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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 provide additional tools for states and the Centers for Medicare & Medicaid Services (CMS) to improve the monitoring and oversight of managed care in Medicaid and the Children's Health Insurance Program (CHIP).

Introduction

In a CIB dated June 28, 2021, CMS recognized the need to develop tools to help states improve their monitoring and oversight of Medicaid and CHIP managed care programs. The June 2021 CIB also released a reporting template for the Managed Care Program Annual Report, announced the development of a web-based reporting portal for the collection of all required managed care reports, and released two technical assistance toolkits for state use. CMS also committed to developing additional tools for monitoring and oversight of managed care.

Today, CMS is providing an update on the web-based reporting portal. We are also releasing two additional reporting templates, related to Medical Loss Ratio (MLR) and network adequacy and access assurances; a new technical assistance toolkit for states to oversee access in Managed Long-Term Services and Supports (MLTSS) programs; and initial recommended practices and strategies for ensuring timely and accurate payment to Indian health care providers.

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

In June 2021, CMS announced its intention to develop a web-based reporting portal, creating a single submission process and repository for all state reporting requirements related to managed care. These reports include: the Managed Care Program Annual Report required in 42 CFR § 438.66(e), the Medical Loss Ratio (MLR) Summary Report required in 42 CFR § 438.74(a), and the Network Adequacy and Access Assurances Report required in 42 CFR § 438.207(d).

The web-based portal will be built within the Medicaid Data Collection Tool (MDCT) currently used by CMS to collect, and states to submit, several required Medicaid and CHIP reports including CARTS, SEDS, and QMR. A separate module titled "MDCT-Managed Care Reporting" will be built to house the managed care reports.

MDCT-Managed Care Reporting will consist of fillable forms to be filled out by States based on the data they collected using the indicators contained in the Excel template. 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 for 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.

Information about MDCT-Managed Care Reporting is available at https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html. Currently, the website contains basic information about each report and its deadlines, along with links to download the Excel template version of each report. It also contains a link to MDCT-Managed Care Reporting that will only be available to state staff with access to this web-based portal. CMCS staff will be reaching out to states directly to make sure that appropriate state staff are granted access. This will start in the very near future so that each state has access when the web-based forms are ready for use.

As the web-based forms are developed, CMS will announce their availability to states. At those times, states will be able to enter their information directly into the fillable forms, creating efficiency for states and CMS. The fillable forms will collect exactly the same information that is included in the Excel templates for each report. CMS anticipates that the Managed Care Program Annual Report will be available first, in early November 2022. Please note, CMS acknowledges that it is delayed in making this web-based portal available; however, the reporting deadlines communicated in the prior guidance will remain in effect because states are able to access the report templates now on Medicaid.gov. This gives states the ability to start compiling the information to be prepared for their first report. CMS believes this is particularly important for states whose first report is due no later than December 27, 2022.

Reporting and New Templates

Medical Loss Ratio (MLR) Reporting Template

CMS regulations at 42 CFR § 438.74(a) require that states annually submit, with their rate certification required in 42 CFR § 438.7, a summary description of the MLR report(s) received from the managed care organization (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) under contract with the state. CMS has developed a standard format, with instructions, for this required MLR Report. An Excel version of the report is available on Medicaid.gov at https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html. 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.

The requirement for states to submit this information to CMS began for rating periods starting on or after July 1, 2017. However, to date, there has been no requirement to use a standard reporting template. The Excel template is available for states to use immediately if they choose. However, all states submitting rate certification packages on or after October 1, 2022 are required to use the template. Further, it should be submitted as additional documentation when

the annual rate certification is submitted. Once the web-based forms are available in MDCT-Managed Care Reporting, states will be required to submit the report through the electronic portal. The web-based forms will collect exactly the same information that is included in the Excel workbook, and CMS will update states when they are available.

CMS encourages states to review the template to ensure they understand the required fields and instructions. If states would like to request technical assistance related to the report, contact the CMCS managed care state lead for your respective State or complete the Medicaid Managed Care – State Technical Assistance Request Form.

Network Adequacy and Access Assurances Report

CMS regulations at 42 CFR § 438.207(d) require that states:

- Submit an assurance of compliance to CMS that the each MCO, PIHP, and PAHP meets the state's requirement for availability of services; and
- Include documentation of an analysis that supports the assurance of the adequacy of the network for each contracted MCO, PIHP, or PAHP related to its provider network.

