Managed Care Program Annual Report (MCPAR) Workbook: A requirement of 42 CFR 438.66(e)

Version 2022.1	
Overview	
What is a MCPAR?	Beginning on June 28, 2021, the Centers for Medicare and Medicaid Services (CMS) is requiring that, as part of its monitoring system for all Medicaid managed care programs, **each state must submit to CMS no later than 180 days after each contract year, a report on each managed care program administered by the State, regardless of the authority under which the program operates.** (For purposes of the MCPAR, a program is defined by a specified set of benefits and eligibility criteria that is articulated in a contract between the state and managed care plans, and that has associated rate cells.) The initial report will be due for the contract year beginning on or after June 28, 2021; reports are required annually thereafter and aligned with state contract cycles (42 CFR 438.68(e)(1)). (See the Glossary tab for a definition of "reporting year;" see Instructions tab for example reporting timeframes.) This document provides instructions for data collection and a workbook for states to use to submit the required information, hereafter referred to as the **Managed Care Program Annual Report (MCPAR)**.
How to start a MCPAR	States must complete one MCPAR workbook (i.e., complete lettered sheets A-E in this Excel file) for each managed care program operating in the state during the year. Data should cover the 12-month period of the contract term during which your state is reporting information to CMS; this is referred to as the "reporting year." **Create one workbook per program. Eventually, you will submit the MCPAR data to CMS through an online form available early November 2022. Use this MCPAR Excel workbook to help you plan and manage your data collection.** ***You will not submit data to CMS through this Excel workbook.*** Upon completion, this MCPAR report must also be posted on your state's website as required at 438.66(e)(3)(i), and provided to the Medical Care Advisory Committee as required at 438.66(e)(i) and, if applicable, the MLTSS consultation group as required at 438.66(e)(iii). Post either the completed MCPAR Excel workbook or a 508 compliant PDF printout.
When and how can I submit the official MCPAR?	Submit the MCPAR through an online form at https://mdctmcr.cms.gov/ available early November 2022. Refer to https://mdctmcr.cms.gov/ for more guidance on due dates.
How does CMS define a program?	For purposes of the MCPAR, a program is defined by a distinct set of benefits and eligibility criteria that is articulated in a contract between the state and managed care plans. "Programs" may also be differentiated from one another based on their associated rate cells.

Where can I find more information about filling out this MCPAR?	Refer to the Instructions and Glossary tabs.
Who can I contact if I have questions?	Email questions about MCPAR to ManagedCareTA@mathematica-mpr.com
Table of Contents	
Data on each topic is organized by reporting level: state, program, plan, and other entity (i.e. beneficiary support system). Within this report, states will find data elements with specific drop downs that CMS has pre-selected to standardize data across states, as well as places with instructions for states to report state-specific indicators or free text. Tabs are organized as follows:	
Tab Name	**Topic**
Instructions	Instructions
A_Program_Info	Program information
B_State	State-Level Set Indicators
C1_Program_Set	Program-Level Set Indicators
C2_Program_State	Program-Level State-Specific Indicators
D1_Plan_Set	Plan-Level Set Indicators
D2_Plan_Measures	Plan-Level State-Specific Indicators: Quality and Performance Measures
D3_Plan_Sanctions	Plan-Level State-Specific Indicators: Sanctions
E_BSS_Entities	Beneficiary Support System (BSS) Entities, Set Indicators
Glossary	
Crosswalk	List of all indicators in the MCPAR, crosswalked to the tab on which they appear

PRA Disclosure and Accessibility Statements	
PRA Disclosure Statement	According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0920 (Expires: June 30,2024). The time required to complete this information collection is estimated to average 6 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Accessibility Statement	Review CMS's commitment to Section 508 compliance: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/Section508

Reporting Instructions	
MCPAR Workbook Organization	Consistent with 438.66(e), this template provides space for states to report indicators related to the following nine topics: (I) Program Characteristics and Enrollment; (II) Financial Performance; (III) Encounter Data Reporting; (IV) Grievance, Appeals, and State Fair Hearings; (V) Availability, Accessibility, and Network adequacy; (VI) Topic reserved; (VII) Quality and Performance Measures; (VIII) Sanctions and Corrective Action Plans; (IX) Beneficiary Support System; and (X) Program Integrity. Data on each topic is organized by reporting level: state, program, plan, and other entity (i.e. beneficiary support system). Within this report, states will find data elements with specific drop downs that CMS has pre-selected to standardize data across states, as well as places with instructions for states to report state-specific indicators or free text.
Inputting data	Enter information into tabs A-E, and only input values in white cells. Key terms are defined in the glossary.
Reporting timeframe	The State must submit MPCAR reports to CMS no later than 180 days after each contract year. The initial MCPAR report will be due after the contract year following the release of CMS guidance on the content and form of the report (i.e. after release of this form) (42 CFR 438.68(e)(1). Example timeframe: If CMS releases guidance on the MCPAR in the beginning 2021, states that have contracts on a calendar cycle (for example, states with contracts running from July, 2021 to June, 2022), would have their first required report due December 31, 2022. For states with calendar year contracts, the calendar year following release of the guidance would be 2022, and their first reports would be due June 2023.
Exclusion of CHIP from MCPAR	Separate CHIP enrollees and programs should not be reported in the MCPAR. **Please use free text to flag any items for which the state is unable to remove information about Separate CHIP from required reporting for Medicaid-only or Medicaid Expansion CHIP programs.**
Preparing the first MCPAR	CMS acknowledges that states may need to update their contracts with plans to collect some information requested in the MCPAR and that states will need time to create the first MCPAR report. CMS will be available to provide technical assistance to states to help prepare the MCPAR. Requests for technical assistance can be submitted to ManagedCareTA@mathematica-mpr.com.

Overlap with other state reporting requirements	CMS acknowledges that some of the indicators requested in the MCPAR are also reported to CMS through other means. For example, state EQRO reports include measure validation results and measure rates for some or all measures collected by states, although measure rates may not be program specific and may not be reported for all managed care programs operating in the state in a given year. States should consider leveraging existing reports and/or contractors (such as EQROs) to populate the MCPAR. CMS will explore opportunities to align the MCPAR with other data collection efforts in future years.
1115 reports overlap	Per 42 CFR 438.66(e)(1)(ii), states that operate managed care programs under 1115(a) authority **may reference 1115 reports required by its Special Terms and Conditions (STCs) in lieu of entering an indicator into the MCPAR if the report includes the information required by the indicator including the same level of detail (e.g. plan-level data).** However, CMS has worked to ensure that most of the managed care reporting requirements in the MCPAR are not duplicated in STCs; therefore, CMS anticipates few instances where the information required in 1115 quarterly and annual reports will directly overlap with what is required in the MCPAR. If a state would like assistance in determining whether an existing 1115 reporting requirement can be deemed to satisfy requirements of the MCPAR, please request technical assistance via ManagedCareTA@mathematica-mpr.com.
Data lags	If the state does not have data available over the time period with which it is requested in the MCPAR, use the most recent data available and note the reporting period that the data covers.

[A] Program Information			
#	**Question or Indicator**	**Instruction**	**Your response**
A.1	**State name**	Select the state for which you are submitting this report.	**Tennessee**
A.2a	**Contact name**	Enter person's name or a position title for CMS to contact with questions about this report. 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.	**Aaron Butler**
A.2b	**Contact email address**	Enter email address. Department or program-wide email addresses ok.	**aaron.c.butler@tn.gov**
A.3a	**Submitter name**	Enter your name as the person submitting the report.	**Aaron Butler**
A.3b	**Submitter email address**	Enter your email address as the person submitting the report.	**aaron.c.butler@tn.gov**
A.4	**Date of report submission**	Enter the date the report is being submitted to CMS.	**June 30th, 2023**
A.5a	**Reporting period start date**	Enter the start date of the reporting period represented in the report.	**January 1st, 2022**
A.5b	**Reporting period end date**	Enter the end date of the reporting period represented in the report.	**December 31st, 2022**

A.6	**Program name**	Enter name of the program for which the state is reporting data. For this report, a program is defined by a contract between the state and a managed care plan (or group of plans), which articulates a standard set of benefits, eligibility criteria, reporting requirements, and has a set of rate cells specific to that program.	**TennCare**
A.7	**Plan 1**	Enter the name of each plan that participates in the program for which the state is reporting data. If the program contracts with fewer than 35 plans, leave unused fields blank.	**Amerigroup**
	Plan 2		**BlueCare**
	Plan 3		**UnitedHealthcare Community Plan (UHCCP)**
	Plan 4		**TennCare Select**
A.8	**BSS entity 1**	Enter the names of the beneficiary support system (BSS) entities that support enrollees in the program for which the state is reporting data. If the program contracts with fewer than 10 BSS entities, leave unused fields blank. If the program includes more than 10 BSS entities, contact CMS for guidance.	**Disability Rights Tennessee (DRT)**

