Medicaid Managed Care Program Annual Report (MCPAR)

Technical Assistance Resource for States

Updated August 2025

Section 1. General Questions

1. Where can I get more information on MDCT MCR or the MCPAR?

For questions about Medicaid Data Collection Tool Managed Care Reporting (MDCT MCR) access or other technical issues, please email the MDCT Help Desk at mdct_help@cms.hhs.gov.

For questions about MCPAR content (e.g., how to complete a specific MCPAR field or interpret a question), please email the Managed Care TA team at ManagedCareTA@cms.hhs.gov.

2. When is the deadline for submitting MCPARs?

MCPARs are due annually, no later than 180 days after the end of each program's contract year (i.e., the time period associated with plan annual obligations and performance). For example, for a contract year from January 1, 2023, through December 31, 2023, the associated MCPAR report was due June 28, 2024. Additional example deadlines are available at https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html#AMCPR.

For contracts that are longer or shorter than a 12-month period, please email ManagedCareTA@cms.hhs.gov for your specific deadline.

3. Do we have to submit separate MCPARs for each program?

Yes, the MCPAR is a program-specific report and States must submit one MCPAR for each program as required in 42 CFR 438.66(e)(1). States may not combine multiple programs into a single MCPAR. For the purposes of the MCPAR, a program is defined by a specified set of benefits and eligibility criteria that is articulated in a contract between the States and managed care plans, and that has associated rate cells. The program name list in MDCT MCR was compiled and reconciled from official program names submitted to CMS by States. Additional details on this change are included in Section 3 of these FAQs.

4. Where do I find the most recent version of the MCPAR Excel template?

The Excel template is available within the MDCT MCR portal and is also online at https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html. As a reminder, States must use the MDCT MCR portal, not the Excel template, to submit their MCPARs. The Excel template is available only as a supporting resource

for States and their managed care plans.[1]

5. Is the MCPAR replacing the Medicaid Managed Care Data Collection System (MMCDCS)?

No, the MCPAR collects a wide range of information including financial performance, encounter data quality, appeals and grievances volume, network adequacy, quality performance, and sanctions in accordance with 42 CFR 438.66(e). MMCDCS is a separate reporting process that specifically collects information on managed care enrollment and generates an annual Medicaid Enrollment Data Report by State describing program and plan characteristics.

Section 2. Questions on MDCT MCR Access, Use, and Report Submission

1. How do state staff obtain access to the MDCT MCR portal?

The MDCT MCR portal is online at https://mdctmcr.cms.gov.

To access the portal, you must register for one of two user roles: State Representative or State User. Information to help you decide the appropriate user role and for requesting access to these roles can be found in the MCR IDM Access Guide for State Representatives and the MCR IDM Access Guide for State Users.

For additional information about gaining access to MDCT MCR, please visit https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html#MDCT.

2. What is the difference between the State Representative and State User role?

State Representatives and State Users have the same privileges (add data, edit data, review data/report, save report, submit report, etc.) within the MDCT MCR portal. The only difference is State Representatives can approve and remove State Users' access to MDCT MCR.

3. Can State Representatives request access for State Users on their behalf?

No, State Users must register for MDCT MCR themselves.

4. How can states get the name of their State Representative or get assistance if the State Representative no longer works for the State?

States can obtain the name of their current State Representative or get assistance if their State Representative no longer works for the State by emailing ManagedCareTA@cms.hhs.gov. CMS recommends that States maintain more than one State Representative so that the State can always access MDCT.

[1] The term "managed care plan" is utilized in this document to refer to managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs) and primary care case management entities (PCCM entities).

5. **How does the State Representative receive notification that a State User needs to be approved?**

The State Representative will receive an email notification from CMS's Identity Management (IDM) system to notify them of pending State User requests.

6. **If I have an IDM User ID for other CMS system applications (QMR, CARTS, etc.), do I still need to request access specific to MDCT MCR for MCPAR reporting?**

Yes, having access to other CMS systems such as QMR and CARTS will not grant you automatic access to the MDCT MCR portal. However, if you have an existing IDM User ID you can use that same User ID to request the appropriate MDCT MCR role in IDM (i.e., State Representative or State User).

7. **We filled out the MCPAR Excel template that is available on Medicaid.gov; can we upload the MCPAR template to MDCT MCR or email it to CMS instead of manually entering the data in MDCT MCR?**

No, the only way to submit a MCPAR is via the MDCT MCR portal using the MCPAR web-form. States may elect to use the template to collect program and plan specific information in a format that supports data entry to complete the report.

