Managed Care Program Annual Report (MCPAR) for Utah: Utah Medicaid

Due date	Last edited	Edited by	Status
12/27/2022	04/21/2023	Jennifer Meyer-Smart	Submitted

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

Point of Contact

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A.1	**State name** Auto-populated from your account profile.	Utah
A.2a	**Contact name**	Jennifer Meyer-Smart

	First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	
A.2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	jmeyersmart@utah.gov
A.3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Jennifer Meyer-Smart
A.3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	jmeyersmart@utah.gov
A.4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	04/21/2023

Reporting Period

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A.5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2021
A.5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2022
A.6	**Program name**	Utah Medicaid

		Auto-populated from report dashboard.

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Find in the Excel Workbook
A_Program_Info

	Indicator	Response
	Plan name	Healthy Outcomes Medical Excellence (HOME)

Add BSS entities (A.8)

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

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

Find in the Excel Workbook
A_Program_Info

	Indicator	Response
	BSS entity name	N/A

Topic I. Program Characteristics and Enrollment

Find in the Excel Workbook
B_State

Number	Indicator	Response
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.	471148
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.	458311

Topic III. Encounter Data Report

Find in the Excel Workbook
B_State

Number	Indicator	Response
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	State Medicaid agency staff

Glossary in Excel Workbook for more information.

Topic X: Program Integrity

Find in the Excel Workbook
B_State

Number	Indicator	Response
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.	The Utah Office of Inspector General (UOIG) focused on several activities to identify, address, and prevent fraud, waste, and abuse within Utah's managed care plans (MCPs). Using MCP encounter data to identify areas of concern, the UOIG reviewed inpatient data to determine if a member's hospital admission met billing criteria, outpatient data to determine if evaluation and management codes were billed appropriately, and site visits to review medical records of outlier encounters. The UOIG notified the MCPs' special investigation units to recover funds, as necessary.
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**	Attachment B Articles 11.1.6 and 11.1.7

	Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	
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.	The Contractor may retain its overpayment recoveries; if the OIG collects the overpayment it retains its recoveries.
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 compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	As per Attachment B Articles 11.1.5 and 6.1.3, plans submit quarterly overpayments reports. The State monitors the quarterly reports, including timeliness of reporting.
B.X.6	**Changes in beneficiary circumstances**	Enrollments are determined daily with the receipt of the Eligibility File from DWS. The system automatically evaluates eligibility for new enrollments or changes in enrollment and takes the appropriate action in the system. An Benefit Enrollment and

	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).	Maintenance (834) file is sent to each plan daily through the clearinghouse (UHIN) based on member enrollment activity. Any deviation in the expected file or file size would prompt an email from either the Plan or UHIN to the state to confirm. The state also monitors for the complete file transmission to UHIN. In addition, an Audit 834 file is also sent once a month to each plan with a retrospective point in time roster for reconciliation purposes.
B.X.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
B.X.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	No
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	No

	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.	
B.X.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	Yes
B.X.9b	**Website posting of 5 percent or more ownership control: Link** What is the link to the website? Refer to 42 CFR 602(g)(3).	https://medicaid.utah.gov/Documents/pdfs/Ownership%20MCE.pdf
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, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	Audits are conducted to determine the accuracy, truthfulness and completeness of the encounter and financial data submitted by the plans. The State performs quarterly encounter data reviews via email exchanges with the plans. Annual financial (MLR) examination reports can be found at medicaid.utah.gov/managed-care by clicking on the link "Medical Loss Ratio (MLR) Reports".

Topic I: Program Characteristics

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1.I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Utah Medicaid HOME Program Contract
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	07/01/2022
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://medicaid.utah.gov/Documents/pdfs/managedcare/SFY23-HOME%20Program%20Contract.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.	Managed Care Organization (MCO)
C1.I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care	Behavioral health

	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.	
C1.I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
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.	1,389
C1.I.6	**Changes to enrollment or benefits**	Public Health Emergency impacts only. There were no new benefits.

	Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	

Topic III: Encounter Data Report

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
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. 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
C1.III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data corrections Timeliness of data certifications Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation)
C1.III.3	**Encounter data performance criteria**	12.3.1 Encounter Data, Generally (E) The Contractor shall transmit Encounter Data within

	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.	30 calendar days of the service or Claim adjudication date. The Encounter Data shall represent all Encounter Claim types (professional and institutional) received and adjudicated by the Contractor.
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.	12.3.1 Encounter Data, Generally (H) If the Contractor fails to transmit at least 95 percent of its Encounter Data within the timely submission standard in Article 12.3.1(E) of this attachment, the Department may require corrective action. 14.3.2 Liquidated Damages, Per Day Amounts (3) $1,000 per calendar day the Contractor fails to submit accurate and complete Encounter Data (as required by Article 12.3 of this attachment) or Post Adjudication Pharmacy file (as required by Article 11.3.3(B) of this attachment);
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.	Working with multiple agencies with different systems and interpretations.