[B] State-Level Indicators			
#	Indicator	Instruction	Your Response
I. Program Characteristics and Enrollment			
B.I.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.	1,720,611
B.I.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.	1,720,611
III. Encounter Data Reporting			
B.III.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 definition for more information.)	State Medicaid agency staff (Encounter Operations unit within Information Systems)
B.III.2	**HIPAA compliance of proprietary system(s) for encounter data validation**	If the state selected “proprietary system(s)” in previous question, were the system(s) utilized fully HIPAA compliant? Select one.	No
X. Program Integrity			

B.X.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.	In addition to running frequent peer comparison reviews we also reviewed or are reviewing, services involving ventilator use, COVID-19, LTSS overlapping services, and Ivermectin. Additionally our MCOs perform various reviews: Use of an artificial intelligence data mining platform for detecting potential FWA, proactive audits on providers identified as billing outliers for services such as COVID-19 testing, Healthcare Common Procedure Coding System (HCPCS) code G2023/G2024, subcutaneous hormone pellet implantation, adaptive behavior treatment, anesthesia blocks billed with surgery, and billing Q0091 and G0101 for the same visit, billing spikes week to week, routine audits to look at issues such as Home Health Agency (HHA) and Health Information Technology (HIT) services billed while a member is inpatient, duplicates, unbundling of maternity services, multiple surgeries, etc.
B.X.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
B.X.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).	Overpayment language can be found in Sections A.2.12, A.2.20, A.2.22, A.3.7, C.5 of the state's MCO contract.
B.X.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.	As outlined in the MCO contract, the MCOs are allowed to keep overpayments, but there are circumstances where the state may retain or collect the overpayments from the MCO or the provider.

B.X.5	**State overpayment reporting monitoring**	Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track reporting from plans with requirements 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.	TennCare Office of Program Integrity requires the MCOs to report overpayments using two deliverables; the Quarterly Fraud, Waste, and Abuse report which includes all administrative overpayments, and the Annual Recoveries report which includes all overpayments for TennCare lines of business.
B.X.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).	TennCare requires the MCOs to reconcile their capitation 820s Per Member Per Month (PMPM) payment transaction to their eligibility and report any discrepancies to TennCare Information Systems (IS) and TennCare Fiscal. In addition, TennCare IS requires the managed care contracotrs (MCC) to provide aggregate enrollments counts to compare against MMIS enrollments reports. Discrepancies trigger detail research for potential issues and resolution.
B.X.7a	**Changes in provider circumstances: Monitoring plans**	Does the state monitors whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
B.X.7b	**Changes in provider circumstances: Metrics**	If the state monitors whether plans report provider “for cause” terminations in a timely manner in the previous indicator, does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
B.X.7c	**Changes in provider circumstances: Describe metric**	If the state uses a metric or indicator to assess plan reporting performance in item B.9a, describe the metric or indicator that the state uses.	The state monitors the MCOs by use of an Involuntary Terminations report. The report is submitted monthly and notifies the state of any Terminations due to Program Integrity (PI) concerns. The date of termination is an element of the report.

B.X.8a	**Federal database checks: Excluded person or entities**	During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	Yes
B.X.8b	**Federal database checks: Summarize instances of exclusion**	If the state responded "yes" to the previous indicator, summarize the instances and whether the entity was notified as required in 438.602(d). Enter N/A if not applicable. Report actions taken, such as plan-level sanctions and corrective actions.	There were 16 instances of exclusion resulting from federal database checks and in every case the entity was notified of termination. Summary of instances: Seven instances of Noncompliance (surrender in lieu of disciplinary action, suspended license, etc.); One instance of Terminated under a separate Medicare enrollments; Two instances of 1128a1 - Conviction of program-related crimes; One instance of Provider conduct (OIG exclusion); One instance of 1128a4 - Felony conviction relating to controlled substance; Two instances of 1128b4 - License revocation, suspension, or surrender;
B.X.9a	**Website posting of 5 percent or more ownership control**	Does the state posts 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

B.X.9b	**Website posting of 5 percent or more ownership control**	If the state responded "yes" in the previous indicator, what is the link to the website? Enter N/A if not applicable. Refer to 42 CFR 602(g)(3)	https://www.tn.gov/tenncare/providers/managed-care-contractors/health-plans.html
B.X.10	**Periodic audits**	If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results? Refer to 42 CFR 438.602(e)	The public may retrieve the document from TennCare's website by visiting https://tn.gov/tenncare and selecting the drop down menu for Members & Applicants and selecting the link for Managed Care Organizations. Once on this webpage (https://www.tn.gov/tenncare/members-applicants/managed-care-organizations.html), the encounter audit report summary is located under the Health Plans section underneath the NCQA Accreditation results.

[C1] Program-Level, Set Indicators			
#	Indicator	Instruction	Your Response
I. Program Characteristics and Enrollment			
C1.I.1	**Program contract**	Enter the title and date of the contract between the state and plans participating in the managed care program.	CRA contract for the 1/1/22 – 12/31/22 period
C1.I.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.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf
C1.I.3	**Program type**	What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	3 MCOs and 1 PIHP
C1.I.4	**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.	1) behavioral health, (2) long-term services and supports, and (4) transportation
C1.I.5	**Variation in special benefits**	Are there any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	No
C1.I.6	**Program enrollment**	Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	1,720,611
C1.I.7	**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.	At this time, there are no changes planned to the populations enrolled in managed care in Tennessee. Tennessee has a pending demonstration amendment under CMS review to integrate certain Home and Community Based Services (HCBS) for persons with intellectual disabilities into managed care.
III. Encounter Data Reporting			

C1.III.1	**Uses of encounter data**	For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more and/or use free text for "other". 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
C1.III.2	**Criteria/ measures used 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 and/or use free text for "other". 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; Timeliness of data certifications; Use of correct file formats; Provider ID field complete; Overall data accuracy
C1.III.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.	Contract reference A.2.23.4.2
C1.III.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.	MCO Contract A.2.23.13
C1.III.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
C1.III.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?	MCO Contract Section 2.23.4.3. The state does not provide any incentives awarded for quality of encounter data submission. The state requires the MCO to meet all established data quality standards.

IV. Appeals, State Fair Hearings & Grievances			
C1.IV.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.	**Reportable Events:** An event that is classified as Tier 1, or Tier 2, or an Additional Reportable Event as defined by TennCare, that the provider, MCO, or FEA staff shall be responsible for reporting to the MCO and/or DIDD as specified in the Reportable Event Management (REM) protocol. Expansion of the definition is found at**: https://www.dropbox.com/s/t1st0dmapd8plhr/One%20System%20REM%20Protocol.pdf?dl=0**
C1.IV.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.	14 calendar days
C1.IV.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.	72 hours
C1.IV.4	**State definition of "timely" resolution for grievances**	Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	90 calendar days
V. Availability, Accessibility, and Network Adequacy			

C1.V.1	**Gaps/challenges in network adequacy**	What are the state's biggest challenges? Describe any challenges MCPS have maintaining adequate networks and meeting standards.	The state's biggest challenge with regard to network adequacy in Calendar Year 2022 stemmed from the ongoing COVID-19 public health emergency and the related FFCRA continuous coverage requirement. Nonetheless, all managed care plans made efforts to ensure that their networks were sufficiently robust to accommodate the increased enrollment.
C1.V.2	**State response to gaps in network adequacy**	How does the state work with MCPs to address gaps in network adequacy?	The state requires the submission of a Correction Action Plan (CAP), an On Request Report (ORR) or sends a Request for Information (RFI) asking for detailed information surrounding the deficiency and the MCO's plan of action to rectify the deficiency.
IX. Beneficiary Support System (BSS)			
C1.IX.1	**BSS website**	List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means?	https://www.ltsshelptn.org/
C1.IX.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))? 42 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.	Section A.3 (d) of the BSS contract requires "the Grantee must perform outreach to Enrollees and/or authorized representatives and be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested. The Grantee shall be obligated to provide in-person assistance only as requested and when other forms of assistance are not sufficient to meet the need for assistance."
C1.IX.3	**BSS LTSS program data**	How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	Disability Rights Tennessee (DRT) assists TennCare in identifying, remediating, and resolving systemic issues using LTSS data. Through quarterly meetings and reports, DRT brings to our attention systemic issues that they identify using LTSS data related to appeals, grievances, reportable events, and service initiation. DRT also uses the information on the types of inquiries they receive and inquiry trends to address systemic issues.

