

Managed Care Program Annual Report (MCPAR) for Puerto Rico: Medicare Platino

Due date	Last edited	Edited by	Status
06/29/2025	06/24/2025	Hector Vazquez	Submitted

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

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	State name Auto-populated from your account profile.	Puerto Rico
A2a	Contact name First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Elia E Rivera Soto
A2b	Contact email address Enter email address. Department or program-wide email addresses ok.	mcp@ases.pr.gov
A3a	Submitter name CMS receives this data upon submission of this MCPAR report.	Hector Vazquez
A3b	Submitter email address CMS receives this data upon submission of this MCPAR report.	hvazquez@ases.pr.gov
A4	Date of report submission CMS receives this date upon submission of this MCPAR report.	06/27/2025

Reporting Period

Number	Indicator	Response
A5a	Reporting period start date Auto-populated from report dashboard.	01/01/2024
A5b	Reporting period end date Auto-populated from report dashboard.	12/31/2024
A6	Program name Auto-populated from report dashboard.	Medicare Platino

Add plans (A.7)

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

Indicator	Response
Plan name	Triple S Advantage
	MCS Advantage
	Humana
	MMM Healthcare


Add BSS entities (A.8)

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

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

Indicator	Response
BSS entity name	None

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

 **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** Guidance on In Lieu of Services on Medicaid.gov.

Indicator	Response
ILOS name	N/A

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	Statewide Medicaid enrollment Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	72,252
BI.2	Statewide Medicaid managed care enrollment Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	72,252

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	<p data-bbox="310 107 618 136">Data validation entity</p> <p data-bbox="310 161 722 699">Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.</p>	<p data-bbox="760 107 1117 136">State Medicaid agency staff</p> <p data-bbox="760 180 1073 210">Other state agency staff</p> <p data-bbox="760 254 954 283">State actuaries</p> <p data-bbox="760 327 1084 357">Other third-party vendor</p> <p data-bbox="760 401 1036 430">Proprietary system(s)</p>
BIII.2	<p data-bbox="310 751 678 865">HIPAA compliance of proprietary system(s) for encounter data validation</p> <p data-bbox="310 890 722 951">Were the system(s) utilized fully HIPAA compliant? Select one.</p>	Yes

Topic X: Program Integrity

Number	Indicator	Response
BX.1	<p data-bbox="310 107 727 180">Payment risks between the state and plans</p> <p data-bbox="310 201 727 867">Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter "No PI activities were performed during the reporting period" as your response. "N/A" is not an acceptable response.</p>	<p data-bbox="760 107 1395 816">The Program Integrity Unit (PIU) is an important division within the Puerto Rico Medicaid Program. Its primary responsibility is to maintain the integrity and accountability of the program. The PIU accomplishes this by identifying instances of fraud, waste, and abuse within the program. This ensures the program's resources are being utilized appropriately to provide high-quality healthcare services to eligible beneficiaries. To achieve its objectives, the PIU works in collaboration with other agencies, including law enforcement. It also conducts audits and reviews of Medicaid providers to ensure they comply with program policies and regulations. The PIU carries out its responsibilities through data analysis and investigative efforts, including interviews with healthcare providers and beneficiaries.</p>
BX.2	<p data-bbox="310 919 727 993">Contract standard for overpayments</p> <p data-bbox="310 1014 727 1171">Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.</p>	<p data-bbox="760 919 1395 949">State requires the return of overpayments</p>
BX.3	<p data-bbox="310 1224 727 1339">Location of contract provision stating overpayment standard</p> <p data-bbox="310 1360 727 1518">Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).</p>	<p data-bbox="760 1224 1395 1253">ASES contract with MCO, Section 19.1.9</p>
BX.4	<p data-bbox="310 1570 727 1644">Description of overpayment contract standard</p> <p data-bbox="310 1665 727 1917">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.</p>	<p data-bbox="760 1570 1395 2039">"The Contractor shall report and return to ASES an overpayment within sixty (60) calendar days after the date on which the overpayment was identified. The Contractor must specify their retention policies for the treatment of recoveries for all overpayments to a Provider, including specifically for the treatment of overpayments due to Fraud, Waste or Abuse. The Contractor must also have and require the use of a mechanism for a Network Provider to report to Contractor an overpayment, and to return the overpayment with a written</p>

explanation of the reason for the overpayment in accordance with this Section."

