Managed Care Program Annual Report (MCPAR) for Puerto Rico: Plan VItal

Due date	Last edited	Edited by	Status
06/29/2023	11/10/2023	Eddie Perez	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.	Waiting to determine who will submit the MCPAR at ASES
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	mcpar@asespr.org
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Eddie Perez
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	eperez@asespr.org
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	01/18/2024

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	10/01/2021
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2022
A6	**Program name** Auto-populated from report dashboard.	Plan VItal

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	First Medical Health Plan MMM Multi-Health Plan de Salud Menonita Triple S Salud

Add BSS entities (A.8)

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

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

Indicator	Response
BSS entity name	TrueNorth

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled.	1,292,749
BI.2	**Statewide Medicaid managed care enrollment** Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or more than one managed care plan.	1,292,749

Topic III. Encounter Data Report

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

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities.	The 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.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State requires the return of overpayments
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	ASES contract with MCO, Section 22.1.21, Attachment 23
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	The Contractor shall refund (i) the share of the Overpayment due to ASES within eleven (11) months of the discovery and (ii) the share of an Overpayment due to ASES within fifteen (15) Calendar Days from a final judgment on an FWA Action. The Contractor must also require and have a mechanism for a Provider to report to the Contractor when it has received an Overpayment, to return that Overpayment to the Contractor with a written reason for the Overpayment within sixty (60) Calendar Days after the date on which the Overpayment was identified.

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 pieces (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** Does the state use a metric or indicator to assess plan reporting performance? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	Yes
BX.8b	**Federal database checks: Summarize instances of exclusion** 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.	Found four (4) excluded Providers due to Fraud and twenty-three (23) terminations due to Provider Death, Office Closure and Inactivity.
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	No
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans,	Puerto Rico did not complete the audit in the 2022 reporting year. Puerto Rico is actively working on finishing this activity.

what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	MODEL CONTRACT BETWEEN ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO (ASES) and NOMBRE ASEGURADORA for PROVISION OF PHYSICAL & BEHAVIORAL HEALTH SERVICES UNDER THE GOVERNMENT HEALTH PLAN PROGRAM
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	10/01/2021
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.asespr.org/proveedores-2/contratos/
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Dental
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1I.5	**Program enrollment** Enter the total number of individuals enrolled in the	1,292,749

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

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation)
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	16.3 16.4.3 17.3.5 18.2.3 Attachment 26

C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	20.5.1.3
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	Ensuring all contractors submit all the encounters, including the capitated providers.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	The Contractor shall resolve each standard Appeal and provide written notice of the disposition, as expeditiously as the Enrollee's health condition requires but no more than thirty (30) Calendar Days from the date the Contractor receives the Appeal.
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	The Contractor shall resolve each expedited Appeal and provide a written Notice of Disposition, as expeditiously as the Enrollee's health condition requires, but no longer than seventy-two (72) hours after the Contractor receives the Appeal and make reasonable efforts to provide oral notice.

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.	Written notice of the disposition of the Grievance as expeditiously as the Enrollee's health condition requires, but in any event, within ninety (90) Calendar Days from the day the Contractor receives the Grievance.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	The two biggest network gap concerns identified are a lack of available providers, with some municipalities having no providers present to contract, and providers leaving Puerto Rico due to the inability to provide salaries congruent with what providers receive in the United States mainland.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	The MCOs have engaged in a variety of efforts from care management to streamlined provider enrollment and engagement with the School of Medicine to combat provider reluctance to join the Medicaid network. Some key efforts include tax credits for newly graduated students, free office space, and reduced paperwork for provider enrollment, with increased technical assistance from MCO staff to reduce the administrative burden of tasks such as credentialing. Although some efforts have been productive, others, such as the expansion of telehealth and broadband internet access, will take additional resources and time to fully demonstrate intervention success or failure. Multi-specialty clinics are one way MCOs have worked to address the availability of specialist care in integrated care settings, by providing primary and specialty care in one location. Multi-specialty options allow for optimal leveraging of specialists, especially in less densely populated areas, creating more of a one stop shopping opportunity to enrollees.