C1.IX.4	**State evaluation of BSS entity performance**	How does the state evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	The state requested a desk review at the launch of the BSS Program, which required Disability Rights Tennessee (DRT) to produce various policies relating to education, outreach, in-persons support, intake and outcome, community relations, and reporting abuse. The state requested a second desk review in 2021, which required DRT to produce polices on civil rights compliance and cultural competency. DRT submits Quarterly Beneficiary Support System Report including data elements as specified by the state and an annual Civil Rights compliance report to the state.
X. Program Integrity			
C1.X.3	**Prohibited affiliation disclosure**	Did any plans disclose prohibited affiliations? If the state took action, enter those actions on Tab D3 Sanctions. Select one. Refer to 42 CFR 438.610(d).	No

[C2] Program-Level, State-Specific Indicators: Availability, Accessibility, and Network Adequacy

#	Indicator	Instruction	Measure #1	Measure #2	Measure #3	Measure #4	Measure #5	Measure #6	Measure #7	Measure #8
V. Availability, Accessibility & Network Adequacy										
C2.V.1	**General category**	Select one	General quantitative	General quantitative	General quantitative	General quantitative	General quantitative	General quantitative	General quantitative	General quantitative
C2.V.2	**Measure standard**	What is the standard for your program-level indicators? Add a description	30 Miles	30 Minutes	60 Miles - 75%	90 Miles - 100%	90 Minutes - 75%	120 Minutes - 100%	30 Miles - 75%	60 Miles - 100%
C2.V.3	**Standard type**	What is the standard type? Select one or add free text if you select "Other"	Maximum distance to travel	Maximum time to travel	Maximum distance to travel	Maximum distance to travel	Maximum time to travel	Maximum time to travel	Maximum distance to travel	Maximum distance to travel
C2.V.4	**Provider type**	What is the provider type? Select one or add free text if you select "Other"	Adult and Pediatric primary care, OB/GYN, Hospital	Adult and Pediatric primary care, OB/GYN, Hospital	Adult and Pediatric specialist	Adult and Pediatric specialist	Adult and Pediatric specialist	Adult and Pediatric specialist	Behavioral - outpatient non-MD services, outpatient treatment services	Behavioral - outpatient non-MD services
C2.V.5	**Applicable region(s)**	What is the applicable region? Select one or add free text if you select "Other"	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide
C2.V.6	**Population**	What is the population? Select one or add free text if you select "Other"	Adult and pediatric	Adult and pediatric	Adult and pediatric	Adult and pediatric	Adult and pediatric	Adult and pediatric	Adult and pediatric	Adult and pediatric
C2.V.7	**Monitoring methods**	What are the monitoring methods? Select one or add free text if you select "Other"	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey
C2.V.8	**Frequency of oversight methods**	What is the frequency of oversight methods? Select one or add free text if you select "Other"	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly

#	Measure #9	Measure #10	Measure #11	Measure #12	Measure #13	Measure #14	Measure #15	Measure #16
V. Availability, Accessibility & Network Adequacy								
C2.V.1	General quantitative	General quantitative	General quantitative	General quantitative	General quantitative	General quantitative	General quantitative	General quantitative
C2.V.2	45 Minutes - 75%	60 Minutes - 100%	90 Miles - 75%	120 Miles - 100%	90 Minutes - 75%	120 Minutes - 100%	90 Miles - 100%	30 Minutes - 75%
C2.V.3	Maximum time to travel	Maximum time to travel	Maximum distance to travel	Maximum distance to travel	Maximum time to travel	Maximum time to travel	Maximum distance to travel	Maximum time to travel
C2.V.4	Behavioral - outpatient non-MD services	Behavioral - outpatient non-MD services	Behavioral - intensive outpatient	Behavioral - intensive outpatient	Behavioral - intensive outpatient	Behavioral - psych inpatient hospital services, inpatient facility services	Behavioral - psych inpatient hospital services, inpatient facility services	Behavioral - outpatient treatment services
C2.V.5	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide
C2.V.6	Adult and pediatric	Adult and pediatric	Adult and pediatric	Adult and pediatric	Adult and pediatric	Adult and pediatric	Adult and pediatric	Adult and pediatric
C2.V.7	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey
C2.V.8	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly

#	Measure #17	Measure #18	Measure #19	Measure #20	Measure #21	Measure #22	Measure #23	Measure #24
V. Availability, Accessibility & Network Adequacy								
C2.V.1	General quantitative	General quantitative	General quantitative	General quantitative	General quantitative	General quantitative	General quantitative	General quantitative
C2.V.2	45 Miles - 100%	45 Minutes - 100%	2 per county	30 Miles - 100%	45 Minutes - 100%	20 Miles - 100%	30 Minutes - 100%	30 Miles - 100%
C2.V.3	Maximum distance to travel	Maximum time to travel	Minimum # of network providers	Maximum distance to travel	Maximum time to travel	Maximum distance to travel	Maximum time to travel	Maximum distance to travel
C2.V.4	Behavioral - outpatient treatment services	Behavioral - outpatient treatment services	LTSS - HCBS/ECF	Optometry	Optometry	Adult Day Care	Adult Day Care	Adult Day Care
C2.V.5	Statewide	Statewide	Statewide	Statewide	Statewide	Urban	Urban	Suburban
C2.V.6	Adult and pediatric	Adult and pediatric	MLTSS	Pediatric	Pediatric	Adult	Adult	Adult
C2.V.7	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey
C2.V.8	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly

#	Measure #25	Measure #26	Measure #27	Measure #28	Measure #29	Measure #30	Measure #31
V. Availability, Accessibility & Network Adequacy							
C2.V.1	General quantitative	General quantitative	General quantitative	General quantitative	General quantitative	General quantitative	General quantitative
C2.V.2	45 Minutes - 100%	60 Miles - 100%	90 Minutes - 100%	45 Miles - 75%	60 Miles - 100%	45 Minutes - 75%	60 Minutes - 100%
C2.V.3	Maximum time to travel	Maximum distance to travel	Maximum time to travel	Maximum distance to travel	Maximum distance to travel	Maximum time to travel	Maximum time to travel
C2.V.4	Adult Day Care	Adult Day Care	Adult Day Care	Opioid Use Disorder	Opioid Use Disorder	Opioid Use Disorder	Opioid Use Disorder
C2.V.5	Suburban	Rural	Rural	Statewide	Statewide	Statewide	Statewide
C2.V.6	Adult	Adult	Adult	Adult and pediatric	Adult and pediatric	Adult and pediatric	Adult and pediatric
C2.V.7	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey	Geomapping; Review of grievances related to access; Plan Provider Directory Review; Provider Data Validation Survey
C2.V.8	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly	Geomapping - Monthly; Review of grievances related to access - Quarterly; Plan Provider Directory Review - Quarterly; Provider Data Validation Survey - Quarterly

[D1] Plan-Level, Set Indicators						
#	Indicator	Instruction	Amerigroup	BlueCare	UnitedHealthcare Community Plan (UHCCP)	TennCare Select
I. Program Characteristics and Enrollment						
D1.I.1	**Plan enrollment**	Enter total number of individuals enrolled in each plan as of the first day of the last month of the reporting year.	513,689	637,722	514,687	54,513
D1.I.2	**Plan share of Medicaid**	Automatically calculated. Sum of 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)	29.86%	37.06%	29.91%	3.17%
D1.I.3	**Plan share of any Medicaid managed care**	Automatically calculated. Sum of 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)	29.86%	37.06%	29.91%	3.17%
II. Financial Performance						
D1.II.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.4 below. See glossary for the regulatory definition of MLR.	90%	92%	91%	N/A
D1.II.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.	Statewide all programs & populations	Statewide all programs & populations	Statewide all programs & populations	Statewide all programs & populations
D1.II.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.	MLRs are calculated for CHOICES and non-CHOICES populations. (CHOICES is the state's managed LTSS program for persons who are elderly or who have physical disabilities.)	MLRs are calculated for CHOICES and non-CHOICES populations. (CHOICES is the state's managed LTSS program for persons who are elderly or who have physical disabilities.)	MLRs are calculated for CHOICES and non-CHOICES populations. (CHOICES is the state's managed LTSS program for persons who are elderly or who have physical disabilities.)	N/A
D1.II.3	**MLR reporting period discrepancies**	If the data reported in item D1.II.1a covers a different time period than the MCPAR report, enter the start and end date for that data.	We have provided MLRs for Calendar Year 2022. This data may be impacted by reporting lags.	We have provided MLRs for Calendar Year 2022. This data may be impacted by reporting lags.	We have provided MLRs for Calendar Year 2022. This data may be impacted by reporting lags.	N/A

