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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

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SUBJECT: Medicaid and CHIP Managed Care Monitoring and Oversight Tools

The purpose of this Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CIB) is to introduce a series of tools for states and the Centers for Medicare & Medicaid Services (CMS) to utilize to improve the monitoring and oversight of managed care in Medicaid and the Children's Health Insurance Program (CHIP). This CIB also provides guidance setting the content and format of the Annual Managed Care Program Report required by CMS regulations at 42 CFR § 438.66(e)(1)(i), and introduces additional resources and technical assistance toolkits that states can use to improve compliance with managed care standards and requirements. The annual report is part of CMS's overall strategy to improve access to services by supporting Federal and state access monitoring for Medicaid beneficiaries within a managed care delivery system.

Introduction

Over the last decade, states have drastically increased their use of managed care to deliver Medicaid and CHIP benefits, becoming the dominant delivery system in both programs. For example:

- As of July 2018, 53.9 million individuals were enrolled in Medicaid managed care, which represents 69 percent of the total Medicaid enrollment.
- In fiscal year 2018, total federal and state Medicaid managed care expenditures were $296 billion, which is approximately 50 percent of total Medicaid expenditures.
- In 31 states, about 79 percent of CHIP children were enrolled in managed care.
- Twenty-two states had Managed Long-Term Supports and Services (MLTSS) programs in operation as of July 1, 2018.

The increased prevalence in the use of managed care delivery systems underscores the continued need for strong federal and state oversight of managed care in Medicaid and CHIP. Over the last decade, CMS has engaged in numerous monitoring and oversight activities for Medicaid and CHIP managed care programs, and while these activities have been effective in assuring state compliance with specific regulatory and statutory requirements, CMS recognizes the need for additional tools to improve monitoring and oversight efforts. Accordingly, CMS has begun to develop several state tools described below.

Development of a Web-Based Reporting Portal for the Collection of Required Managed Care Reports

The May 2016 Medicaid and CHIP managed care final rule strengthened the federal oversight of state managed care programs in several ways, one of which was to create new reporting requirements for states on their managed care programs and operations. CMS is developing reporting templates for each of the following reports: the Annual Program Oversight Report required in 42 CFR § 438.66(e), the Medical Loss Ratio (MLR) Summary Report required in 42 CFR § 438.74(a), and the Access Standards Report required in 42 CFR § 438.207(d) and (e). CMS intends to develop these templates in a web-based reporting portal, thereby creating a single submission process and repository for all state reporting requirements related to managed care.

The structured data captured by this system will allow CMS to generate and analyze state-specific and nationwide data across the universe of managed care programs and requirements. This data analysis will allow CMS to identify areas of technical assistance and to target efforts to assist states in improving their managed care programs while also ensuring compliance with managed care statutes and regulations, such as ensuring access to care.

Annual Managed Care Program Report

CMS regulations at 42 CFR § 438.66(e) require states to submit an Annual Managed Care Program Report. Under the regulation, each state must submit to CMS, no later than 180 days after each contract year, a report on each managed care program administered by the state which will contain data from all involved plans. The initial report is due after the contract year following the release of CMS guidance on the content and form of the report and would cover that contract year. The information below and the template available on Medicaid.gov at https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-monitoring-and-oversight-initiative/index.html with instructions serves as the CMS guidance on the content and format of the required report so the initial report will be due for contract years starting on or after [insert date] and due 180 days after the end of that contract year.

During the development of this report template, CMS consulted with states and other stakeholders on the content and form of the report. The final report template includes changes made to address comments and concerns from those entities.

Timing of the Report

The chart below clarifies the reporting period and due date of the first Annual Managed Care Program Report for each state, based on the contract year of each managed care program.

Contract Year of the Managed Care Program	Contract Period of First Report	First Report Due
July through June	7/1/2021 – 6/30/2022	December 27, 2022
September through August	9/1/2021 – 8/31/2022	February 27, 2023
October through September	10/1/2021 – 9/30/2022	March 29, 2023
January through December	1/1/2022 – 12/31/2022	June 29, 2023
February through January	2/1/2022 – 1/31/2023	July 30, 2023
April through March	4/1/2022 – 3/31/2023	September 27, 2023

Content of the Report

Every state must submit a report for each managed care program administered by the state, including behavioral health plans and managed LTSS plans. As defined by the regulation, the report will collect information in the following categories:

1. Program enrollment and service area expansions**
2. Financial performance
3. Encounter data reporting
4. Grievances, appeals, and state fair hearings
5. Availability, accessibility, and network adequacy
6. Delegated entities
7. Quality and performance measures
8. Sanctions and corrective action plans**
9. Beneficiary support system (BSS)
10. Program integrity

All 10 categories apply to Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs). Only those categories marked by ** apply to Primary Care Case Management (PCCM) entities. Each of the above categories have data indicators (data elements) that are organized by and will be reported at state, program, or plan levels for ease of data entry. The excel workbook is available on Medicaid.gov at https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-monitoring-and-oversight-initiative/index.html and provides the exact indicators that will be required, along with instructions on how to complete each field.