Access Measures

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

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

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

Access measure total count: 75

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 1 / 75

C2.V.2 Measure standard

1 to 1700

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 2 / 75

C2.V.2 Measure standard

1 to 2800

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Gynecologist	Island Wide	Females aged 12 and older

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

3 / 75

C2.V.2 Measure standard

1 to 50000

C2.V.3 Standard type

Provider to enrollee ratios

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

4 / 75

C2.V.2 Measure standard

2 per Municipality

C2.V.3 Standard type

Minimum number of network providers

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

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

5 / 75

C2.V.2 Measure standard

1 per municipality

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Per Municipality	Pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

6 / 75

C2.V.2 Measure standard

1 per Municipality

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

7 / 75

C2.V.2 Measure standard

1

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
FQHC	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

8 / 75

C2.V.2 Measure standard

All Available Providers

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Government Health Care Facilities	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

9 / 75

C2.V.2 Measure standard

All Available Providers

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Psychiatric Hospital	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 10 / 75

C2.V.2 Measure standard

All Available Providers

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Psychiatric Partial Hospitals	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 11 / 75

C2.V.2 Measure standard

All Available Providers

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Certefied Buprenorphine Providers	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

12 / 75

C2.V.2 Measure standard

All Available Providers

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Emergency Stabilization Program	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Monthly

Complete

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

13 / 75

C2.V.2 Measure standard

At least 2 within fifteen (15) miles/thirty (30) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Urban and Non Urban Areas	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

14 / 75

C2.V.2 Measure standard

At least 2 within fifteen (15) miles/thirty (30) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Gynecologist	Urban and Non Urban Areas	(Females aged 12 and older

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

15 / 75

C2.V.2 Measure standard

At least 1 within thirty (30) miles/sixty(60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Cardiologist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

16 / 75

C2.V.2 Measure standard

At least 1 within forty-five (45) miles/ninety(90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Cardiologist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

17 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dermatologist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

18 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dermatologist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

19 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Endocrinologist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

20 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Endocrinologist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

21 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Gastroenterologist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

22 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Gastroenterologist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

23 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hematologist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

24 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hematologist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

25 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Oncologist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Oncologist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Nephrologist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

28 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Nephrologist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

29 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Neurologist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

30 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Neurologist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

31 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Orthopedic Surgeon	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

32 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Orthopedic Surgeon	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

33 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Otolaryngology	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

34 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Otolaryngology	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

35 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Podiatrist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

36 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Podiatrist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

37 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Psychiatrist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

38 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Psychiatrist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

39 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pulmonologist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

40 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pulmonologist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

41 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Rheumatologist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

42 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Rheumatologist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

43 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Surgeon	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

44 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Surgeon	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

45 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urologist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

46 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urologist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

47 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Substance Use Disorder Provider	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

48 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Substance Use Disorder Provider	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 49 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 50 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

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

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

51 / 75

C2.V.2 Measure standard

At least one within twenty (20) miles/thirty (30) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Emergency Room	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

52 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Podiatrist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

53 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Podiatrist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

54 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Podiatrist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

55 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Podiatrist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

56 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Podiatrist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

57 / 75

C2.V.2 Measure standard

At least one within thirty (30) miles/sixty (60) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Podiatrist	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

58 / 75

C2.V.2 Measure standard

At least one within forty five (45) miles/ninety (90) minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Podiatrist	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

59 / 75

C2.V.2 Measure standard

Physical Exam within thirty (30) days of request

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

60 / 75

C2.V.2 Measure standard

Routine evaluation for primary care with thirty (30) days of request

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

61 / 75

C2.V.2 Measure standard

Covered services provided within fourteen (14) days of request

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
All covered services	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

62 / 75

C2.V.2 Measure standard

Specialist services provided within thirty (30) days of request

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist services	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

63 / 75

C2.V.2 Measure standard

Dental services provided within sixty (60) days of request

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

64 / 75

C2.V.2 Measure standard

Behavioral health services provided within fourteen (14) days of request

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

65 / 75

C2.V.2 Measure standard

Diagnostic laboratory, diagnostic imaging, and other testing no more than fourteen (14) days

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Diagnostic laboratory, diagnostic imaging, and other testing	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

66 / 75

C2.V.2 Measure standard

Primary medical, dental, and Behavioral Health Care outpatient appointments for urgent conditions shall be available within twenty-four (24) hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary medical, dental, and Behavioral Health Care outpatient	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 67 / 75

C2.V.2 Measure standard

Urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than forty-eight (48) hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urgent outpatient diagnostic laboratory, diagnostic imaging and other testing	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 68 / 75

C2.V.2 Measure standard

Behavioral Health crisis services, face-to-face appointments shall be available within two (2) hours

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health crisis services	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

69 / 75

C2.V.2 Measure standard

Detoxification services shall be provided Immediately according to clinical necessity

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Detoxification services	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

70 / 75

C2.V.2 Measure standard

Psychiatric Hospitals (or a unit within a general hospital), Emergency or Stabilization Units to have open service hours covering twenty-four (24) hours a day, seven (7) days a week