BX.5	State overpayment reporting monitoring Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	Per contract, the Plan must report overpayments as part of required quarterly reporting. This reporting is reviewed by ASES when received.
BX.6	Changes in beneficiary circumstances Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	As part of the beneficiary reconciliation and status change process, PRMP uses internal and state resources to complement the process. The demographic registry under the Department of Health is consulted prior to removing beneficiaries due to death. For individual waivers, the beneficiary must report the change of circumstance; for mass waivers it is conducted through a change request. Currently, PRMP has no interface with the Department of Corrections, so there is no way to know when a Medicaid beneficiary becomes confined until the beneficiary applies for renewal. The other scenario is when the confined beneficiary is hospitalized for more than 24 hours. The Department of Corrections notifies PRMP, and the beneficiary's eligibility is suspended. Partial eligibility is given to cover hospital expenses. This partial eligibility is provided for one year, and ASES only pays the hospital expenses incurred by the inmate.
BX.7a	Changes in provider circumstances: Monitoring plans Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	Changes in provider circumstances: Metrics	No

Does the state use a metric or indicator to assess plan reporting performance? Select one.

BX.8a	Federal database checks: Excluded person or entities	Yes
<p>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.</p>		
BX.8b	Federal database checks: Summarize instances of exclusion	Found two (2) excluded providers due to Fraud. Found one (1) termination due to Provider death.
<p>Summarize the instances and whether the entity was notified as required in 438.602(d). Report actions taken, such as plan-level sanctions and corrective actions.</p>		
BX.9a	Website posting of 5 percent or more ownership control	No
<p>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 42 CFR 438.602(g)(3) and 455.104.</p>		
BX.10	Periodic audits	No such audits were conducted during the reporting year
<p>If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter "No such audits were conducted"</p>		

during the reporting year” as your response. “N/A” is not an acceptable response.

Topic XIII. Prior Authorization

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

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026?	Not reporting data

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C11.1	<p>Program contract</p> <p>Enter the title of the contract between the state and plans participating in the managed care program.</p>	<p>"ADMINISTRACION DE SEGUROS DE SALUD DE PUERTO RICO (ASES) and MCO for PROVISION OF MEDICAID WRAPAROUND COVERAGE FOR THE GOVERNMENT HEALTH INSURANCE MEDICARE AND MEDICAID DUAL-ELIGIBLE POPULATION</p>
N/A	<p>Enter the date of the contract between the state and plans participating in the managed care program.</p>	07/01/2024
C11.2	<p>Contract URL</p> <p>Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.</p>	<p>https://www.ases.pr.gov/beneficiarios/medicared-platino/companias-contratadas/</p>
C11.3	<p>Program type</p> <p>What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.</p>	Managed Care Organization (MCO)
C11.4a	<p>Special program benefits</p> <p>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.</p> <p>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.</p>	<p>Behavioral health</p> <p>Dental</p>
C11.4b	<p>Variation in special benefits</p> <p>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.</p>	N/A
C11.5	<p>Program enrollment</p> <p>Enter the average number of individuals enrolled in this</p>	289,917

managed care program per month during the reporting year (i.e., average member months).

C11.6

Changes to enrollment or benefits

N/A

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

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	<p>Uses of encounter data</p> <p>For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more.</p> <p>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)).</p>	<p>Rate setting</p> <p>Quality/performance measurement</p> <p>Monitoring and reporting</p> <p>Program integrity</p> <p>Policy making and decision support</p>
C1III.2	<p>Criteria/measures to evaluate MCP performance</p> <p>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.</p> <p>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).</p>	<p>Timeliness of initial data submissions</p> <p>Timeliness of data corrections</p> <p>Timeliness of data certifications</p> <p>Use of correct file formats</p> <p>Overall data accuracy (as determined through data validation)</p>
C1III.3	<p>Encounter data performance criteria contract language</p> <p>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.</p>	<p>"13.8 14.3.3 15.2.1.2 15.2.1.21"</p>

C1III.4	Financial penalties contract language	17.5.1.3
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.		
C1III.5	Incentives for encounter data quality	N/A
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.		
C1III.6	Barriers to collecting/validating encounter data	Ensuring all contractors submit all the encounters, including those from capitated providers.
Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter "The state did not experience any barriers to collecting or validating encounter data during the reporting year" as your response. "N/A" is not an acceptable response.		