III. Encounter Data						
D1.III.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.	Within two (2) business days of the end of a payment cycle the MCO must generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If the MCO has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week.	Within two (2) business days of the end of a payment cycle the MCO must generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If the MCO has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week.	Within two (2) business days of the end of a payment cycle the MCO must generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If the MCO has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week.	Within two (2) business days of the end of a payment cycle the MCO must generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If the MCO has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week.
D1.III.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.	100%	100%	100%	100%
D1.III.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.	99.40%	100.00%	99.70%	100%
IV. Appeals, State Fair Hearings and Grievances						
Subtopic: Appeals						
D1.IV.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.	499	355	460	142

D1.IV.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.	67	60	54	18
D1.IV.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. If not applicable, write "N/A." 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).	25	14	27	9
D1.IV.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, write "N/A" in this field. 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, the state can write "N/A" in this field. The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	0	0	0	0
D1.IV.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.	491	351	437	142
D1.IV.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.	8	1	21	0
D1.IV.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 D1.20).	437	294	386	78

D1.IV.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.	59	67	61	70
D1.IV.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.	0	3	2	0
D1.IV.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).	0	0	0	0
D1.IV.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.	0	0	0	0
D1.IV.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).	N/A	N/A	N/A	N/A
D1.IV.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.	0	0	0	0
Number of appeals resolved during the reporting period related to the following services:	***(A single appeal may be related to multiple service types and may therefore be counted in multiple categories below.)***					
D1.IV.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.16. If the managed care plan does not cover general inpatient services, enter "N/A".	75	30	55	0
D1.IV.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.17. If the managed care plan does not cover general outpatient services, enter "N/A".	94	131	92	4

D1.IV.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".	44	12	9	4
D1.IV.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".	3	19	16	4
D1.IV.7e	**Resolved appeals related to covered outpatient prescription drugs**	Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	N/A	N/A	N/A	N/A
D1.IV.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".	0	0	1	1
D1.IV.7g	**Resolved appeals related to long-term services and supports (LTSS)**	Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	32	67	47	87
D1.IV.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".	0	0	0	0
D1.IV.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".	1	0	1	0
D1.IV.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".	179	87	220	46
Subtopic: State Fair Hearings and External Medical Reviews By Originating Plan						
D1.IV.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.	222	129	247	81
D1.IV.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.	24	4	17	4

D1.IV.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.	109	50	133	37
D1.IV.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.	136	80	126	35
D1.IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee**	If your state does offers 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, please enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	N/A	N/A	N/A	N/A
D1.IV.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, please enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	N/A	N/A	N/A	N/A
Subtopic: Grievances						
D1.IV.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.	1935	1015	242	0
D1.IV.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.	2	60	7	0
D1.IV.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).	48	84	3	0

D1.IV.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. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. 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. 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.	14 total between the 3 MCOs and TennCare Select	14 total between the 3 MCOs and TennCare Select	14 total between the 3 MCOs and TennCare Select	14 total between the 3 MCOs and TennCare Select
D1.IV.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.	1933	1015	242	0
Number of grievances resolved by plan during the reporting period related to the following services:	***(A single grievance may be related to multiple service types and may therefore be counted in multiple categories below.)***					
D1.IV.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.37. If the managed care plan does not cover this type of service, enter "N/A". 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".	65	0	2	0

D1.IV.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.38. If the managed care plan does not cover this type of service, enter "N/A".	881	0	82	0
D1.IV.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".	14	0	0	0
D1.IV.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".	13	0	16	0
D1.IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs**	Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	N/A	N/A	N/A	N/A
D1.IV.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".	4	0	0	0
D1.IV.15g	**Resolved grievances related to long-term services and supports (LTSS)**	Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	19	59	2	0
D1.IV.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".	N/A	N/A	N/A	N/A
D1.IV.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".	658	378	138	0
D1.IV.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 the previous 10 items, enter "N/A".	315	0	2	0

Number of grievances resolved by plan during the reporting period related to the following reasons:	*(A single grievance may be related to multiple reasons and may therefore be counted in multiple categories below.)*					
D1.IV.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.	65	607	9	0
D1.IV.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.	11	27	0	0
D1.IV.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.	11	245	92	0
D1.IV.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.	173	156	7	0
D1.IV.16e	**Resolved grievances related to plan communications**	Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	31	3	0	0
D1.IV.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.	494	3	0	0
D1.IV.16g	**Resolved grievances related to suspected fraud**	Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	8	0	0	0

D1.IV.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.	0	0	0	0
D1.IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)**	Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	0	0	0	0
D1.IV.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.	0	0	0	0
D1.IV.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.	342	0	134	0
X. Program Integrity						
D1.X.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).	9	6	8	6
D1.X.2	**Count of opened program integrity investigations**	How many program integrity investigations have been opened by the plan in the past year?	98	230	63	184
D1.X.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?	0.19:1,000	0.36:1,000	0.12:1,000	3.38:1,000
D1.X.4	**Count of resolved program integrity investigations**	How many program integrity investigations have been resolved by the plan in the past year?	178	240	56	183
D1.X.5	**Ratio of resolved program integrity investigations to enrollees**	What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	0.36:1,000	0.39:1,000	0.11:1,000	3.50:1,000
D1.X.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.	The plan makes referrals to the SMA and MFCU concurrently.	The plan makes referrals to the SMA and MFCU concurrently.	The plan makes referrals to the SMA and MFCU concurrently.	The plan makes referrals to the SMA and MFCU concurrently.

D1.X.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 using the referral path selected in the previous indicator. · If the plan makes referrals to the MFCU only, enter the count of referrals made. · If the plan makes referrals to the SMA and MFCU concurrently, enter the count of unduplicated referrals. · If the plan makes some referrals to the SMA and others directly to the MFCU, enter the count of referrals made to the SMA and the MFCU in aggregate.	17	31	25	31
D1.X.8	**Ratio of program integrity referrals to the state**	What is the ratio of program integrity referrals 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.	0.032:1,000	0.05:1,000	.048:1,000	0.57:1,000
D1.X.9	**Plan overpayment reporting to the state**	Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information: · The date of the report (rating period or calendar year). · The dollar amount of overpayments recovered. · The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2).	Date of Report: 01/01/2022 - 12/31/2022 Dollar Amount of Overpayments Recovered: $15,358,607 Percent of Premium Revenue: 0.61%	Date of Report: 01/01/2022 - 12/31/2022 Dollar Amount of Overpayments Recovered: $69,693,406 Percent of Premium Revenue: 2.26%	Date of Report: 01/01/2022 - 12/31/2022 Dollar Amount of Overpayments Recovered: $48,437,812 Percent of Premium Revenue: 2.01%	N/A
D1.X.10	**Changes in beneficiary circumstances**	Select the frequency the plan reports changes in beneficiary circumstances to the state.	Quarterly	Quarterly	Quarterly	Quarterly