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Psychiatric Hospitals (or a unit within a general hospital), Emergency or Stabilization Units	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

71 / 75

C2.V.2 Measure standard

Partial Hospitalization Facilities to have open service hours covering ten (10) hours per day at least five (5) days per week and shall have available one (1) nurse, one (1) social worker and one (1) psychologist/psychiatrist

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Appointment Wait Time	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

72 / 75

C2.V.2 Measure standard

All other Behavioral Health Facilities to have open service hours covering twelve (12) hours per day, at least (5) days per week and shall have available one (1) nurse, one (1) social worker and one (1) psychologist/psychiatrist

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
All other Behavioral Health Facilities	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

73 / 75

C2.V.2 Measure standard

Preferential Turns refers to a policy of requiring Providers to give priority in treating Enrollees from these island municipalities, so that they may be seen by a physician within a reasonable time after arriving in the Provider's office.

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
All Providers	Residents of the island municipalities of Vieques and Culebra	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

74 / 75

C2.V.2 Measure standard

each Provider that offers urgent care services, as well as any other qualified Provider willing to provide urgent care services, shall have sufficient personnel to offer urgent care services during extended periods Monday through Friday from 6:00 p.m. to 9:00 p.m. (Atlantic Time)

C2.V.3 Standard type

Hours of operation

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
	Island Wide	Adult and pediatric

Primary Medical Groups

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 75 / 75

C2.V.2 Measure standard

Each Provider that offers urgent care services, as well as any other qualified Provider willing to provide urgent care services, shall have sufficient personnel to offer urgent care services during extended periods Monday through Friday from 6:00 p.m. to 9:00 p.m. (Atlantic Time)

C2.V.3 Standard type

Hours of operation

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urgent Care Providers	Island Wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	www.planvitalpr.com, https://planvital.org/EnrollmentPrincipal/Principal/Overview
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	"TrueNorth provides counseling for all Potential Enrollees and Enrollees who select their MCO or MCO and PCP during any Annual or New Enrollment Open Enrollment Period 1. Phone (Call Center — 8:00 AM–6:00 PM) 2. Online Choice Counseling 3. ASES application (smart phone) 4. TTY/TDD service available"
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	N/A
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	ASES monitors the performance of the contracted BSS on a regular basis by: 1. Reviewing monthly call metric reports (abonnement rate, average handled time, average speed of answer) 2. Conducting periodic onsite visits 3. Listening and monitoring calls 4. Taking calls from members who are not satisfied 5. Reviewing results of the member satisfaction survey

Topic X: Program Integrity

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

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	**First Medical Health Plan** 328,845 **MMM Multi-Health** 321,957 **Plan de Salud Menonita** 174,941 **Triple S Salud** 467,006
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**First Medical Health Plan** 25.4% **MMM Multi-Health** 24.9% **Plan de Salud Menonita** 13.5% **Triple S Salud** 36.1%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**First Medical Health Plan** 24.5% **MMM Multi-Health** 24.9% **Plan de Salud Menonita** 13.5% **Triple S Salud**

36.1%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	**First Medical Health Plan** 92% **MMM Multi-Health** 92% **Plan de Salud Menonita** 98% **Triple S Salud** 104%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**First Medical Health Plan** Other, specify – N/A — no aggregation **MMM Multi-Health** Other, specify – N/A — no aggregation **Plan de Salud Menonita** Other, specify – N/A — no aggregation **Triple S Salud** Other, specify – N/A — no aggregation
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**First Medical Health Plan** No **MMM Multi-Health** No **Plan de Salud Menonita** No **Triple S Salud**

		No
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**First Medical Health Plan** Yes **MMM Multi-Health** Yes **Plan de Salud Menonita** Yes **Triple S Salud** Yes
N/A	Enter the start date.	**First Medical Health Plan** 10/01/2021 **MMM Multi-Health** 10/01/2021 **Plan de Salud Menonita** 10/01/2021 **Triple S Salud** 10/01/2021
N/A	Enter the end date.	**First Medical Health Plan** 09/30/2022 **MMM Multi-Health** 09/30/2022 **Plan de Salud Menonita** 09/30/2022