Topic IV. Appeals, State Fair Hearings & Grievances

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response

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.	N/A
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.	Att B 8.3.4 Timeframes for Standard Appeal Resolution and Notification (A) The Contractor shall complete each standard Appeal and provide a Notice of Appeal Resolution to the affected parties as expeditiously as the Enrollee's health condition requires, but no later than 30 calendar days from the day the Contractor receives the Appeal request.
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.	Att B 8.4.6 Timeframes for Expedited Appeal Resolution and Notification (A) The Contractor shall complete each expedited Appeal and provide a Notice of Appeal Resolution to affected parties as expeditiously as the Enrollee's health condition requires, but no later than 72 hours after the Contractor receives the expedited Appeal request.
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	Att B.8.6.4 Timeframes for Grievance Resolution and Notification (A) The Contractor shall dispose of each Grievance and provide notice to the affected parties as expeditiously as the Enrollee's health condition requires, but not to exceed 90 calendar days from the day the Contractor receives the Grievance.

	day the MCO, PIHP or PAHP receives the grievance.	

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
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.	N/A. The members need to apply to enroll in the HOME program. There are no challenges with network adequacy.
C1.V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	N/A

Topic V. Availability, Accessibility and Network Adequacy

Access Measures

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

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

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

Find in the Excel Workbook
C2_Program_State

Access measure total count: 6

Complete

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

1 / 6

C2.V.2 Measure standard

Network Adequacy Validation

C2.V.3 Standard type

Maximum time to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care, Behavioral Health and Specialists	Urban, Rural, Frontier	Adult and pediatric

C2.V.7 Monitoring Methods

EQRO Tableau Dashboard

C2.V.8 Frequency of oversight methods

Annually

Complete

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

2 / 6

C2.V.2 Measure standard

Network Adequacy Validation

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care, Behavioral Health, and Specialists	Urban, Rural, Frontier	Adult and pediatric

C2.V.7 Monitoring Methods

EQRO Tableau Dashboard

C2.V.8 Frequency of oversight methods

Annually

Complete

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

3 / 6

C2.V.2 Measure standard

Network Adequacy Validation

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care, Behavioral Health, and Specialists	Urban, Rural, Frontier	Adult and pediatric

C2.V.7 Monitoring Methods

EQRO Tableau Dashboard

C2.V.8 Frequency of oversight methods

Annually

Complete

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

4 / 6

C2.V.2 Measure standard

Network Adequacy Validation

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care, Behavioral Health, and Specialists	Urban, rural, frontier	Adult and pediatric

C2.V.7 Monitoring Methods

EQRO Tableau Dashboard

C2.V.8 Frequency of oversight methods

Annually

Complete

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

5 / 6

C2.V.2 Measure standard

Network Adequacy Validation

C2.V.3 Standard type

Provider Saturation

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care, Behavioral Health, and Specialists	Urban, Rural, Frontier	Adult and pediatric

C2.V.7 Monitoring Methods

EQRO Tableau Dashboard

C2.V.8 Frequency of oversight methods

Annually

Complete

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

6 / 6

C2.V.2 Measure standard

Network Adequacy Validation

C2.V.3 Standard type

NAV Trending

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care, Behavioral Health and Specialists	Urban, Rural ,Frontier	Adult and pediatric

C2.V.7 Monitoring Methods

EQRO Tableau Dashboard

C2.V.8 Frequency of oversight methods

Annually

Topic IX: Beneficiary Support System (BSS)

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
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. Separate entries with commas.	HPRs https://medicaid.utah.gov/health-program-representatives/, Mybenefits-https://medicaid.utah.gov/mybenefits-login/
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))? 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.	Beneficiaries are able to access support services through a variety of ways. The main access point for beneficiaries is to call our Health Program Representatives (HPRs) Monday - Friday, between 8:00 A.M. and 5:00 P.M. HPRs can receive calls in both English and Spanish. If there are other languages spoken by the beneficiaries, translators can be used in a 3 way call. Relay services can also be used for the hearing impaired. Beneficiaries are able to access their benefit information online by using the MyBenefits portal. In the MyBenefits portal, beneficiaries can see all of their coverage information, including Co-pay information, Medical plan, Dental Plan, Mental Health plan, etc. They can also request a Non-emergency transportation card through the portal. Beneficiaries can also email our HPR team at any time. The email questions and requests are answered daily by the HPR team.
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).	N/A. The plan is not responsible for LTSS.
C1.IX.4	**State evaluation of BSS entity performance**	The State maintains goals for the telephone system. The HPR team has a set goal that the

	What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	average speed of calls answered will be under 1 minute, 30 seconds. The abandonment rate for calls is to be under 6%. Calls are also monitored and reviewed for accuracy by lead workers and Supervisors.