Form of the Report

The report will be collected electronically through a web-based submission portal. This portal will collect exactly the information that is included in the excel workbook. As presented in the workbook, each indicator will require a response in a specified format based on the indicator. The formats include selections for a drop down list, numerical counts, free text, percentages, and dates. CMS will make the web-based portal available to states at least 6 months prior to the date the first reports are due, no later than June 27, 2022.

Technical Assistance on Completing the Report

CMS strongly encourages states to review the attached excel workbook version of the report over the next few months and begin planning any changes to state data gathering or processes that will need to be implemented to complete the report. States could also use the excel version to collect information from individual managed care plans to facilitate data collection. As states are reviewing the tool or planning their data collection, CMS is available to provide one on one technical assistance. Please contact your CMCS managed care state lead or complete the Medicaid Managed Care – State Technical Assistance Request Form to request technical assistance.

Appeals and Grievances Data Collection Pilot

As required by 42 CFR § 438.66(a) and (b), all states must have a monitoring system for all managed care programs, including, among other things, appeals and grievances systems. In

addition, CMS regulations at 42 CFR § 438.66(d) require each state to conduct a readiness review of each MCO, PIHP, PAHP, or PCCM entity with which it contracts to assess the ability of each entity to perform satisfactorily in several areas, including appeals and grievances.

CMS believes that appeals and grievances data can provide critical insight into the performance of a managed care program and managed care plans, especially during the first year of implementation. Such data could quickly reveal areas of weakness in a program or plan, and identifying those early will allow states to remedy the issue before plan members are disadvantaged or critical incidents occur.

To that end, CMS has developed a standard appeals and grievances data collection tool to be used for the first year of implementation as a second part of a readiness review. Through the CMCS Managed Care Technical Advisory Group, CMS consulted with states during the development of the tool, and incorporated state feedback into the final tool. Over the next 12 to 18 months, CMS will pilot the tool with states that are completing their readiness review process within that timeframe. Based on the results of the pilot, the tool will be edited as necessary. Once final, the tool will be incorporated into the web-based reporting portal described above and become a regular part of the readiness review process.

Technical Assistance Toolkits to Improve State Compliance and Oversight
CMS is also developing a series of technical assistance toolkits to assist states in complying with various managed care standards and regulations, and to help improve state monitoring and oversight of their managed care programs. The topics will include:

- Behavioral Health Access*
- Managed Long-Term Services and Supports
- Managing Plan Transitions
- Provider Screening and Enrollment
- Managed Care Quality Strategies*
- Program Integrity
- Tribal Protections in Medicaid and CHIP Managed Care

*See more detail below

Tools to Assist States in Managed Care Monitoring and Oversight
As part of the strategy described above, CMS is making the following resources and tools available to states:

<u>Behavioral Health (BH) Access Toolkit</u>
Recent increases in substance use disorders, as well as repercussions of the COVID-19 pandemic, have underscored the importance of behavioral health services that treat substance use and mental health disorders. Medicaid plays a critical role in the financing and delivery of behavioral health services. In 2015, Medicaid was the primary source of health coverage for 26 percent of adults with serious mental illness and 17 percent of adults with substance use disorders. State Medicaid agencies have increasingly covered behavioral health services through comprehensive managed care plans rather than paying for them on a fee-for-service (FFS) basis

or covering them through limited-benefit managed care plans, sometimes called behavioral health organizations. The expanded role that Medicaid managed care plans play in delivering behavioral health services—and the greater demand for such services among Medicaid beneficiaries—raises the importance of access to these critical services through robust provider networks. This toolkit aims to help state Medicaid agencies and the managed care plans with which they contract meet the network adequacy requirements for behavioral health care providers. Numerous state Medicaid agencies have developed innovative approaches to strengthen their behavioral health workforce and improve access to services within Medicaid managed care. This toolkit highlights promising practices and strategies implemented by state Medicaid agencies and managed care plans and is available on Medicaid.gov at https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-monitoring-and-oversight-initiative/index.html.

Quality Strategy Toolkit

Under regulations at 42 CFR §§ 438.340(a) and 457.1240(e), CMS requires state Medicaid and CHIP agencies that contract with MCOs, PIHPs, PAHPs, and certain PCCM entities to develop and maintain a Medicaid and CHIP quality strategy to assess and improve the quality of health care and services provided by managed care plans. To support states in implementing managed care quality strategy requirements, CMS has developed the Medicaid and CHIP Quality Strategy Toolkit. CMS recommends that states use this toolkit as a part of their quality strategy development, revision, and submission processes to ensure that their quality strategies address regulatory requirements and leverage best practices. This toolkit describes quality strategy regulatory requirements and provides considerations for states to improve their quality strategy and is available on Medicaid.gov at https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-monitoring-and-oversight-initiative/index.html..

Closing

CMS is committed to strengthening the monitoring and oversight of Medicaid and CHIP managed care programs. To do so, the agency is developing a series of reporting templates and technical assistance toolkits described above. CMS looks forward to engaging and collaborating with states on the implementation of these tools and anticipates issuing additional tools periodically over the next two years to improve its monitoring and oversight activities.

If you have any questions or need additional information, please contact John Giles, Director, Division of Managed Care Plans at 410-786-5545 or John.Giles1@cms.hhs.gov.