VII. Quality and Performance Measures									
D2.VII.1	**Measure domain**	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. **Select domains from the dropdown or add your own as needed.**	Primary care access and preventive care	Maternal and perinatal health	Care of acute and chronic conditions	Behavioral health care	Behavioral health care	Health plan enrollee experience of care	Long-term services and supports
D2.VII.2	**Measure name**	What is the measure name?	Cervical Cancer Screening (CCS-AD)	Timeliness of Prenatal Care (PPC-CH)	Controlling High Blood Pressure (CBP-AD)	Follow-up After Hospitalization for Mental Illness (FUH-CH)	Follow-up After Hospitalization for Mental Illness (FUH-AD)	Getting Needed Care Quickly Composite (Always + Usually)	Comprehensive Care Plan and Update (CPU)
D2.VII.3	**NFQ**	What is the NFQ number?	0032	1517	0018	0576	0576	N/A	N/A
D2.VII.4	**Measure reporting**	Is measure reporting program-specific or cross-program? Select one.	Program-specific rate	Program-specific rate	Program-specific rate	Program-specific rate	Program-specific rate	Program-specific rate	Program-specific rate
D2.VII.5	**Measure reporting: List programs**	If measure reporting is cross-program, what are the programs? Select one.	TennCare	TennCare	TennCare	TennCare	TennCare	TennCare	TennCare
D2.VII.6	**Measure set**	What is the measure set? Select one or use free text for "other".	Medicaid Adult Core Set	Medicaid Child Core Set	Medicaid Adult Core Set	Medicaid Child Core Set	Medicaid Adult Core Set	Medicaid Child Core Set	HEDIS
D2.VII.7a	**Reporting period**	Is the reporting period the same as what is requested in this report? Select yes or no.	No, 2022 data were not available prior to the submission of this report.	No, 2022 data were not available prior to the submission of this report.	No, 2022 data were not available prior to the submission of this report.	No, 2022 data were not available prior to the submission of this report.	No, 2022 data were not available prior to the submission of this report.	No, 2022 data were not available prior to the submission of this report.	No, 2022 data were not available prior to the submission of this report.
D2.VII.7b	**Reporting period: Date range**	If not, what is the reporting period covered by the measure? Add a date range.	Jan 1, 2021 - Dec 31, 2021	Jan 1, 2021 - Dec 31, 2021	Jan 1, 2021 - Dec 31, 2021	Jan 1, 2021 - Dec 31, 2021	Jan 1, 2021 - Dec 31, 2021	Jan 1, 2021 - Dec 31, 2021	Jan 1, 2021 - Dec 31, 2021
D2.VII.8	**Measure description**	For measures that are not part of standardized national measure sets (i.e. state-specific measures), states should provide a description of the measure (for example, numerator and denominator).	Percentage of women ages 12 to 64 who were screened for cervical cancer. **Note: separate CHIP members are included in the rate calculations**	Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in Medicaid/CHIP. **Note: separate CHIP members are included in the rate calculations**	Percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year. **Note: separate CHIP members are included in the rate calculations.**	Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis and who had a follow-up visit with a mental health provider. The 30-day follow up rate is reported. **Note: separate CHIP members are included in the rate calculations.**	Percentage of discharges for members age 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis and who had a follow-up visit with a mental health provider. The 30-day follow up rate is reported. **Note: separate CHIP members are included in the rate calculations.**	CAHPS Survey question for the general child population: In the past 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed? **Note: separate CHIP members are included in the rate calculations**	Percentage of LTSS members 18 years of age and older who had documentation of a comprehensive LTSS care plan with 9 core elements documented within 120 days of enrollment (for new members) or during the measurement year (for established members).
Add plan-level details for each measure. Plan names autopopulate from the Program Information tab.									
N/A	**Amerigroup: Measure results**	What are the measure results for this plan? Add free text or N/A if not applicable.	54.99%	86.13%	62.77%	76.58%	52.50%	91.54%	95.83%
N/A	**BlueCare: Measure results**	What are the measure results for this plan? Add free text or N/A if not applicable.	63.34%	83.33%	65.10%	73.03%	60.47%	86.62%	93.75%
N/A	**UnitedHealthcare Community Plan (UHCCP): Measure results**	What are the measure results for this plan? Add free text or N/A if not applicable.	55.47%	82.97%	64.96%	78.47%	56.16%	87.27%	91.67%

[D3] Plan-Level, State-Specific Indicators: Sanctions

#	Indicator	Instruction	Sanction #1	Sanction #2	Sanction #3	Sanction #4	Sanction #5	Sanction #6
VII. Sanctions								
D3.VIII.1	Intervention type	What type of intervention? Select one.	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages
D3.VIII.2	Intervention topic	What was the topic of intervention? Select one.	Reporting	Timely access	Timely access	Timely access	Timely access	Timely access
D3.VIII.3	Plan name	What is the name of the plan attached to the sanction or corrective action plan? Select plan name.	AMERIGROUP	AMERIGROUP	AMERIGROUP	AMERIGROUP	AMERIGROUP	AMERIGROUP
D3.VIII.4	Reason for intervention	What was the reason for intervention? Add a description.	Edifecs rejected encounters not being corrected within 45 days of initial rejection.	Late ORR Response AMG - TennCare Guidance for TAA UPL Initiative MCO Provider Agreement Due: 11/22/2021 Received: 11/23/2021	Late Deliverable submission - A.2.30.10.2 - Monthly Check Run Summaries Due: 11/22/2021 Received: 11/24/2021	Late ORR Response - Effective Rates for Nursing Facilities being added to September's Withholds Due: 9/15/2022 Received: 9/19/2022	Late ORR Response - Weekly RMHI Report Due: 11/22/2021 Received: 11/24/2021	Late ORR Response - Amerigroup Provider Original Due Date: 12/14/2021 Extension Approved until 12/16/2021 Response received: 12/17/2021
			81 rejected encounters	NA	NA	NA	NA	NA
D3.VIII.5	Instances of non-compliance	How many instances were there of non compliance in the reporting year? Add a number.	9	1	1	1	1	1
D3.VIII.6	Sanction amount	Add a dollar amount. Choose N/A for sanctions that do not carry financial penalties.	$ 8,100.00	$ 100.00	$ 200.00	$ 400.00	$ 200.00	$ 100.00
D3.VIII.7	Date assessed	When was the plan sanctioned? Select a date.	1/7/2022, 2/4/2022, 3/4/2022, 4/1/2022, 5/6/2022, 6/3/2022	1/7/2022	1/7/2022	10/7/2022	1/7/2022	2/4/2022
D3.VIII.8	Remediation date non-compliance was corrected	What day was it remediated, i.e. When was the non-compliance corrected? Select a date.	1/7/2022, 2/4/2022, 3/4/2022, 4/1/2022, 5/6/2022, 6/3/2022	11/23/2021	11/24/2021	9/19/2022	11/24/2021	12/17/2021
D3.VIII.9	Corrective action plan	Has the state sanctioned the plan within the previous two years, (e.g. corrective action plans or other informal interventions such as special outreach, focused technical assistance)?	Yes	No	No	No	No	No

#	Sanction #7	Sanction #8	Sanction #9	Sanction #10	Sanction #11	Sanction #12	Sanction #13
VII. Sanctions							
D3.VIII.1	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages
D3.VIII.2	Reporting	Reporting	Timely access	Reporting	Reporting	Reporting	Reporting
D3.VIII.3	AMERIGROUP	AMERIGROUP	AMERIGROUP	AMERIGROUP	AMERIGROUP	AMERIGROUP	AMERIGROUP
D3.VIII.4	Failure to meet Medical and All claims benchmark - December 2021 (Prompt Pay)	Failure to meet 97% benchmark for Claims Payment Accuracy (All Others or ECF Choices)	Amerigroup's ORR response on February 22nd did not fully address all of the state's questions as part of this ORR. Amerigroup shall be assessed damages in the amount of $100 per day from February 22nd until February 28th which was the date a corrected response has been submitted that completely addresses all of the state's questions.	Amerigroup Middle Failure to Provide Approved PDN (missed PDN shifts). Damages accrue at $500 for each day with a missed shift ($14,000), plus the amount it would have cost Amerigroup had the services been conferred (250 hours of PDN missed = $9157.50)	Amerigroup is responsible for 34 Missed PDN Shifts. Damages accrue at $500 for each day with a missed shift, plus the amount it would have cost Amerigroup had the services been conferred. [34 days @ $500/day=$17,000] + [408 hours missed @ $41/hr= $16,728] = $33,728.	Late Submission - Failure to provide the written report to the state within 5 business days in accordance with Section A.19.5.6.1. Incident date: 2/24/2022 Written report due to the state: 3/3/2022 Received written report: 3/7/2022.	Late Submission - Failure to notify the state of an accident with injuries within 5 business days in accordance with Section A.19.5.6.1.Accident: 8/25/2022Due to the state: 9/1/2022Report Received: 9/7/2022
	NA	9 points below benchmark	NA	NA	NA	NA	NA
D3.VIII.5	1	4	1	1	1	1	1
D3.VIII.6	$ 10,000.00	$ 45,000.00	$ 700.00	$ 23,157.50	$ 33,728.00	$ 1,000.00	$ 1,000.00
D3.VIII.7	3/4/2022	4/1/2022,5/6/2022, 8/5/2022 10/7/2022	4/1/2022	2/4/2022	10/7/2022	5/6/2022	10/7/2022
D3.VIII.8	3/4/2022	4/1/2022,5/6/2022, 8/5/2022 10/7/2022	2/28/2022	2/4/2022	10/7/2022	3/7/2022	9/7/2022
D3.VIII.9	No	No	No	No	No	No	No