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	<p>State’s definition of “critical incident”, as used for reporting purposes in its MLTSS program</p> <p>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.</p>	N/A
C1IV.2	<p>State definition of “timely” resolution for standard appeals</p> <p>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.</p>	<p>"The Contractor shall resolve each Appeal and provide written Notice of the Disposition of the appeal as expeditiously as the Enrollee’s health condition requires but no more than: For standard appeals, thirty (30) Calendar Days from the date the Contractor receives the appeal. "</p>
C1IV.3	<p>State definition of “timely” resolution for expedited appeals</p> <p>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.</p>	<p>"The Contractor shall resolve each appeal and provide written Notice of the Disposition of the appeal as expeditiously as the Enrollee’s health condition requires but no more than: For expedited appeals, seventy-two (72) hours after the Contractor receives the appeal. In addition to required written notice, Contractor must make reasonable efforts to provide prompt oral notice of the expedited resolution to the Enrollee."</p>

C1IV.4 State definition of “timely” resolution for grievances

Provide the state’s definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.

The Contractor shall provide written notice of the disposition of the grievance as expeditiously as the Enrollee’s health condition requires, but no later than thirty (30) Calendar Days from the date the Contractor receives the grievance.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	<p>Gaps/challenges in network adequacy</p> <p>What are the state’s biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter “No challenges were encountered” as your response. “N/A” is not an acceptable response.</p>	<p>The Medicaid portion for Platino population covers limited services only (wraparound services). The MAOs do not have Network Adequacy reporting requirements written in the contract; therefore, no data were reported. The MAOs follow the Medicare requirements for network standards.</p>
C1V.2	<p>State response to gaps in network adequacy</p> <p>How does the state work with MCPs to address gaps in network adequacy?</p>	<p>The Medicaid portion for Platino population covers limited services only (wraparound services). MAOs do not have Network Adequacy reporting requirements written in the contract; therefore, no data were reported. The MAOs follow the Medicare requirements for network standards.</p>

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.



Complete

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

1 / 1

C2.V.2 Measure standard

The Medicaid portion for Platino population covers limited services only (wraparound services). The MAOs do not have Network Adequacy reporting requirements written in the contract; therefore, no data were reported. The MAOs follow the Medicare requirements for network standards.

C2.V.3 Standard type

N/A

C2.V.4 Provider

N/A

C2.V.5 Region

N/A

C2.V.6 Population

N/A

C2.V.7 Monitoring Methods

N/A

C2.V.8 Frequency of oversight methods

N/A

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	<p data-bbox="313 107 480 136">BSS website</p> <p data-bbox="313 161 724 317">List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.</p>	<p data-bbox="760 107 1349 178">planvitalpr.com, ases.pr.gov, asesdenuncia@ases.pr.gov, info@ases.pr.gov</p>
C1IX.2	<p data-bbox="313 369 618 441">BSS auxiliary aids and services</p> <p data-bbox="313 466 708 877">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.</p>	<p data-bbox="760 369 1029 399">1.787.474.3389 (TTY)</p>
C1IX.3	<p data-bbox="313 930 634 959">BSS LTSS program data</p> <p data-bbox="313 984 724 1241">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).</p>	<p data-bbox="760 930 813 959">N/A</p>
C1IX.4	<p data-bbox="313 1293 724 1365">State evaluation of BSS entity performance</p> <p data-bbox="313 1390 724 1514">What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?</p>	<p data-bbox="760 1293 813 1323">N/A</p>

Topic X: Program Integrity

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

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	Does this program include MCOs? If "Yes", please complete the following questions.	No

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	<p>Plan enrollment</p> <p>Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).</p>	<p>Triple S Advantage</p> <p>39,334</p> <p>MCS Advantage</p> <p>123,831</p> <p>Humana</p> <p>17,383</p> <p>MMM Healthcare</p> <p>108,465</p>
D1I.2	<p>Plan share of Medicaid</p> <p>What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment?</p> <ul style="list-style-type: none"> • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1) 	<p>Triple S Advantage</p> <p>13.6%</p> <p>MCS Advantage</p> <p>42.7%</p> <p>Humana</p> <p>6%</p> <p>MMM Healthcare</p> <p>37.4%</p>
D1I.3	<p>Plan share of any Medicaid managed care</p> <p>What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care?</p> <ul style="list-style-type: none"> • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2) 	<p>Triple S Advantage</p> <p>13.6%</p> <p>MCS Advantage</p> <p>42.7%</p> <p>Humana</p> <p>6%</p> <p>MMM Healthcare</p> <p>37.4%</p>