Topic X: Program Integrity

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1.X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic I. Program Characteristics & Enrollment

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
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?	**Healthy Outcomes Medical Excellence (HOME)** 1,389
D1.I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1)	**Healthy Outcomes Medical Excellence (HOME)** 0.29%

	• Denominator: Statewide Medicaid enrollment (B.I.1)	
D1.I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Healthy Outcomes Medical Excellence (HOME)** 0.3%

Topic II. Financial Performance

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
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.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	**Healthy Outcomes Medical Excellence (HOME)** 88.98%
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.	**Healthy Outcomes Medical Excellence (HOME)** Program-specific regional

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.	**Healthy Outcomes Medical Excellence (HOME)** N/A
D1.II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Healthy Outcomes Medical Excellence (HOME)** Yes
N/A	Enter the start date.	**Healthy Outcomes Medical Excellence (HOME)** 07/01/2019
N/A	Enter the end date.	**Healthy Outcomes Medical Excellence (HOME)** 06/30/2020

Topic III. Encounter Data

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
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.	**Healthy Outcomes Medical Excellence (HOME)** Within 30 calendar days of the service or claim adjudication date.

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.	**Healthy Outcomes Medical Excellence (HOME)** 99%
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.	**Healthy Outcomes Medical Excellence (HOME)** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
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	**Healthy Outcomes Medical Excellence (HOME)** 4

	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.	
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.	**Healthy Outcomes Medical Excellence (HOME)** 0
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. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	**Healthy Outcomes Medical Excellence (HOME)** N/A
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, enter “N/A”. Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was	**Healthy Outcomes Medical Excellence (HOME)** N/A

	submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
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.	**Healthy Outcomes Medical Excellence (HOME)** 4
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.	**Healthy Outcomes Medical Excellence (HOME)** 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	**Healthy Outcomes Medical Excellence (HOME)** 3

	denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	
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.	**Healthy Outcomes Medical Excellence (HOME)** 0
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.	**Healthy Outcomes Medical Excellence (HOME)** 1
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).	**Healthy Outcomes Medical Excellence (HOME)** 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.	**Healthy Outcomes Medical Excellence (HOME)** 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).	**Healthy Outcomes Medical Excellence (HOME)** 0
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.	**Healthy Outcomes Medical Excellence (HOME)** 0

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals by Service

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

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
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.	**Healthy Outcomes Medical Excellence (HOME)** 0

	Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	
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.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Healthy Outcomes Medical Excellence (HOME)** 0
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".	**Healthy Outcomes Medical Excellence (HOME)** 0
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".	**Healthy Outcomes Medical Excellence (HOME)** 0
D1.IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan	**Healthy Outcomes Medical Excellence (HOME)** N/A

	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".	
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".	**Healthy Outcomes Medical Excellence (HOME)** 0
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".	**Healthy Outcomes Medical Excellence (HOME)** N/A
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".	**Healthy Outcomes Medical Excellence (HOME)** N/A
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".	**Healthy Outcomes Medical Excellence (HOME)** N/A

Number	Indicator	Response
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".	**Healthy Outcomes Medical Excellence (HOME)** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

State Fair Hearings

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
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.	**Healthy Outcomes Medical Excellence (HOME)** 0
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.	**Healthy Outcomes Medical Excellence (HOME)** 0
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.	**Healthy Outcomes Medical Excellence (HOME)** 0
D1.IV.8d	**State Fair Hearings retracted prior to reaching a decision**	**Healthy Outcomes Medical Excellence (HOME)**

	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.	0
D1.IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Healthy Outcomes Medical Excellence (HOME)** 0
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, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Healthy Outcomes Medical Excellence (HOME)** 0

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances Overview

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response

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.	**Healthy Outcomes Medical Excellence (HOME)** 5
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.	**Healthy Outcomes Medical Excellence (HOME)** 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). If this does not apply, enter N/A.	**Healthy Outcomes Medical Excellence (HOME)** 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. 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	**Healthy Outcomes Medical Excellence (HOME)** N/A

critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user.
If the managed care plan does not cover LTSS, the state should enter "N/A" in this field.
Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field.
To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.