These regulations require states to submit this information:

- At the time the state enters into a contract with each MCO, PIHP, or PAHP;
- On an annual basis; and
- Any time there is a significant change in the operations that would affect the adequacy of capacity and services of an MCO, PIHP, or PAHP.
- *Note: CMS recommends that the report be submitted at the same time a state submits the associated managed care contract to CMS for approval, including a new contract, a renewal, or an amendment.*

CMS has developed a standard format, with instructions, for this required Network Adequacy and Access Assurances Report. An Excel version of the report is available on Medicaid.gov at https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html. 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.

The requirement for states to submit this information to CMS began with all contracts with rating periods beginning on or after July 1, 2018. However, to date, there has been no requirement to use a standard reporting template. The Excel template is now available for states to use immediately if they choose. All states submitting the report on or after October 1, 2022 are required to use the template. Once the web-based forms are available in MDCT-Managed Care Reporting, states will be required to submit the report through the electronic portal. The web-based forms will collect exactly the same information that is included in the Excel workbook, and CMS will update states when they are available.

CMS encourages states to review the template on Medicaid.gov to ensure they understand the required fields and instructions. If states would like to request technical assistance related to the

report, contact your CMCS managed care state lead or complete the Medicaid Managed Care – State Technical Assistance Request Form.

Transparency Requirements Relative to the Network Adequacy and Access Assurances Report

CMS regulations at 42 CFR § 438.68(e) require states to publish their network adequacy standards developed pursuant to 42 CFR § 438.66(b) on their state operated website. Additionally, 42 CFR § 438.602(g)(2) requires states to post documentation described in 42 CFR § 438.207(b) on which it based its assurance of compliance of availability and accessibility of services as required in 42 CFR § 438.207(d). CMS expects the information that states publish pursuant to these requirements to include the Network Adequacy and Access Assurances Report for each program that it operates.

Reminder: Managed Care Program Annual Report

In the CIB dated June 28, 2021, CMS provided guidance on the Managed Care Program Annual Report, including information on the timing, content, and form of the report, and a standard reporting template available at https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html. Note: The Excel version of the template has been updated slightly. The updates are cosmetic in nature to improve ease of use and align more closely to the format of the web-based form in MDCT-Managed Care Reporting. Both versions and the web form will collect exactly the same information. States can use the Excel template to begin collecting the information needed for the web form.

Because the requirement to submit the annual report was triggered by the June 2021 CIB, and the due dates are dependent upon the Contract Year of each managed care program, CMS is taking this opportunity to remind states of the upcoming due dates for the first round of reports.

Contract Year of the Managed Care Program	Contract Period of First Report	First Report
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

The report will be collected electronically through MDCT-Managed Care Reporting. Information about MDCT-Managed Care Reporting is available at https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html. Currently, the website contains basic information about the report and its deadlines, along with a link to download the Excel template version of the report. It also contains a link to MDCT-Managed Care Reporting that will only be available to state staff with access to this web-based portal. CMCS staff will be reaching out to states directly to make sure that appropriate state staff are granted access. This will start in the very near future so that each state has access when the web-based forms are ready for use. When the web-based form is

ready, CMS will announce its availability to states. CMS anticipates that the web-based submission form for the Managed Care Program Annual Report will be available in early November 2022.

Public Availability of Reports

CMS will make all reports submitted through MDCT-Managed Care Reporting available after CMS has completed an initial review of the reports. Once a Medicaid.gov page is established for the reports, CMS will announce its availability. Until that time, reports will be made available upon request.

Promoting Access in Medicaid and CHIP Managed Care: Managed Long-Term Services and Supports Access Monitoring Toolkit

In the June 2021 CIB, CMS committed to 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. Today, CMS is releasing a toolkit entitled, "Promoting Access in Medicaid and CHIP Managed Care: Managed Long-Term Services and Supports Access Monitoring Toolkit".