Triple S Salud

09/30/2022

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**First Medical Health Plan** Valid extracts of Encounter Information for a specific month is due within fifteen (15) Calendar Days of the close of the month. **MMM Multi-Health** Valid extracts of Encounter Information for a specific month is due within fifteen (15) Calendar Days of the close of the month. **Plan de Salud Menonita** Valid extracts of Encounter Information for a specific month is due within fifteen (15) Calendar Days of the close of the month. **Triple S Salud** Valid extracts of Encounter Information for a specific month is due within fifteen (15) Calendar Days of the close of the month.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	**First Medical Health Plan** 67% **MMM Multi-Health** 75% **Plan de Salud Menonita** 93% **Triple S Salud** 87%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting	**First Medical Health Plan** 100% **MMM Multi-Health**

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.	100% **Plan de Salud Menonita** 100% **Triple S Salud** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved as of the first day of the last month of the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**First Medical Health Plan** 542 **MMM Multi-Health** 1,009 **Plan de Salud Menonita** 2,323 **Triple S Salud** 290
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**First Medical Health Plan** 37 **MMM Multi-Health** 55 **Plan de Salud Menonita** 167 **Triple S Salud** 28
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).	**First Medical Health Plan** N/A **MMM Multi-Health** N/A **Plan de Salud Menonita** N/A **Triple S Salud**

N/A

D1IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the 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.	**First Medical Health Plan** N/A **MMM Multi-Health** N/A **Plan de Salud Menonita** N/A **Triple S Salud** N/A
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided	**First Medical Health Plan** 408 **MMM Multi-Health**

	by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	858 **Plan de Salud Menonita** 2,156 **Triple S Salud** 157
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**First Medical Health Plan** 102 **MMM Multi-Health** 97 **Plan de Salud Menonita** 167 **Triple S Salud** 129
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**First Medical Health Plan** 494 **MMM Multi-Health** 1,009 **Plan de Salud Menonita** 2,323 **Triple S Salud** 289
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service**	**First Medical Health Plan** 0

	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.	**MMM Multi-Health** 0 **Plan de Salud Menonita** 0 **Triple S Salud** 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.	**First Medical Health Plan** 0 **MMM Multi-Health** 0 **Plan de Salud Menonita** 0 **Triple S Salud** 0
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).	**First Medical Health Plan** 0 **MMM Multi-Health** 0 **Plan de Salud Menonita** 0 **Triple S Salud** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance**	**First Medical Health Plan** 0

	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.	**MMM Multi-Health** 0 **Plan de Salud Menonita** 0 **Triple S Salud** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**First Medical Health Plan** 0 **MMM Multi-Health** 0 **Plan de Salud Menonita** 0 **Triple S Salud** 0
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**First Medical Health Plan** 0 **MMM Multi-Health** 0 **Plan de Salud Menonita** 0 **Triple S Salud** 0

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**First Medical Health Plan** 4 **MMM Multi-Health** 4 **Plan de Salud Menonita** 5 **Triple S Salud** 0
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**First Medical Health Plan** 338 **MMM Multi-Health** 789 **Plan de Salud Menonita** 2,217 **Triple S Salud** 136
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**First Medical Health Plan** 4 **MMM Multi-Health** 7 **Plan de Salud Menonita** 1 **Triple S Salud**

4

D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**First Medical Health Plan** 16 **MMM Multi-Health** 53 **Plan de Salud Menonita** 10 **Triple S Salud** 11
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".	**First Medical Health Plan** 39 **MMM Multi-Health** 124 **Plan de Salud Menonita** 16 **Triple S Salud** 138
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".	**First Medical Health Plan** 0 **MMM Multi-Health** 1 **Plan de Salud Menonita** 7

		Triple S Salud 0
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	**First Medical Health Plan** N/A **MMM Multi-Health** N/A **Plan de Salud Menonita** N/A **Triple S Salud** N/A
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**First Medical Health Plan** 0 **MMM Multi-Health** 2 **Plan de Salud Menonita** 0 **Triple S Salud** 0
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".	**First Medical Health Plan** 22 **MMM Multi-Health** 29 **Plan de Salud Menonita** 9

Triple S Salud

0

D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".	**First Medical Health Plan** 119 **MMM Multi-Health** 0 **Plan de Salud Menonita** 58 **Triple S Salud** 1

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	**First Medical Health Plan** 7 **MMM Multi-Health** 19 **Plan de Salud Menonita** 39 **Triple S Salud** 14
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.	**First Medical Health Plan** 1 **MMM Multi-Health** 3 **Plan de Salud Menonita** 27 **Triple S Salud** 5
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.	**First Medical Health Plan** 7 **MMM Multi-Health** 8 **Plan de Salud Menonita** 12 **Triple S Salud**