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	<p>Medical Loss Ratio (MLR)</p> <p>What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.</p>	<p>Triple S Advantage 258%</p> <p>MCS Advantage 248%</p> <p>Humana 259%</p> <p>MMM Healthcare 247%</p>
D1II.1b	<p>Level of aggregation</p> <p>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.</p>	<p>Triple S Advantage Other, specify – N/A</p> <p>MCS Advantage Other, specify – N/A</p> <p>Humana Other, specify – N/A</p> <p>MMM Healthcare Other, specify – N/A</p>
D1II.2	<p>Population specific MLR description</p> <p>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.</p>	<p>Triple S Advantage N/A</p> <p>MCS Advantage N/A</p> <p>Humana N/A</p> <p>MMM Healthcare N/A</p>
D1II.3	<p>MLR reporting period discrepancies</p>	<p>Triple S Advantage</p>

Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?

Yes

MCS Advantage

Yes

Humana

Yes

MMM Healthcare

Yes

N/A

Enter the start date.

Triple S Advantage

01/01/2023

MCS Advantage

01/01/2023

Humana

01/01/2023

MMM Healthcare

01/01/2023

N/A

Enter the end date.

Triple S Advantage

12/31/2023

MCS Advantage

12/31/2023

Humana

12/31/2023

MMM Healthcare

12/31/2023

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	<p>Definition of timely encounter data submissions</p> <p>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.</p>	<p>Triple S Advantage</p> <p>In the 837 format that PRMP receives, the files are daily, in ASES they are received on the 15th of each month with data from the previous month.</p> <p>MCS Advantage</p> <p>In the 837 format that PRMP receives, the files are daily, in ASES they are received on the 15th of each month with data from the previous month.</p> <p>Humana</p> <p>In the 837 format that PRMP receives, the files are daily, in ASES they are received on the 15th of each month with data from the previous month.</p> <p>MMM Healthcare</p> <p>In the 837 format that PRMP receives, the files are daily, in ASES they are received on the 15th of each month with data from the previous month.</p>
D1III.2	<p>Share of encounter data submissions that met state’s timely submission requirements</p> <p>What percent of the plan’s encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.</p>	<p>Triple S Advantage</p> <p>92%</p> <p>MCS Advantage</p> <p>92%</p> <p>Humana</p> <p>75%</p> <p>MMM Healthcare</p> <p>83%</p>
D1III.3	<p>Share of encounter data submissions that were HIPAA compliant</p> <p>What percent of the plan’s encounter data submissions (submitted during the reporting year) met state requirements</p>	<p>Triple S Advantage</p> <p>100%</p> <p>MCS Advantage</p> <p>100%</p>

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


Humana

100%

MMM Healthcare

100%

Topic IV. Appeals, State Fair Hearings & Grievances

 **Beginning June 2025, Indicators D1.IV.1a-c must be completed. Submission of this data before June 2025 is optional; if you choose not to respond prior to June 2025, enter "N/A".**

Appeals Overview

Number	Indicator	Response
D1IV.1	<p>Appeals resolved (at the plan level)</p> <p>Enter the total number of appeals resolved during the reporting year. An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.</p>	<p>Triple S Advantage 691</p> <p>MCS Advantage 4,218</p> <p>Humana 670</p> <p>MMM Healthcare 2,088</p>
D1IV.1a	<p>Appeals denied</p> <p>Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.</p>	<p>Triple S Advantage 77</p> <p>MCS Advantage 1,038</p> <p>Humana 124</p> <p>MMM Healthcare 394</p>
D1IV.1b	<p>Appeals resolved in partial favor of enrollee</p> <p>Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.</p>	<p>Triple S Advantage 0</p> <p>MCS Advantage 0</p> <p>Humana 3</p> <p>MMM Healthcare 9</p>
D1IV.1c	<p>Appeals resolved in favor of enrollee</p> <p>Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee. If you</p>	<p>Triple S Advantage 614</p> <p>MCS Advantage 3,180</p>

choose not to respond prior to June 2025, enter "N/A".

Humana

543

MMM Healthcare

1,685

D1IV.2

Active appeals

Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.

Triple S Advantage

15

MCS Advantage

125

Humana

0

MMM Healthcare

86

D1IV.3

Appeals filed on behalf of LTSS users

Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter "N/A" if not applicable.