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.	**Healthy Outcomes Medical Excellence (HOME)** 5

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
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.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Healthy Outcomes Medical Excellence (HOME)** 3
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.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Healthy Outcomes Medical Excellence (HOME)** 1
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	**Healthy Outcomes Medical Excellence (HOME)** 0

cover this type of service, enter "N/A".

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".	**Healthy Outcomes Medical Excellence (HOME)** 1
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".	**Healthy Outcomes Medical Excellence (HOME)** 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".	**Healthy Outcomes Medical Excellence (HOME)** 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".	**Healthy Outcomes Medical Excellence (HOME)** N/A

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".	**Healthy Outcomes Medical Excellence (HOME)** 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".	**Healthy Outcomes Medical Excellence (HOME)** N/A
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 items D1.IV.15a-i, enter "N/A".	**Healthy Outcomes Medical Excellence (HOME)** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1.IV.16a	**Resolved grievances related to plan or**	**Healthy Outcomes Medical Excellence (HOME)**

	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.	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.	**Healthy Outcomes Medical Excellence (HOME)** 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.	**Healthy Outcomes Medical Excellence (HOME)** 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.	**Healthy Outcomes Medical Excellence (HOME)** 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.	**Healthy Outcomes Medical Excellence (HOME)** 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.	**Healthy Outcomes Medical Excellence (HOME)** 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,	**Healthy Outcomes Medical Excellence (HOME)** 0

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.

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.	**Healthy Outcomes Medical Excellence (HOME)** 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).	**Healthy Outcomes Medical Excellence (HOME)** 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	**Healthy Outcomes Medical Excellence (HOME)** 0

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.

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.	**Healthy Outcomes Medical Excellence (HOME)** 0

Topic VII: Quality & Performance Measures

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

Find in the Excel Workbook
D2_Plan_Measures

Quality & performance measure total count: 4

Complete

D2.VII.1 Measure Name: Follow-up After Hospitalization for Mental Illness 1 / 4

D2.VII.2 Measure Domain
Behavioral health care

D2.VII.3 National Quality Forum (NQF) number
N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

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

D2.VII.8 Measure Description
N/A

Measure results

Healthy Outcomes Medical Excellence (HOME)

90%

Complete

D2.VII.1 Measure Name: Readmission Rate

2 / 4

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

Readmission rate is the percentage of admitted patients who return to the hospital for a related reason to the previous admission within 30 days of discharge.

Measure results

Healthy Outcomes Medical Excellence (HOME)

11.6%

Complete

D2.VII.1 Measure Name: Provider Accessibility and Availability

3 / 4

D2.VII.2 Measure Domain

Primary care access and preventative care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

Availability score is number of days until each HOME provider has two or more appointment slots open on the same day. The measure is based on a

routine, non-urgent appointment scheduled within 30 days of the request.

Measure results

Healthy Outcomes Medical Excellence (HOME)

23.2

Complete

D2.VII.1 Measure Name: Coordinated Services 4 / 4

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

Visits during the query date range in which the patient saw at least two providers of their care team.

Measure results

Healthy Outcomes Medical Excellence (HOME)

84.4%

Topic VIII. Sanctions

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

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

Find in the Excel Workbook
D3_Plan_Sanctions

Sanction total count:

0 - No sanctions entered

Topic X. Program Integrity

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
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).	**Healthy Outcomes Medical Excellence (HOME)** 3.5
D1.X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**Healthy Outcomes Medical Excellence (HOME)** 0
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?	**Healthy Outcomes Medical Excellence (HOME)** 0:1,000
D1.X.4	**Count of resolved program integrity investigations** How many program integrity investigations have been resolved by the plan in the past year?	**Healthy Outcomes Medical Excellence (HOME)** 0
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	**Healthy Outcomes Medical Excellence (HOME)** 0:1,000

	1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	
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.	**Healthy Outcomes Medical Excellence (HOME)** Makes referrals to the State Medicaid Agency (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. Enter the count of unduplicated referrals	**Healthy Outcomes Medical Excellence (HOME)** 0
D1.X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.2) as the denominator.	**Healthy Outcomes Medical Excellence (HOME)** 0:1,000
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).	**Healthy Outcomes Medical Excellence (HOME)** There were no overpayments for this year.
D1.X.10	**Changes in beneficiary circumstances**	**Healthy Outcomes Medical Excellence (HOME)**

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

Topic IX. Beneficiary Support System (BSS) Entities

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

Find in the Excel Workbook
E_BSS_Entities

Number	Indicator	Response
E.IX.1	**BSS entity type** What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**N/A** State Government Entity
E.IX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**N/A** Beneficiary Outreach