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D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) prior to reaching a decision.	**First Medical Health Plan** 0 **MMM Multi-Health** 0 **Plan de Salud Menonita** 0 **Triple S Salud** 0
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).	**First Medical Health Plan** 1 **MMM Multi-Health** 3 **Plan de Salud Menonita** 27 **Triple S Salud** 5
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".	**First Medical Health Plan** 7 **MMM Multi-Health** 8 **Plan de Salud Menonita** 12

External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Triple S Salud** 5

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**First Medical Health Plan** 1,730 **MMM Multi-Health** 1,956 **Plan de Salud Menonita** 374 **Triple S Salud** 1,425
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**First Medical Health Plan** 192 **MMM Multi-Health** 275 **Plan de Salud Menonita** 69 **Triple S Salud** 85
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was	**First Medical Health Plan** N/A **MMM Multi-Health** N/A **Plan de Salud Menonita** N/A **Triple S Salud**

	filed). If this does not apply, enter N/A.	N/A
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should 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	**First Medical Health Plan** N/A **MMM Multi-Health** N/A **Plan de Salud Menonita** N/A **Triple S Salud** N/A

	whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**First Medical Health Plan** 1,730 **MMM Multi-Health** 1,881 **Plan de Salud Menonita** 373 **Triple S Salud** 1,425

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**First Medical Health Plan** 15 **MMM Multi-Health** 76 **Plan de Salud Menonita** 1 **Triple S Salud** 24
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**First Medical Health Plan** 1,172 **MMM Multi-Health** 1,596 **Plan de Salud Menonita** 311 **Triple S Salud** 1,166
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**First Medical Health Plan** 13 **MMM Multi-Health** 11 **Plan de Salud Menonita** 1 **Triple S Salud**

111

D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**First Medical Health Plan** 125 **MMM Multi-Health** 35 **Plan de Salud Menonita** 19 **Triple S Salud** 99
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**First Medical Health Plan** 20 **MMM Multi-Health** 105 **Plan de Salud Menonita** 0 **Triple S Salud** 27
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**First Medical Health Plan** 0 **MMM Multi-Health** 2 **Plan de Salud Menonita** 0

		Triple S Salud 1
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**First Medical Health Plan** N/A **MMM Multi-Health** N/A **Plan de Salud Menonita** N/A **Triple S Salud** N/A
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**First Medical Health Plan** 36 **MMM Multi-Health** 79 **Plan de Salud Menonita** 2 **Triple S Salud** 44
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".	**First Medical Health Plan** 3 **MMM Multi-Health** 41 **Plan de Salud Menonita** 11

		Triple S Salud 10
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	**First Medical Health Plan** 346 **MMM Multi-Health** 11 **Plan de Salud Menonita** 29 **Triple S Salud** 43

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**First Medical Health Plan** 454 **MMM Multi-Health** 128 **Plan de Salud Menonita** 75 **Triple S Salud** 282
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**First Medical Health Plan** 0 **MMM Multi-Health** 49 **Plan de Salud Menonita** 1 **Triple S Salud** 0

D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**First Medical Health Plan** 481 **MMM Multi-Health** 995 **Plan de Salud Menonita** 190 **Triple S Salud** 709
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**First Medical Health Plan** 42 **MMM Multi-Health** 86 **Plan de Salud Menonita** 11 **Triple S Salud** 100

D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**First Medical Health Plan** 0 **MMM Multi-Health** 6 **Plan de Salud Menonita** 0 **Triple S Salud** 13
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	**First Medical Health Plan** 108 **MMM Multi-Health** 616 **Plan de Salud Menonita** 82 **Triple S Salud** 166
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a	**First Medical Health Plan** 1 **MMM Multi-Health** 14 **Plan de Salud Menonita** 0 **Triple S Salud**

	state Ombudsman or Office of the Inspector General.	19
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**First Medical Health Plan** 0 **MMM Multi-Health** 1 **Plan de Salud Menonita** 0 **Triple S Salud** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**First Medical Health Plan** 0 **MMM Multi-Health** 1 **Plan de Salud Menonita** 0 **Triple S Salud** 7
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no	**First Medical Health Plan** 0 **MMM Multi-Health** 10 **Plan de Salud Menonita** 0

	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 Salud** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	**First Medical Health Plan** 346 **MMM Multi-Health** 11 **Plan de Salud Menonita** 29 **Triple S Salud** 43