An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).

Triple S Advantage

N/A

MCS Advantage

N/A

Humana

N/A

MMM Healthcare

N/A

D1IV.4

Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A".

Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the

Triple S Advantage

N/A

MCS Advantage

N/A

Humana

N/A

MMM Healthcare

N/A

reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A".

The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.

To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

D1IV.5a	<p>Standard appeals for which timely resolution was provided</p> <p>Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.</p>	<p>Triple S Advantage 491</p> <p>MCS Advantage 3,337</p> <p>Humana 386</p> <p>MMM Healthcare 1,799</p>
D1IV.5b	<p>Expedited appeals for which timely resolution was provided</p> <p>Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.</p>	<p>Triple S Advantage 181</p> <p>MCS Advantage 624</p> <p>Humana 284</p> <p>MMM Healthcare 270</p>
D1IV.6a	<p>Resolved appeals related to denial of authorization or</p>	<p>Triple S Advantage</p>

limited authorization of a service

565

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service.
(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).

MCS Advantage

3,402

Humana

353

MMM Healthcare

252

D1IV.6b

Resolved appeals related to reduction, suspension, or termination of a previously authorized service

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.

Triple S Advantage

17

MCS Advantage

0

Humana

0

MMM Healthcare

0

D1IV.6c

Resolved appeals related to payment denial

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.

Triple S Advantage

109

MCS Advantage

719

Humana

49

MMM Healthcare

77

D1IV.6d

Resolved appeals related to service timeliness

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).

Triple S Advantage

0

MCS Advantage

0

Humana

0

MMM Healthcare

0

D1IV.6e	Resolved appeals related to lack of timely plan response to an appeal or grievance	<p>Triple S Advantage 0</p> <p>MCS Advantage 0</p> <p>Humana 0</p> <p>MMM Healthcare 0</p>
D1IV.6f	Resolved appeals related to plan denial of an enrollee's right to request out-of-network care	<p>Triple S Advantage 0</p> <p>MCS Advantage 0</p> <p>Humana 0</p> <p>MMM Healthcare 0</p>
D1IV.6g	Resolved appeals related to denial of an enrollee's request to dispute financial liability	<p>Triple S Advantage 0</p> <p>MCS Advantage 97</p> <p>Humana 0</p> <p>MMM Healthcare 1</p>

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	<p>Resolved appeals related to general inpatient services</p> <p>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.</p> <p>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”.</p>	<p>Triple S Advantage 0</p> <p>MCS Advantage 19</p> <p>Humana 2</p> <p>MMM Healthcare 87</p>
D1IV.7b	<p>Resolved appeals related to general outpatient services</p> <p>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”.</p>	<p>Triple S Advantage 108</p> <p>MCS Advantage 1,536</p> <p>Humana 77</p> <p>MMM Healthcare 489</p>
D1IV.7c	<p>Resolved appeals related to inpatient behavioral health services</p> <p>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”.</p>	<p>Triple S Advantage 0</p> <p>MCS Advantage 1</p> <p>Humana 0</p> <p>MMM Healthcare 4</p>
D1IV.7d	<p>Resolved appeals related to outpatient behavioral health services</p>	<p>Triple S Advantage 2</p> <p>MCS Advantage</p>

	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".	60 Humana 2 MMM Healthcare 42
D1IV.7e	Resolved appeals related to covered outpatient prescription drugs Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	Triple S Advantage 343 MCS Advantage 2,392 Humana 206 MMM Healthcare 247
D1IV.7f	Resolved appeals related to skilled nursing facility (SNF) services Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	Triple S Advantage 0 MCS Advantage 4 Humana 0 MMM Healthcare 2
D1IV.7g	Resolved appeals related to long-term services and supports (LTSS) Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	Triple S Advantage N/A MCS Advantage N/A Humana N/A MMM Healthcare N/A
D1IV.7h	Resolved appeals related to dental services	Triple S Advantage 7

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".

MCS Advantage
184
Humana
11
MMM Healthcare
268

D1IV.7i Resolved appeals related to non-emergency medical transportation (NEMT)

Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".

Triple S Advantage
10
MCS Advantage
21
Humana
43
MMM Healthcare
11

D1IV.7j Resolved appeals related to other service types

Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i paid primarily by Medicaid, enter "N/A".