#	Sanction #14	Sanction #15	Sanction #16	Sanction #17	Sanction #18	Sanction #19	Sanction #20
VII. Sanctions							
D3.VIII.1	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages
D3.VIII.2	Reporting	Timely access	Reporting	Timely access	Reporting	Timely access	Reporting
D3.VIII.3	AMERIGROUP	AMERIGROUP	BlueCare	BlueCare	BlueCare	BlueCare	BlueCare
D3.VIII.4	Failure to meet the benchmark for Telephone Numbers	Failure to submit an acceptable Provider Enrollment File by the 5th of the month.	Attached is an updated version of the provider agreement associated with TennCare's AA Physician UPL directed payment program. TennCare has provided TDCI with an advanced copy. TennCare is requesting and TDCI is expecting that BlueCare request expedited review of the provider agreement. Additionally, TennCare is requesting that BlueCare send the provider agreement to the providers on 11/22/2021. On 11/22/2021, please respond to TennCare with confirmation that	Late Deliverable Submission - A.2.30.17.3 - Weekly Claims Activity Report Due: 12/22/2021 Received: 12/27/2021	Missed PDN Shifts	Late Notification A.19.5.6.1 - NEMT Accident/Incident Report NEMT Provider Date of the incident: June 27, 2022 Reported to SET/BlueCare: June 30, 2022 Report due to the state: July 5, 2022 Reported to the state: July 20, 2022	Failure to meet the benchmark for Telephone Numbers
	NA	NA	NA	NA	28 missed shifts	NA	NA
D3.VIII.5	4	1	1	1	3	1	3
D3.VIII.6	$ 20,000.00	$ 500.00	$ 100.00	$ 100.00	$ 26,341.76	$ 1,000.00	$ 15,000.00
D3.VIII.7	1/7/2022, 4/1/2022, 7/8/2022, 10/7/2022	5/6/2022	1/7/2022	2/4/2022	7/8/2022	9/2/2022	1/7/2022, 4/1/2022,7/8/2022
D3.VIII.8	1/7/2022, 4/1/2022, 7/8/2022, 10/7/2022	4/7/2022	11/23/2021	12/27/2022	7/8/2022	7/20/2022	1/7/2022, 4/1/2022,7/8/2022
D3.VIII.9	Yes	No	No	No	No	No	Yes

#	Sanction #21	Sanction #22	Sanction #23	Sanction #24	Sanction #25	Sanction #26	Sanction #27
VII. Sanctions							
D3.VIII.1	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages
D3.VIII.2	Reporting	Timely access	Timely access	Reporting	Timely access	Timely access	Timely access
D3.VIII.3	TennCare Select	UHCCP	UHCCP	UHCCP	UHCCP	UHCCP	UHCCP
D3.VIII.4	Failure to meet the benchmark for Telephone Numbers	Late ORR Response - Overturned Claim(s) Payment Dollar Amount Due: 1/13/2022 Received: 1/14/2022	Late ORR Response340B Reporting and Provider Education Process	Damages accrue at $500 for each day with a missed AC shift (11 x $500=$5500), plus the cost of services not conferred $1101.24). Total: $6601.24	Late Submission - Failure to notify the state of an Incident within 5 business days in accordance with Section A.19.5.6.1. Incident: 12/13/2021 Due to the state: 12/20/2021 TDCI became aware of this incident on 3/31/2022. Report Received: 4/11/2022	Untimely corrected report - A.19.1.4 - NEMT Utilization Report (January 2022) Monthly Report due: 2/22/2022 Denied submission: 3/2/2022 Corrected report was due 3/8/2022	Late ORR Response - Member Mileage Reimbursement Update - Letters and Debit/Pay Card Option Due: 8/2/2022 Received: 8/3/2022
	NA	NA	2 days late	NA	NA	NA	NA
D3.VIII.5	3	1	2	1	1	1	1
D3.VIII.6	$ 15,000.00	$ 100.00	$ 200.00	$ 6,601.24	$ 1,000.00	$ 3,700.00	$ 100.00
D3.VIII.7	4/1/2022, 7/8/2022, 11/4/2022	2/4/2022	10/7/2022, 11/4/2022	7/8/2022	5/6/2022	5/6/2022	9/2/2022
D3.VIII.8	4/1/2022, 7/8/2022, 11/4/2022	1/14/2022	8/17/2022, 10/18/2022	7/8/2022	4/11/2022	3/8/2022	8/3/2022
D3.VIII.9	Yes	No	No	No	No	No	No

#	Sanction #28	Sanction #29	Sanction #30	Sanction #31	Sanction #32	Sanction #33	Sanction #34
VII. Sanctions							
D3.VIII.1	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages	Liquidated damages
D3.VIII.2	Timely access	Timely access	Reporting	Timely access	Timely access	Timely access	Timely access
D3.VIII.3	UHCCP	UHCCP	UHCCP	UHCCP	UHCCP	UHCCP	UHCCP
D3.VIII.4	Late ORR Response - NEMT Complaint. Due: 10/26/2022Received: 10/27/2022	Failure to comply with time frames for the 3rd Quarter 2022 TennCare Member Newsletters as required in Section A.2.17	Failure to meet the benchmark for Telephone Numbers	Late ORR Response UHCCP - DOO Matching to Provider File 8-5-2022 Due: 8/5/2022 Received: 8/8/2022	Late Deliverable - A.2.30.6.17 - Weekly Member MCO Selection/Assignment Report Due: 4/13/2022 Received: 4/18/2022	Late Deliverable - A.2.30.4.8 - Weekly THL Attribution Files Due: 7/29/2022 Received: 8/01/2022	Late Deliverable Submission - A.2.30.4.6.6 - Quarterly PCMH Provider Sample Reports Due: 11/7/2022Received: 11/8/2022
	NA	NA	NA	NA	NA	NA	NA
D3.VIII.5	1	2	4	1	1	1	1
D3.VIII.6	$ 100.00	$ 10,000.00	$ 20,000.00	$ 300.00	$ 500.00	$ 300.00	$ 100.00
D3.VIII.7	12/2/2022	12/2/2022	1/7/2022, 4/1/2022, 7/8/2022, 11/4/2022	9/2/2022	5/6/2022	9/2/2022	12/2/2022
D3.VIII.8	10/27/2022	9/13/2022	1/7/2022, 4/1/2022, 7/8/2022, 11/4/2022	8/8/2022	4/18/2022	8/1/2022	11/8/2022
D3.VIII.9	No	No	Yes	No	No	No	No

[E] Beneficiary Support System (BSS) Entities, Set Indicators			
#	**Indicator**	**Instruction**	**Disability Rights Tennessee (DRT)**
E.IX.1	**BSS entity type**	What type of entity was contracted to perform each BSS activity? Select multiple and/or use free text for "other". Refer to 42 CFR 438.71(b).	Legal Assistance Organization
E.IX.2	**BSS entity role**	What are the roles performed by the BSS entity? Select multiple and/or use free text for "other". Refer to 42 CFR 438.71(b).	Other: Enrollment Broker/Choice Counseling, Beneficiary Outreach, LTSS Complaint Access Point, LTSS Grievance/Appeals Education and Assistance, Review of LTSS Data

Glossary

This tab defines key terms used in the workbook.