This toolkit is intended as a resource for state Medicaid and CHIP agency staff who are developing or implementing monitoring practices to oversee access in Managed Long-Term Services and Supports (MLTSS) programs. It highlights effective or promising practices currently used in states as examples. The toolkit was developed in response to the growth in MLTSS programs in recent years and concerns raised by federal oversight agencies about access to services and quality of care for individuals enrolled in MLTSS programs. Chapter I describes federal regulations issued from 2016 and 2020 and previous guidance from 2013 that establish access monitoring requirements for states operating MLTSS programs. Chapter I also highlights the importance of care quality, in particular the health and welfare of MLTSS enrollees. However, methods to assure quality of care broadly are outside the scope of this toolkit. The toolkit includes two additional Chapters: Chapter II describes key data sources and strategies for monitoring MLTSS access, and Chapter III provides examples of how to apply these strategies to monitor access to MLTSS. The toolkit is available on Medicaid.gov at www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-monitoring-and-oversight-initiative/index.html.

Ensuring Timely and Accurate Payment to Indian Health Care Providers

In a 2016 final rule,[1] CMS codified a range of Indian managed care protections at 42 C.F.R. §§ 438.14 and 457.1209 that allow Indians enrolled in Medicaid and CHIP managed care plans to continue to receive services from an Indian Health Care Provider (IHCP), even if the IHCP does not participate in the plan's network, and ensures IHCPs are appropriately paid for services provided. The 2016 final rule also addressed other Tribal issues, such as sufficient network and payment requirements for managed care plans that serve Indians, network provider agreements

[1] The final 2016 rule is available at https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managedcare-chip-delivered.

with IHCPs, state-Tribal consultation requirements, and referrals and prior authorization requirements. In December 2016, CMS issued a CIB to summarize the Indian managed care protections set forth in the regulations.[2]

To assist states in complying with the Indian managed care protections, CMS has been working with states, Tribes, IHCPs, and managed care plans to identify and resolve implementation and compliance issues on a state-by-state basis. To address the issues from a national perspective, CMS also collaborated with the National Indian Health Board (NIHB) to convene a Managed Care Listening Session of Tribal leaders and, in May 2021, NIHB convened a Roundtable of Tribal health directors and Medicaid staff to discuss strategies and identify recommended practices and resources to aid all states and managed care plans in implementing the statutory and regulatory Medicaid managed care protections for Indians. The recommended practices and strategies include:

(1) States should engage with Tribes through effective Tribal consultation to identify and resolve issues;
(2) Medicaid and CHIP managed care plans should use the Indian contract addendum to negotiate contracts between plans and IHCPs (see Appendix A of the 2016 CIB);
(3) States and managed care plans should institutionalize knowledge of the Indian health care delivery system and Indian managed care protections;
(4) States and managed care plans should have a single state point of contact to handle Medicaid managed care issues for IHCPs;
(5) Medicaid managed care plans should develop internal claims processing practices specific to IHCPs to resolve claims in a timely manner; and
(6) For state Medicaid agencies, including a managed care contract provision requiring managed care plans pay IHCPs the full Indian Health Service All-Inclusive Rate, rather than the plan paying at the plan's regular provider payment rate and requiring IHCPs to bill the state for a wrap-around payment.[3] (This would also be a best practice for managed care plans to employ, even if not directed by the state Medicaid agency to do so).

NIHB will be posting a full report of the findings from the Roundtable and CMS will alert states when it is available. CMS also will be providing additional guidance to assist states and managed care plans regarding implementing the statutory and regulatory Medicaid managed care protections for Indians, including a toolkit that will describe in more detail the practices and strategies identified through the NIHB Roundtable.

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[2] December 14, 2016 CIB, "Indian Provisions in the Final Medicaid and Children's Health Insurance Program Managed Care Regulations." available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib121416).

[3] On an annual basis, the Indian Health Service calculates and publishes in the Federal Register calendar year inpatient and outpatient Medicare and Medicaid reimbursement rates, referred to as the "All-Inclusive Rates." The rate is applicable to reimbursement methodologies under the Medicare and Medicaid programs. *See* 2022 IHS reimbursement rates: https://www.federalregister.gov/documents/2022/04/08/2022-07468/reimbursement-rates-for-calendar-year-2022

Closing

CMS is committed to strengthening the monitoring and oversight of Medicaid and CHIP managed care programs. CMS looks forward to continuing to collaborate with states on the implementation of these tools and anticipates issuing additional tools periodically to improve its monitoring and oversight activities in Medicaid and CHIP managed care. If you have any questions or need additional information, please contact John Giles, Director, Division of Managed Care Policy at 410-786-5545 or John.Giles1@cms.hhs.gov.