Triple S Advantage
0
MCS Advantage
1
Humana
329
MMM Healthcare
938

State Fair Hearings

Number	Indicator	Response
D1IV.8a	State Fair Hearing requests Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	Triple S Advantage 0
		MCS Advantage 0
		Humana 0
		MMM Healthcare 0
D1IV.8b	State Fair Hearings resulting in a favorable decision for the enrollee Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	Triple S Advantage 0
		MCS Advantage 0
		Humana 0
		MMM Healthcare 0
D1IV.8c	State Fair Hearings resulting in an adverse decision for the enrollee Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	Triple S Advantage 0
		MCS Advantage 0
		Humana 0
		MMM Healthcare 0
D1IV.8d	State Fair Hearings retracted prior to reaching a decision Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	Triple S Advantage 0
		MCS Advantage 0
		Humana 0
		MMM Healthcare

D1IV.9a	External Medical Reviews resulting in a favorable decision for the enrollee If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	Triple S Advantage 0 MCS Advantage 0 Humana 0 MMM Healthcare 0
<hr/>		
D1IV.9b	External Medical Reviews resulting in an adverse decision for the enrollee If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	Triple S Advantage 0 MCS Advantage 0 Humana 0 MMM Healthcare 0

Grievances Overview

Number	Indicator	Response
D1IV.10	<p>Grievances resolved</p> <p>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.</p>	<p>Triple S Advantage</p> <p>291</p> <p>MCS Advantage</p> <p>2,443</p> <p>Humana</p> <p>374</p> <p>MMM Healthcare</p> <p>2,250</p>
D1IV.11	<p>Active grievances</p> <p>Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.</p>	<p>Triple S Advantage</p> <p>1</p> <p>MCS Advantage</p> <p>640</p> <p>Humana</p> <p>0</p> <p>MMM Healthcare</p> <p>115</p>
D1IV.12	<p>Grievances filed on behalf of LTSS users</p> <p>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.</p>	<p>Triple S Advantage</p> <p>N/A</p> <p>MCS Advantage</p> <p>N/A</p> <p>Humana</p> <p>N/A</p> <p>MMM Healthcare</p> <p>N/A</p>
D1IV.13	<p>Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance</p> <p>For managed care plans that cover LTSS, enter the number</p>	<p>Triple S Advantage</p> <p>N/A</p> <p>MCS Advantage</p> <p>N/A</p> <p>Humana</p>

of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been “related” to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user.

If the managed care plan does not cover LTSS, the state should enter “N/A” in this field.

Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter “N/A” in this field.

To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.

N/A

MMM Healthcare

N/A

D1IV.14

Number of grievances for which timely resolution was provided

Enter the number of grievances for which timely resolution was

Triple S Advantage

291

MCS Advantage

2,572

provided by plan during the reporting year.	Humana
See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	374
	MMM Healthcare
	2,248

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	<p>Resolved grievances related to general inpatient services</p> <p>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”.</p>	<p>Triple S Advantage 21</p> <p>MCS Advantage 37</p> <p>Humana 7</p> <p>MMM Healthcare 80</p>
D1IV.15b	<p>Resolved grievances related to general outpatient services</p> <p>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”.</p>	<p>Triple S Advantage 72</p> <p>MCS Advantage 651</p> <p>Humana 131</p> <p>MMM Healthcare 5</p>
D1IV.15c	<p>Resolved grievances related to inpatient behavioral health services</p> <p>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”.</p>	<p>Triple S Advantage 3</p> <p>MCS Advantage 8</p> <p>Humana 1</p> <p>MMM Healthcare 5</p>
D1IV.15d	<p>Resolved grievances related to outpatient behavioral health services</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that</p>	<p>Triple S Advantage 11</p> <p>MCS Advantage 9</p>

	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".	<p>Humana 6</p> <p>MMM Healthcare 20</p>
D1IV.15e	<p>Resolved grievances related to coverage of outpatient prescription drugs</p> <p>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".</p>	<p>Triple S Advantage 4</p> <p>MCS Advantage 180</p> <p>Humana 9</p> <p>MMM Healthcare 81</p>
D1IV.15f	<p>Resolved grievances related to skilled nursing facility (SNF) services</p> <p>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".</p>	<p>Triple S Advantage 0</p> <p>MCS Advantage 3</p> <p>Humana 0</p> <p>MMM Healthcare 1</p>
D1IV.15g	<p>Resolved grievances related to long-term services and supports (LTSS)</p> <p>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".</p>	<p>Triple S Advantage N/A</p> <p>MCS Advantage N/A</p> <p>Humana N/A</p> <p>MMM Healthcare N/A</p>
D1IV.15h	<p>Resolved grievances related to dental services</p> <p>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</p>	<p>Triple S Advantage 21</p> <p>MCS Advantage 104</p>

not cover this type of service, enter "N/A".