Topic VII: Quality & Performance Measures

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

Quality & performance measure total count: 48

Complete

D2.VII.1 Measure Name: Cervical Cancer Screening

1 / 48

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0032

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

42.3

MMM Multi-Health

47.7

Plan de Salud Menonita

43.5

Triple S Salud

38.3

Complete

D2.VII.1 Measure Name: Chlamydia Screening in Women Ages 21 to 24

2 / 48

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0033

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

58

MMM Multi-Health

61.5

Plan de Salud Menonita

65.2

Triple S Salud

59.2

Complete

D2.VII.1 Measure Name: Breast Cancer Screening

D2.VII.2 Measure Domain

Primary care access and preventative care

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

2372

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

55.3

MMM Multi-Health

52.8

Plan de Salud Menonita

59

Triple S Salud

59.2

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care: Timeliness of Prenatal Care

D2.VII.2 Measure Domain

Maternal and perinatal health

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

2902

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

64.3

MMM Multi-Health

93.9

Plan de Salud Menonita

36.8

Triple S Salud

85.6

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care: Postpartum Care

5 / 48

D2.VII.2 Measure Domain

Maternal and perinatal health

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

1517*

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

26.4

MMM Multi-Health

93.9

Plan de Salud Menonita

31.8

Triple S Salud

66.7

Complete

D2.VII.1 Measure Name: "Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents BMI Percentile"

6 / 48

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0024

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

.5

MMM Multi-Health

30.7

Plan de Salud Menonita

19.33

Triple S Salud

31.3

Complete

D2.VII.1 Measure Name: "Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Counseling for nutrition"

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0024

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

4.1

MMM Multi-Health

33.6

Plan de Salud Menonita

42.9

Triple S Salud

18.6

Complete

D2.VII.1 Measure Name: "Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Counseling for physical activity"

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0024

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

.3

MMM Multi-Health

18.2

Plan de Salud Menonita

46.8

Triple S Salud

12.1

Complete

D2.VII.1 Measure Name: Childhood Immunization Status Combo 10

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

.03

MMM Multi-Health

.2

Plan de Salud Menonita

.21

Triple S Salud

29.78

Complete

D2.VII.1 Measure Name: "Childhood Immunization Status Combo 3"