8. **Is there a recorded demonstration of how to access and fill in the MCPAR?**

Yes, recordings and transcripts are available on the MDCT Portal page on Medicaid.gov.

9. **During data entry, does the web-form have to be completed in order?**

No, as long as you are saving and progressing by clicking the "Continue" button at the bottom of each screen, you can navigate to different areas of the form and complete them in any order.

10. **Can partially completed forms be saved as "in progress?"**

Yes, the status will continue to show "in progress," but you must click "Continue" to save your data before logging out. Do not click the "Submit" button until the report is complete, as you will not be able to edit it after you click "Submit."

11. **Can multiple people work on the same report? What happens if two people try to edit the same field?**

Yes, multiple people can work on the same report at the same time. It is recommended that individuals work on different sections of the report to avoid overwriting data. If two people are working on the same data, the last person to save the data will override any previously entered information. If someone navigates to a page that has already been filled out and saved, they will have to delete the information and replace it to update the information.

12. **Can reports be reviewed before submission?**

Reports can be viewed from the MDCT MCR dashboard. Click on the report and then review each section using the navigation bar on the left-hand side of the screen. You can also export all

responses into one PDF. This function is available under the "Review and Submit" page: Click "Review PDF" and then click "Download PDF."

13. Can data be edited after submission?

No. The MCPAR reports are locked after submission. Should you need to make a change to your submitted MCPAR, you must email ManagedCareTA@cms.hhs.gov to request approval to make a change. Post-submission changes are not encouraged and will only be approved by CMS in limited circumstances with appropriate justification.

14. Will CMS be able to view our data?

Yes, CMS will have read-only access to the data. This means that CMS will be able to view the data, but not edit the information. In certain cases, CMS will reach out to States to request revisions to the data or to clarify data submitted.

15. Who will CMS contact for questions during the review? If the State Representative is different than the submitter, will both be notified?

CMS will contact both the submitter and the individual listed as the point of contact in the MCPAR under sections A.2a and A.2b of the MCPAR web-form.

16. Does CMS provide feedback to states on MCPAR submissions?

CMS does not approve MCPAR reports, but we have developed standardized MCPAR feedback reports for all MCPARs to continue advancing data quality. CMS has provided in-depth feedback to specific States with the goal of ensuring that States are reporting the correct programs and addressing significant reporting issues. If you are seeking specific feedback on a previous report or have questions as you prepare a new submission, please email ManagedCareTA@cms.hhs.gov.

18. What are the requirements for posting the MCPAR on the State website and distributing it?

42 CFR 438.66(e)(3) requires States to post the MCPAR to the State's website within 30 calendar days of submission to CMS. We encourage States to align their website posting date with their MCPAR submission to CMS. The State must also provide the MCPAR to the Medical Care Advisory Committee and, if the program includes LTSS, to the stakeholder consultation group specified in 42 CFR 438.70.

States may post their MCPAR data in a different format as long as the data are exactly the same as what was submitted to CMS. To maximize accessibility, we encourage states to post the 508-compliant PDF, which can be generated by clicking "Review PDF" followed by "Download PDF" within the Review & Submit tab of the MDCT MCR web-form.

19. Does CMS make the MCPARs public?

Yes. As a first step towards transparency of this data, CMS began posting PDF versions of State MCPARs on Medicaid.gov in 2024.

20. Will the data from previous reporting periods be saved and automatically populated for future submissions?

MDCT MCR saves the data that States submit. As of November 2, 2023, the MCPAR includes a "copy" functionality that will allow States to automatically populate certain portions of a new MCPAR submission using data from an existing MCPAR record. For example, States can carry over managed care plan names, network adequacy standards, quality and performance measures, and contract language from a previous MCPAR record when appropriate, but States must review all data to ensure it continues to be accurate for the annual MCPAR submission. Fields that must be updated each year, such as enrollment numbers and financial, program integrity, and quality performance data, will not be copied over. The Excel template's "Crosswalk" tab indicates which fields can be carried over from an existing MCPAR record.

21. If we contact the MDCT Help Desk, what is the turnaround time for receiving a response?

Usually, the MDCT Help Desk acknowledges the inquiry within the same business day. The resolution time of an issue depends on the severity and complexity of the issue.

22. Are other templates (Network Adequacy and Access Assurances Report (NAAAR), Medical Loss Ratio (MLR) report, etc.) available in a web-based format?