Humana

13

MMM Healthcare

130

D1IV.15i

Resolved grievances related to non-emergency medical transportation (NEMT)

Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".

Triple S Advantage

30

MCS Advantage

451

Humana

96

MMM Healthcare

684

D1IV.15j

Resolved grievances related to other service types

Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i paid primarily by Medicaid, enter "N/A".

Triple S Advantage

129

MCS Advantage

1,000

Humana

111

MMM Healthcare

1,244

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	<p data-bbox="318 107 727 216">Resolved grievances related to plan or provider customer service</p> <p data-bbox="318 243 727 751">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.</p>	<p data-bbox="764 107 1024 191">Triple S Advantage 6</p> <p data-bbox="764 233 980 317">MCS Advantage 1,007</p> <p data-bbox="764 359 883 443">Humana 2</p> <p data-bbox="764 485 1005 569">MMM Healthcare 188</p>
D1IV.16b	<p data-bbox="318 806 727 961">Resolved grievances related to plan or provider care management/case management</p> <p data-bbox="318 989 727 1535">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.</p>	<p data-bbox="764 806 1024 890">Triple S Advantage 0</p> <p data-bbox="764 932 980 1016">MCS Advantage 152</p> <p data-bbox="764 1058 883 1142">Humana 0</p> <p data-bbox="764 1184 1005 1268">MMM Healthcare 1</p>

D1IV.16c	Resolved grievances related to access to care/services from plan or provider	Triple S Advantage
		4
	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.	MCS Advantage
		254
		Humana
		2
		MMM Healthcare
		10
<hr/>		
D1IV.16d	Resolved grievances related to quality of care	Triple S Advantage
		3
	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.	MCS Advantage
		262
		Humana
		2
		MMM Healthcare
		679
<hr/>		
D1IV.16e	Resolved grievances related to plan communications	Triple S Advantage
		0
	Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	MCS Advantage
		121
		Humana
		0
		MMM Healthcare
		0
<hr/>		

D1IV.16f	Resolved grievances related to payment or billing issues	Triple S Advantage
	Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	0
		MCS Advantage
		122
		Humana
		1
		MMM Healthcare
		41
D1IV.16g	Resolved grievances related to suspected fraud	Triple S Advantage
	Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud.	0
	Suspected fraud grievances include suspected cases of financial/payment fraud perpetrated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	MCS Advantage
		100
		Humana
		0
		MMM Healthcare
		15
D1IV.16h	Resolved grievances related to abuse, neglect or exploitation	Triple S Advantage
	Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation.	0
	Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	MCS Advantage
		0
		Humana
		0
		MMM Healthcare
		0
D1IV.16i	Resolved grievances related to lack of timely plan response to a service authorization or appeal	Triple S Advantage
		0
		MCS Advantage

(including requests to expedite or extend appeals)

Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).

0

Humana

0

MMM Healthcare

1

D1IV.16j

Resolved grievances related to plan denial of expedited appeal

Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.

Triple S Advantage

0

MCS Advantage

0

Humana

0

MMM Healthcare

6

D1IV.16k

Resolved grievances filed for other reasons

Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.

Triple S Advantage

1

MCS Advantage

0

Humana

0

MMM Healthcare

1,309

Topic VII: Quality & Performance Measures

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



Complete

D2.VII.1 Measure Name: N/A

1 / 1

D2.VII.2 Measure Domain

The Medicaid portion for Platino population covers limited services only (wraparound services). The MAOs do not have Performance Measure reporting requirements written in the contract; therefore, no data were reported. The MAOs follow the Medicare requirements.

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

N/A

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

Cross-program rate: N/A

D2.VII.6 Measure Set

N/A

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Triple S Advantage

N/A

MCS Advantage

N/A

Humana

N/A

MMM Healthcare

N/A

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

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

Sanction total count: 1



Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 1

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**

Reporting

Humana

D3.VIII.4 Reason for intervention

“Article 15 of the Platino contract between PRHIA and Humana requires the Medicare Advantage Organization (MAO) to submit periodic compliance reports, including a monthly privacy and confidentiality report. This report must include key details about any incidents, such as dates, nature, response, impact, and mitigation efforts. Article 29 further requires Humana to immediately notify PRHIA of any suspected or actual unauthorized disclosures or breaches of confidential information. Notification to ASES must occur without unreasonable delay and no later than 24 hours after identifying a breach, with updates provided as new information becomes available.”