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

3

MMM Multi-Health

2.5

Plan de Salud Menonita

2.1

Triple S Salud

1.72

Complete

D2.VII.1 Measure Name: Childhood Immunization Status Combo 7

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

1.7

MMM Multi-Health

1.5

Plan de Salud Menonita

.9

Triple S Salud

.95

Complete

D2.VII.1 Measure Name: Childhood Immunization Status DTP

12 / 48

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

26.1

MMM Multi-Health

31.6

Plan de Salud Menonita

11.6

Triple S Salud

7.43

Complete

D2.VII.1 Measure Name: Childhood Immunization Status Hep A

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

57.9

MMM Multi-Health

66.8

Plan de Salud Menonita

57.2

Triple S Salud

52.79

Complete

D2.VII.1 Measure Name: Childhood Immunization Status Hep B

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

7

MMM Multi-Health

5

Plan de Salud Menonita

5.9

Triple S Salud

2.67

Complete

D2.VII.1 Measure Name: Childhood Immunization Status HiB

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

50.5

MMM Multi-Health

55

Plan de Salud Menonita

27.1

Triple S Salud

19.44

Complete

D2.VII.1 Measure Name: Childhood Immunization Status Influenza

16 / 48

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

5.4

MMM Multi-Health

3.3

Plan de Salud Menonita

9

Triple S Salud

5.45

Complete

D2.VII.1 Measure Name: Childhood Immunization Status MMR

17 / 48

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

58.7

MMM Multi-Health

62.4

Plan de Salud Menonita

21

Triple S Salud

53.53

Complete

D2.VII.1 Measure Name: Childhood Immunization Status IPV

18 / 48

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

43.5

MMM Multi-Health

46.9

Plan de Salud Menonita

51.6

Triple S Salud

11.22

Complete

D2.VII.1 Measure Name: Childhood Immunization Status Pneumococcal Conjugate

9 / 48

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

24.3

MMM Multi-Health

28.8

Plan de Salud Menonita

10.2

Triple S Salud

6.79

Complete

D2.VII.1 Measure Name: Childhood Immunization Status Rotavirus

20 / 48

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

27.8

MMM Multi-Health

32.3

Plan de Salud Menonita

14.7

Triple S Salud

6.79

Complete

D2.VII.1 Measure Name: Childhood Immunization Status VZV

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

58.1

MMM Multi-Health

62.2

Plan de Salud Menonita

50.7

Triple S Salud

54.34

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents Combo 1

22 / 48

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1407

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

53.7

MMM Multi-Health

59

Plan de Salud Menonita

38.5

Triple S Salud

19

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents Combo 2

23 / 48

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1407

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

25.6

MMM Multi-Health

21.2

Plan de Salud Menonita

17.9

Triple S Salud

7.1

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents HPV

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1407

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

28.3

MMM Multi-Health

22.6

Plan de Salud Menonita

20.8

Triple S Salud

8.3

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents Meningococcal

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1407

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

56.2

MMM Multi-Health

60.2

Plan de Salud Menonita

40.6

Triple S Salud

20

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents Td/Tdap

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1407

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

57.6

MMM Multi-Health

63.3

Plan de Salud Menonita

45.8

Triple S Salud

21.8

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 15 Months of Life

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1392

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

1.14

MMM Multi-Health

6.38

Plan de Salud Menonita

8.43

Triple S Salud

N/A

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life (W30-CH)

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1392

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

6.84

MMM Multi-Health

36.24

Plan de Salud Menonita

36.19

Triple S Salud

26.8

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1516

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

16.06

MMM Multi-Health

41.1

Plan de Salud Menonita

37.4

Triple S Salud

38.43

Complete

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

30 / 48

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0018

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

22.5

MMM Multi-Health

62

Plan de Salud Menonita

43.7

Triple S Salud

53.5

Complete

D2.VII.1 Measure Name: Asthma Medication Ratio: Ages 19 to 64

31 / 48

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

1800

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

80.8

MMM Multi-Health

68.41

Plan de Salud Menonita

68.2

Triple S Salud

71.86

Complete

D2.VII.1 Measure Name: Ambulatory Care: Emergency Department (ED) Visits

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

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

5.3

MMM Multi-Health

3.22

Plan de Salud Menonita

59.7

Triple S Salud

100

Complete

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

33 / 48

D2.VII.2 Measure Domain

Behavioral health care

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

0004

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

10.2

MMM Multi-Health

12.45

Plan de Salud Menonita

5.8

Triple S Salud

10.3

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

0004

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

93.6

MMM Multi-Health

48.4

Plan de Salud Menonita

30.3

Triple S Salud

94.9

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

0105

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

44.1

MMM Multi-Health

55.3

Plan de Salud Menonita

67.1

Triple S Salud

54

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

0105

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

25

MMM Multi-Health

45

Plan de Salud Menonita

54.4

Triple S Salud

42.7

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness 7-day follow-up for ED visit: Ages 18 and older

37 / 48

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

28.3

MMM Multi-Health

28.3

Plan de Salud Menonita

N/A

Triple S Salud

24.3

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness 30-day follow-up for ED visit: Ages 18 and older

38 / 48

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

56.8

MMM Multi-Health

57.3

Plan de Salud Menonita

73.7

Triple S Salud

56.5

Complete

D2.VII.1 Measure Name: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications - Combined

D2.VII.2 Measure Domain

Behavioral health care

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

1932

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

56

MMM Multi-Health

60.9

Plan de Salud Menonita

65.67

Triple S Salud

63.6

Complete

D2.VII.1 Measure Name: "Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence 30 days"

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

10.5

MMM Multi-Health

26.2

Plan de Salud Menonita

30.2

Triple S Salud

30

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence 7 days

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

17.8

MMM Multi-Health

12.7

Plan de Salud Menonita

20.9

Triple S Salud

13.73

Complete

D2.VII.1 Measure Name: "Follow-Up After Emergency Department Visit for Mental Illness 30-day follow-up for ED visit "

42 / 48

D2.VII.2 Measure Domain

Behavioral health care

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

3489

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

70.6

MMM Multi-Health

57.3

Plan de Salud Menonita

51.3

Triple S Salud

69.98

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness 7-day follow-up for ED" 43 / 48

D2.VII.2 Measure Domain

Behavioral health care

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

3489

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

41.2

MMM Multi-Health

28.3

Plan de Salud Menonita

29.1

Triple S Salud

41.86

Complete

D2.VII.1 Measure Name: Adherence to Antipsychotic Medications for Individuals With Schizophrenia

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

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

34

MMM Multi-Health

73.6

Plan de Salud Menonita

73.6

Triple S Salud

72.1

Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed ADHD Medication Initiation

D2.VII.2 Measure Domain

Behavioral health care

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

0108

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

65

MMM Multi-Health

55.1

Plan de Salud Menonita

43.9

Triple S Salud

33.18

Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed ADHD Medication C&M

D2.VII.2 Measure Domain

Behavioral health care

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

0108

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

66.67

MMM Multi-Health

70.1

Plan de Salud Menonita

45.4

Triple S Salud

41.96

Complete

D2.VII.1 Measure Name: Sealant Receipt on Permanent First Molars- All Four Molars Sealed

