations

How many program integrity investigations have been resolved by the plan in the past year?

Wellsense Health Plan

20

Commonwealth Care Alliance

76

Fallon NaviCare

0

Senior Whole Health

19

Tufts Health Plan

46

UnitedHealthCare

5

D1X.5

Ratio of resolved program integrity investigations to enrollees

Wellsense Health Plan

9.61:1,000

What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?

Commonwealth Care Alliance

5.98:1,000

Fallon NaviCare

0.099:1,000

Senior Whole Health

1.32:1,000

Tufts Health Plan

4.4:1,000

UnitedHealthCare

0.2:1,000

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.

Wellsense Health Plan

Makes some referrals to the SMA and others directly to the MFCU

Commonwealth Care Alliance

Makes some referrals to the SMA and others directly to the MFCU

Fallon NaviCare

Makes some referrals to the SMA and others directly to the MFCU

Senior Whole Health

Makes some referrals to the SMA and others directly to the MFCU

Tufts Health Plan

Makes some referrals to the SMA and others directly to the MFCU

UnitedHealthCare

Makes some referrals to the SMA and others directly to the MFCU

D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made to the SMA and the MFCU in aggregate.	**Wellsense Health Plan** 1 **Commonwealth Care Alliance** 6 **Fallon NaviCare** 0 **Senior Whole Health** 8 **Tufts Health Plan** 27 **UnitedHealthCare** 1
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.2) as the denominator.	**Wellsense Health Plan** 0.48:1,000 **Commonwealth Care Alliance** 0.41:1,000 **Fallon NaviCare** 0:1,000 **Senior Whole Health** 0.6:1,000 **Tufts Health Plan** 2.58:1,000 **UnitedHealthCare** 0.04:1,000
D1X.9	**Plan overpayment reporting to the state**	**Wellsense Health Plan**

Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3).
Include, for example, the following information:

- The date of the report (rating period or calendar year).
- The dollar amount of overpayments recovered.
- The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2).

Report covering CY 2022 was submitted in January 2023. $64,697 recovered. As a % of premium revenue: 0.1% of premium revenue.

Commonwealth Care Alliance

When CCA's Providers identify an overpayment, the providers send a refund check to CCA, which is tracked in a Refund Checks Log. Reasons for overpayments may include services covered by capitation which were configured incorrectly or billing errors identified by the provider. In CY 2022, CCA did not receive any refund checks from providers. $0 recovered. As a % of premium revenue: 0% of premium revenue

Fallon NaviCare

Report covering CY 2022. $0.00 recovered. As a % of premium revenue: 0% NOTE: Cases were opened in 2021 and closed during 2023.

Senior Whole Health

Report covering CY 2022. $141,340.82 recovered. As a % of premium revenue: 0.25%

Tufts Health Plan

Report covering CY 2022. $72,797.93 recovered. As a % of premium revenue: 0.02%

UnitedHealthCare

Report covering CY 2022. $16,925.14 recovered.

D1X.10

Changes in beneficiary circumstances

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

Wellsense Health Plan

Daily

Commonwealth Care Alliance

Daily

Fallon NaviCare

Daily

Senior Whole Health

Daily

Tufts Health Plan

Daily

UnitedHealthCare

Daily

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Serving the Health Insurance Needs for Everyone (SHINE)** State Government Entity **My Ombudsman (MYO)** Ombudsman Program Other Community-Based Organization
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**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