Term	Acronym	Definition/ specification
Beneficiary Support System	BSS	As defined at 42 CFR 438.71, a BSS provides support to beneficiaries both prior to and after enrollment in a MCO, PIHP, PAHP, PCCM or PCCM entity. The BSS must provide at a minimum: (i) Choice counseling for all beneficiaries, (ii) Assistance for enrollees in understanding managed care. (iii) Assistance as specified for enrollees who use, or express a desire to receive, LTSS in paragraph (d) of this section. (2) The beneficiary support system must perform outreach to beneficiaries and/or authorized representatives and be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested....(d) Functions specific to LTSS activities: (1) An access point for complaints and concerns about plan enrollment, access to covered services, and other related matters. (2) Education on enrollees' grievance and appeal rights; the State fair hearing process; enrollee rights and responsibilities; and additional resources outside of the MCO, PIHP or PAHP. (3) Assistance, upon request, in navigating the plan grievance and appeal process, as well as appealing adverse benefit determinations by a plan to a State fair hearing. (4) Review and oversight of LTSS program data to provide guidance to the State Medicaid Agency on identification, remediation and resolution of systemic issues.
Corrective action plan	CAP	A corrective action plan is a step by step plan of action that is developed to achieve targeted outcomes for resolution of identified errors in an effort to: (1) identify the most cost-effective actions that can be implemented to correct error causes; (2) develop and implement a plan of action to improve processes or methods so that outcomes are more effective and efficient; (3) achieve measurable improvement in the highest priority areas; and (4) eliminate repeated deficient practices.
Critical incident	--	CMS uses the term "critical incident" to refer to events that adversely impact enrollee health and welfare and the achievement of quality outcomes identified in the person centered plan. However, the exact definition of "critical incident" and the categories that managed care plans are required to report is defined by each state.
Encounter data validation	--	The act of 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 the 2019 State Toolkit for Validating Medicaid Encounter Data for examples of intrafield, interfield, interfile and intersource validation tests that states can use to evaluate encounter data quality. The toolkit is available at: https://www.medicaid.gov/medicaid/downloads/ed-validation-toolkit.pdf.
LTSS user	--	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).
Managed care organization	MCO	Consistent with 42 CFR 438.2, Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is (1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or (2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions: (i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity, (ii) Meets the solvency standards of § 438.116.

Managed care plan	MCP	Consistent with 42 CFR 438.66, this document uses the term “managed care plan” to refer to MCO, PIHP, PAHP, and PCCM entities
Managed care program	--	Consistent with 42 CFR 438.2, Managed care program means a managed care delivery system operated by a State as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act. For purposes of the MCPAR, a program is defined by a specified set of benefits and eligibility criteria that is articulated in a contract between the state and managed care plans, and that has associated rate cells.
Managed long-term services and supports	MLTSS	Managed Long Term Services and Supports (MLTSS) refers to the delivery of long term services and supports through capitated Medicaid managed care programs.
Medical Loss Ratio	MLR	As specified under 42 CFR 438.8(d)-(h), MLR is the sum of an MCP’s incurred claims, quality expenditures, and fraud prevention expenditures divided by its adjusted premium revenue. The MCP’s adjusted premium revenue is its aggregated premium revenue minus taxes, licensing, and regulatory fees. For states that mandate minimum MLR values for MCPs, minimum values must be at least 85 percent under 42 CFR 438.8(c).
Non-emergency medical transportation	NEMT	Medicaid agencies are required to ensure necessary transportation for beneficiaries to and from providers. For situations that do not involve an immediate threat to the life or health of an individual, this requirement is usually called “non-emergency medical transportation,” or NEMT.
Premium deficiency reserve	PDR	Premium deficiency reserve (PDR) indicates whether future premiums plus current reserves are enough to cover future claim payments and expenses for the remainder of a contract period.
Prepaid ambulatory health plan	PAHP	Consistent with 42 CFR 438.2, Prepaid ambulatory health plan (PAHP) means an entity that (1) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates; (2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract.
Prepaid inpatient health plan	PIHP	Consistent with 42 CFR 438.2, Prepaid inpatient health plan (PIHP) means an entity that (1) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates; (2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract.
Primary care case management	PCCM	Consistent with 42 CFR 438.2, Primary care case management means a system under which: (1) A primary care case manager (PCCM) contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries; or (2) A PCCM entity contracts with the State to provide a defined set of functions.
Primary care case management entity	PCCM entity	Consistent with 42 CFR 438.2, Primary care case management entity (PCCM entity) means an organization that provides any of the following functions, in addition to primary care case management services, for the State: (1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line; (2) Development of enrollee care plans; (3) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program; (4) Provision of payments to FFS providers on behalf of the State; (5) Provision of enrollee outreach and education activities; (6) Operation of a customer service call center; (7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement; (8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers; (9) Coordination with behavioral health systems/providers; (10) Coordination with long-term services and supports systems/providers.

Reporting period /Reporting year	--	The 12-month period of the contract term (i.e. the contract year) for which the state is reporting information to CMS. Reporting year may also correspond to “rating period.”
Risk-based capital	RBC	Risk-based capital (RBC) measures the percentage of the required minimum capital that the MCP is holding. The MCP’s minimum capital is calculated using a standard formula that measures the risk of insolvency.
Sanction		Sanctions are enforcement actions taken against a managed care plans. Such actions include monetary and other forms of remedies, such as suspending all or part of new member enrollments, and suspending or terminating all or part of the contract.

Crosswalk of MCPAR indicators by tab			Tab identifier ➤	A	B	C1	C2	D1	D2	D3	E
			Reporting level ➤	Cover sheet	State-level	Program-level		Plan-level			BSS-level
			Indicator type* ➤	Set	Set	Set	Free	Set	Free		Set
#	Indicator	Instructions and definition	Data format								
n/a	**Identifying information on the state, program, plan, and BSS being reported**			**X**							
n/a	Point of contact and email address	(see Tab A)	Free text + Email address	X							
n/a	Date of report submission	(see Tab A)	Date field	X							
n/a	Reporting period start and end date	(see Tab A)	Date fields	X							
n/a	Name of the state, program, plans, and BSS entities being reported on	(see Tab A)	Free text	X							
I	**Program Characteristics and Enrollment****				**X**	**X**		**X**			
B.I.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.	Count		X						
B.I.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.	Count		X						
C1.I.1	Program contract	Enter the title and date of the contract between the state and plans participating in the managed care program.	Free Text			X					
C1.I.2	Contract URL	Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	Free Text (hyperlink)			X					
C1.I.3	Program type	What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Set values (select one)			X					
C1.I.4.a	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.	Set values (select multiple)			X					
C1.I.4.b	Variation in special benefits	Are there any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	Free text			X					
C1.I.5	Program enrollment	Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	Count			X					

C1.I.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.	Free text			X					
D1.I.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?	Count					X			
D1.I.2	Plan share of Medicaid	Automatically calculated. Sum of 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)	Percentage (calculated) *Note: No data entry required; this cell is autopopulated*					X			
D1.I.3	Plan share of any Medicaid managed care	Automatically calculated. Sum of 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)	Percentage (calculated) *Note: No data entry required; this cell is autopopulated*					X			
II	**Financial Performance**							**X**			
D1.II.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.4 below. See glossary for the regulatory definition of MLR.	Percentage					X			
D1.II.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.	Set values (select one) or use free text for "other" response					X			
D1.II.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.	Free text					X			
D1.II.3	MLR reporting period discrepancies	If the data reported in item D1.II.1a covers a different time period than the MCPAR report, enter the start and end date for that data.	Free text					X			
III	**Encounter Data Reporting**				**X**	**X**		**X**			
B.III.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 definition for more information.)	Set values (select multiple) or use free text for "other" response		X						
B.III.2	HIPAA compliance of proprietary system(s) for encounter data validation	If the state selected “proprietary system(s)” in previous question, were the system(s) utilized fully HIPAA compliant? Select one.	Set values (select one)		X						

C1.III.1	Uses of encounter data	For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more and/or use free text for "other". 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)).	Set values (select multiple) or use free text for "other" response			X					
C1.III.2	Criteria/ measures used 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 and/or use free text for "other". 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).	Set values (select multiple) or use free text for "other" response			X					
C1.III.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.	Free text			X					
C1.III.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.	Free text			X					
C1.III.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.	Free text			X					
C1.III.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?	Free text			X					
D.1.III.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.	Free text					X			
D1.III.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.	Percentage					X			
D1.III.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.	Percentage					X			
IV	**Grievance, Appeals, and State Fair Hearings**					**X**		**X**			
C1.IV.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.	Free text or N/A			X					

C1.IV.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.	Free text			X					
C1.IV.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.	Free text			X					
C1.IV.4	State definition of "timely" resolution for grievances	Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	Free text			X					
	Subtopic: Appeals							**X**			
D1.IV.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.	Count					X			
D1.IV.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.	Count					X			
D1.IV.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. If not applicable, write "N/A." 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).	Count					X			
D1.IV.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, write "N/A" in this field. 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, the state can write "N/A" in this field. The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were	Count or N/A					X			
D1.IV.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.	Count					X			