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/13/2024

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

Yes, remediated 11/22/2024

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	<p>Dedicated program integrity staff</p> <p>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).</p>	<p>Triple S Advantage 16</p> <p>MCS Advantage 16</p> <p>Humana 4</p> <p>MMM Healthcare 6</p>
D1X.2	<p>Count of opened program integrity investigations</p> <p>How many program integrity investigations were opened by the plan during the reporting year?</p>	<p>Triple S Advantage 82</p> <p>MCS Advantage 81</p> <p>Humana 38</p> <p>MMM Healthcare 37</p>
D1X.3	<p>Ratio of opened program integrity investigations to enrollees</p> <p>What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.</p>	<p>Triple S Advantage 2.08:1,000</p> <p>MCS Advantage 6.54:1,000</p> <p>Humana 2.18:1,000</p> <p>MMM Healthcare 3.41:1,000</p>
D1X.4	<p>Count of resolved program integrity investigations</p> <p>How many program integrity investigations were resolved by the plan during the reporting year?</p>	<p>Triple S Advantage 87</p> <p>MCS Advantage 78</p> <p>Humana 32</p> <p>MMM Healthcare</p>

D1X.5	Ratio of resolved program integrity investigations to enrollees	Triple S Advantage
		2.21:1,000
	What is the ratio of program integrity investigations resolved by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	MCS Advantage
		6.29:1,000
		Humana
		1.84:1,000
		MMM Healthcare
		2.85:1,000
D1X.6	Referral path for program integrity referrals to the state	Triple S Advantage
	What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	Makes referrals to the SMA and MFCU concurrently
		MCS Advantage
		Makes referrals to the SMA and MFCU concurrently
		Humana
		Makes referrals to the SMA and MFCU concurrently
		MMM Healthcare
		Makes referrals to the SMA and MFCU concurrently
D1X.7	Count of program integrity referrals to the state	Triple S Advantage
	Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals.	1
		MCS Advantage
		24
		Humana
		1
		MMM Healthcare
		0
D1X.8	Ratio of program integrity referral to the state	Triple S Advantage
	What is the ratio of program integrity referrals listed in	0.02:1,000
		MCS Advantage

indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.

1.93:1,000

Humana

0.05:1,000

MMM Healthcare

0:1,000

D1X.9a: Plan overpayment reporting to the state: Start Date

What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?

Triple S Advantage

01/31/2024

MCS Advantage

01/31/2024

Humana

01/31/2024

MMM Healthcare

01/31/2024

D1X.9b: Plan overpayment reporting to the state: End Date

What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?

Triple S Advantage

12/31/2024

MCS Advantage

12/31/2024

Humana

12/31/2024

MMM Healthcare

12/31/2024

D1X.9c: Plan overpayment reporting to the state: Dollar amount

From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?

Triple S Advantage

\$93,063

MCS Advantage

\$53,137.17

Humana

\$7,961

MMM Healthcare

\$3,000

D1X.9d: Plan overpayment reporting to the state: Corresponding premium revenue

Triple S Advantage

\$2,294,711.54

MCS Advantage

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

\$71,043,378.52

Humana

\$83,441.14

MMM Healthcare

\$1,872,567.84

D1X.10

Changes in beneficiary circumstances

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

Triple S Advantage

Daily

MCS Advantage

Daily


Humana

Daily

MMM Healthcare

Daily

Topic XI: ILOS

 **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

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

Number	Indicator	Response
D4XI.1	ILOSs offered by plan Indicate whether this plan offered any ILOS to their enrollees.	Triple S Advantage No ILOSs were offered by this plan MCS Advantage No ILOSs were offered by this plan Humana No ILOSs were offered by this plan MMM Healthcare No ILOSs were offered by this plan

Topic XIII. Prior Authorization

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

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Not reporting data

Topic XIV. Patient Access API Usage

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

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Not reporting data

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

Number	Indicator	Response
EIX.1	BSS entity type What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	None Other, specify - N/A
EIX.2	BSS entity role What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	None Other, specify - N/A