D2.VII.2 Measure Domain

Dental and oral health services

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

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

N/A

MMM Multi-Health

15.09

Plan de Salud Menonita

8.23

Triple S Salud

12.08

Complete

D2.VII.1 Measure Name: Sealant Receipt on Permanent First Molars- At least One Sealant

48 / 48

D2.VII.2 Measure Domain

Dental and oral health services

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

Medicaid Child Core Set

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

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

D2.VII.8 Measure Description

N/A

Measure results

First Medical Health Plan

N/A

MMM Multi-Health

21.23

Plan de Salud Menonita

12.2

Triple S Salud

17.59

Topic VIII. Sanctions

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

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

Sanction total count: 6

Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 6

D3.VIII.2 Plan performance issue

Call Center Performance

D3.VIII.3 Plan name

MMM Multi-Health

D3.VIII.4 Reason for intervention

There was a persistent increase in abandoned calls to the medical advice line that fell outside of contract standards

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/16/2021

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

Yes, remediated 05/17/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

2 / 6

D3.VIII.2 Plan performance issue

Network

D3.VIII.3 Plan name

First Medical Health Plan

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/22/2021

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

Yes, remediated 10/07/2021

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

3 / 6

D3.VIII.2 Plan performance issue

Network

D3.VIII.3 Plan name

MMM Multi-Health

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/22/2021

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

Yes, remediated 10/07/2021

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

4 / 6

D3.VIII.2 Plan performance issue

Network

D3.VIII.3 Plan name

Plan de Salud Menonita

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/22/2021

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

Yes, remediated 10/07/2021

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

5 / 6

D3.VIII.2 Plan performance issue

Network

D3.VIII.3 Plan name

Triple S Salud

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/22/2021

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

Yes, remediated 10/07/2021

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

6 / 6

D3.VIII.2 Plan performance issue

Provider Billing

D3.VIII.3 Plan name

Triple S Salud

D3.VIII.4 Reason for intervention

Failure to honor the extended billing period grnated to health care providers during the Covid-19 Pandemic.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

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

12/06/2021

Yes, remediated 12/31/2021

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**First Medical Health Plan** 7 **MMM Multi-Health** 3 **Plan de Salud Menonita** 0 **Triple S Salud** 17
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**First Medical Health Plan** 10 **MMM Multi-Health** 27 **Plan de Salud Menonita** 47 **Triple S Salud** 71
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	**First Medical Health Plan** 0.03:1,000 **MMM Multi-Health** 0.08:1,000 **Plan de Salud Menonita** 0.27:1,000 **Triple S Salud**

		0.15:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations have been resolved by the plan in the past year?	**First Medical Health Plan** 2 **MMM Multi-Health** 5 **Plan de Salud Menonita** 59 **Triple S Salud** 105
D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**First Medical Health Plan** 0.01:1,000 **MMM Multi-Health** 0.02:1,000 **Plan de Salud Menonita** 0.34:1,000 **Triple S Salud** 0.22:1,000
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**First Medical Health Plan** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **MMM Multi-Health** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Plan de Salud Menonita**

		Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Triple S Salud** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals	**First Medical Health Plan** 9 **MMM Multi-Health** 6 **Plan de Salud Menonita** 47 **Triple S Salud** 92
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.1) as the denominator.	**First Medical Health Plan** 0.03:1,000 **MMM Multi-Health** 0.02:1,000 **Plan de Salud Menonita** 0.27:1,000 **Triple S Salud** 0.2:1,000
D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the	**First Medical Health Plan** data 12/31/2022, OverPmt $2,589.30, ratio $2,589.30/$965,383,139 = 0.00027%(OverPmt/ MLR revenue) **MMM Multi-Health**

	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).	data 12/31/2022, OverPmt $650,010.00, ratio $650,010.00/$944,981,850.34 = 0.06879% (OverPmt/ MLR revenue) **Plan de Salud Menonita** data 12/31/2022, OverPmt $754,227.00, ratio $754,227.00/$505,634,939 = 0.14916% (OverPmt/ MLR revenue) **Triple S Salud** data 12/31/2022, OverPmt $1,012,861.00, ratio $1,012,861.00/$1,315,722,628.76 = 0.07698% (OverPmt/ MLR revenue)
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**First Medical Health Plan** Monthly **MMM Multi-Health** Monthly **Plan de Salud Menonita** Monthly **Triple S Salud** Monthly

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**TrueNorth** Enrollment Broker
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**TrueNorth** Enrollment Broker/Choice Counseling