D1.IV.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.	Count					X			
D1.IV.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 D1.20).	Count					X			
D1.IV.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.	Count					X			
D1.IV.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.	Count					X			
D1.IV.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).	Count					X			
D1.IV.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.	Count					X			
D1.IV.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).	Count					X			
D1.IV.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.	Count					X			
resolved during the reporting period related to the following services: *(A single appeal may be related to multiple service types and may therefore be counted in multiple*								X			
D1.IV.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.16. If the managed care plan does not cover general inpatient services, enter "N/A".	Count					X			
D1.IV.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.17. If the managed care plan does not cover general outpatient services, enter "N/A".	Count					X			

D1.IV.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".	Count					X			
D1.IV.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".	Count					X			
D1.IV.7e	Resolved appeals related to covered outpatient prescription drugs	Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	Count					X			
D1.IV.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".	Count					X			
D1.IV.7g	Resolved appeals related to long-term services and supports (LTSS)	Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	Count					X			
D1.IV.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".	Count					X			
D1.IV.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".	Count					X			
D1.IV.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".	Count					X			
	Subtopic: State Fair Hearings and External Medical Reviews By Originating Plan							**X**			
D1.IV.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.	Count					X			
D1.IV.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.	Count					X			
D1.IV.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.	Count					X			
D1.IV.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.	Count					X			

D1.IV.9a	External Medical Reviews resulting in a favorable decision for the enrollee	If your state does offers 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, please enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	Count or N/A					X			
D1.IV.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, please enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	Count or N/A					X			
	Subtopic: Grievances							**X**			
D1.IV.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.	Count					X			
D1.IV.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.	Count					X			
D1.IV.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).	Count					X			
D1.IV.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. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. 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. 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.	Count					X			
D1.IV.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.	Count					X			

Number of grievances resolved by plan during the reporting period related to the following services: *(A single grievance may be related to multiple service types and may therefore be counted in multiple categories below.)*			(none)					X			
D1.IV.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.37. If the managed care plan does not cover this type of service, enter "N/A". 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".	Count					X			
D1.IV.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.38. If the managed care plan does not cover this type of service, enter "N/A".	Count					X			
D1.IV.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".	Count					X			
D1.IV.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".	Count					X			
D1.IV.15e	Resolved grievances related to coverage of outpatient prescription drugs	Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	Count					X			
D1.IV.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".	Count					X			
D1.IV.15g	Resolved grievances related to long-term services and supports (LTSS)	Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	Count					X			
D1.IV.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".	Count					X			

D1.IV.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".	Count					X			
D1.IV.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 the previous 10 items, enter "N/A".	Count					X			
Number of grievances resolved by plan during the reporting period related to the following reasons: *(A single grievance may be related to multiple reasons and may therefore be counted in multiple*			(none)					X			
D1.IV.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.	Count					X			
D1.IV.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.	Count					X			
D1.IV.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.	Count					X			
D1.IV.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.	Count					X			
D1.IV.16e	Resolved grievances related to plan communications	Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	Count					X			
D1.IV.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.	Count					X			

D1.IV.16g	Resolved grievances related to suspected fraud	Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	Count					X			
D1.IV.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.	Count					X			
D1.IV.16i	Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)	Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	Count					X			
D1.IV.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.	Count					X			
D1.IV.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.	Count					X			
V	**Availability, Accessibility, and Network adequacy**					**X**	**X**				
C1.V.1	Gaps/challenges in network adequacy	What are the state's biggest challenges? Describe any challenges MCPS have maintaining adequate networks and meeting standards.	Free text			X					
C1.V.2	State response to gaps in network adequacy	How does the state work with MCPs to address gaps in network adequacy?	Free text			X					
C2	State-specific measures used to monitor availability, accessibility, and network adequacy.	(see Tab C2) Domain or standard type Standard Standard type Provider type Applicable region(s) Population Monitoring methods Frequency of oversight methods					X				
VII	**Quality and Performance Measures**								**X**		

D2	State-specific measures used to monitor quality and performance across 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.	(see Tab D2) Domain‰QF #‰easure name‰easure reporting (program-specific or cross-program)‰f measure reporting is cross-program, list which programs‰easure set‰easure description							X		
VIII	**Sanctions and Corrective Action Plans****									**X**	
D4	List of sanctions, administrative penalties, and corrective action plans that the state has issued to plans.	(see Tab D4)								X	
IX	**Beneficiary Support System (BSS)**			**X**	**X**	**X**					**X**
n/a	Name of the BSS entities being reported on	(see Tab A)	Free text	X							
C1.IX.1	BSS website	Identify the website and/or email address that beneficiaries use to seek assistance from the BSS through electronic means.	Free text			X					
C1.IX.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))? 42 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.	Free text			X					
C1.IX.3	BSS LTSS program data	How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	Free text			X					
C1.IX.4	State evaluation of BSS entity performance	How does the state evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	Free text			X					
E.IX.1	BSS entity type	What type of entity was contracted to perform each BSS activity? Select multiple and/or use free text for "other". Refer to 42 CFR 438.71(b).	Set values (select multiple) or use free text for "other" response								X
E.IX.2	BSS entity role	What are the roles performed by the BSS entity? Select multiple and/or use free text for "other". Refer to 42 CFR 438.71(b).	Set values (select multiple) or use free text for "other" response								X
X	**Program Integrity**				**X**	**X**		**X**			

B.X.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.	Free text		X						
B.X.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.	Set values (select one)		X						
B.X.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).	Free text		X						
B.X.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.	Free text		X						
B.X.5	State overpayment reporting monitoring	Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track reporting from plans with requirements 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.	Free text		X						
B.X.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).	Free text		X						
B.X.7.a	Changes in provider circumstances: Monitoring plans	Does the state monitors whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Set values (select one)		X						
B.X.7.b	Changes in provider circumstances: Metrics	If the state monitors whether plans report provider “for cause” terminations in a timely manner in the previous indicator, does the state use a metric or indicator to assess plan reporting performance? Select one.	Set values (select one)		X						
B.X.7.c	Changes in provider circumstances: Describe metric	If the state uses a metric or indicator to assess plan reporting performance in item B.9a, describe the metric or indicator that the state uses.	Free text		X						
B.X.8a	Federal database checks: Excluded person or entities	During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	Set values (select one)		X						
B.X.8b	Federal database checks: Summarize instances of exclusion	If the state responded "yes" to the previous indicator, summarize the instances and whether the entity was notified as required in 438.602(d). Enter N/A if not applicable. Report actions taken, such as plan-level sanctions and corrective actions.	Free text		X						

B.X.9a	Website posting of 5 percent or more ownership control	Does the state posts 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)	Set values (select one)		X						
B.X.9b	Website posting of 5 percent or more ownership control	If the state responded "yes" in the previous indicator, what is the link to the website? Enter N/A if not applicable. Refer to 42 CFR 602(g)(3)	Free text		X						
B.X.10	Periodic audits	If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results? Refer to 42 CFR 438.602(e)	Free text		X						
C1.X.3	Prohibited affiliation disclosure	Did any plans disclose prohibited affiliations? If the state took action, enter those actions on Tab D3 Sanctions. Select one. Refer to 42 CFR 438.610(d).	Set values (select one)			X					
D1.X.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).	Count					X			
D1.X.2	Count of opened program integrity investigations	How many program integrity investigations have been opened by the plan in the past year?	Count					X			
D1.X.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?	Ratio					X			
D1.X.4	Count of resolved program integrity investigations	How many program integrity investigations have been resolved by the plan in the past year?	Count					X			
D1.X.5	Ratio of resolved program integrity investigations to enrollees	What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	Ratio					X			
D1.X.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.	Set value (select one)					X			
D1.X.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 using the referral path selected in the previous indicator. · If the plan makes referrals to the MFCU only, enter the count of referrals made. · If the plan makes referrals to the SMA and MFCU concurrently, enter the count of unduplicated referrals. · If the plan makes some referrals to the SMA and others directly to the MFCU, enter the count of referrals made to the SMA and the MFCU in aggregate.	Count					X			
D1.X.8	Ratio of program integrity referrals to the state	What is the ratio of program integrity referrals 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.	Ratio					X			
D1.X.9	Plan overpayment reporting to the state	Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information: · 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).	Free text					X			

D1.X.10	Changes in beneficiary circumstances	Select the frequency the plan reports changes in beneficiary circumstances to the state.	Set values (select one)					X			
* Standardized or pre-set indicators cover specific information that CMS would like reported consistently across all programs and plans (for example, enrollment count). State-specific or free indicators cover information that will vary based on what a state collects from its plans (for example, access measures).											
** Denotes sections that are required for PCCM entities, per 438.66(e)(2).											