Yes. For rating periods beginning on or after July 1, 2024, States were required to submit their MLR reports in a web-based format through MDCT MCR. Submissions using the Excel workbook will no longer be accepted. Federal regulations at 42 CFR 438.74(a) require that MLR summary reports are due with rate certifications required in 42 CFR 438.7. As of July 2025, States will also have the option to submit their NAAAR through the MDCT MCR portal. Please refer to the NAAAR page on Medicaid.gov for more information.

23. NEW: We are reporting network adequacy and access information in both the NAAAR and in MCPAR. How can we reduce the duplication?

Starting July 2025, CMS addressed this duplication with an update to the MCPAR. If a State has already submitted or plans to submit the new version of NAAAR through MDCT for the same reporting period, the State may opt out of the MCPAR Availability, Accessibility and Network Adequacy Section (C2.V.1 through C2.V.8) to reduce State reporting burden.

Section 3. Questions on MCPAR Content

1. What do we do if we are unable to report some data?

CMS acknowledges that States may need to update their contracts with managed care plans to collect some information requested in the MCPAR. If your State does not yet have data available for the period requested in the MCPAR, please email ManagedCareTA@cms.hhs.gov if you would like technical assistance.

2. What do we put in a field if the answer is "none"?

For text fields, write "None" or enter a statement explaining that there is nothing relevant for a response to the question. For numerical fields, enter "0" (zero). For example, if the MCPAR asks for the number of resolved grievances related to quality of care and you had no grievances related to this, you would enter "0." Do not write "N/A" as an answer to questions that apply to your program. MDCT MCR will not allow you to leave fields blank.

3. When is "Not Applicable" (N/A) an acceptable response?

Only use N/A if the question does not apply to your managed care program. For example, if the question is about Long-Term Services and Supports (LTSS) and the program you are reporting on is a dental program or a medical program where LTSS is not a covered benefit, you can write "N/A" or enter a statement explaining that the question does not apply. The MDCT MCR web-form will not allow you to leave fields blank. CMS is working to clarify instructions throughout the MCPAR and is developing additional technical assistance resources related to the use of "N/A". "N/A" should not be used if the answer is "zero" or "none."

4. Do States need to submit MCPARs for prepaid ambulatory health plans (PAHPs) that only cover non-emergency medical transportation (NEMT) services?

No, States do not need to submit MCPARs for NEMT PAHPs as they are not required to do so under 42 CFR 438.9.

5. Do we need to include data on the Children's Health Insurance Program (CHIP)?

States with Medicaid programs that include Title XXI-funded Medicaid expansion CHIP beneficiaries should include CHIP data in their MCPARs. States with separate CHIP programs funded exclusively under Title XXI should not submit MCPARs for those CHIP programs. If you are unable to exclude information about enrollees served through a separate CHIP program in one or more of your MCPARs, you may indicate this constraint through the CHIP Exclusion question at the beginning of the MCPAR web-form.

6. How do we report data for Dual Eligible Special Needs Plans (D-SNPs)?

For D-SNPs that hold a Medicaid contract with the State to cover Medicaid benefits, States must submit a MCPAR for services covered under that Medicaid contract. Specifically, for D-SNPs that qualify as Applicable Integrated Plans (AIPs) under 42 CFR 422.561, States should limit their MCPAR-reported appeals and grievances data to those appeals and grievances filed for Medicaid-only covered services.

7. How do we report data for Medicare-Medicaid Plans (MMPs)?

States that utilize MMPs authorized under the Financial Alignment Initiative in section 1115A of the Social Security Act must submit a MCPAR. To reduce duplication, States completing a MCPAR for MMPs should only report "Availability, Accessibility, and Network Adequacy" standards for provider types that render Medicaid-only covered services. Network adequacy

standards for providers that do not render Medicaid-only covered services do not need to be included in the MCPAR.

8. Do I need to submit a MCPAR report for a Primary Care Case Manager (PCCM) or Primary Care Case Management Entity (PCCM entity)? If I am reporting for a PCCM entity program, what do I have to report and how do I navigate the web-form?

MCPAR reports are not required for PCCMs but are required for PCCM entities. States are only required to complete two sections of the MCPAR for PCCM entities. These include the section on Program Information, Enrollment and Service Expansions and the section on Sanctions (see 42 CFR 438.66(e)(2)(iii) and (viii)). For this reason, CMS has developed a shorter web-form for PCCM entity MCPAR reports in the MDCT MCR portal.

Follow these steps to access the shorter web-form for PCCM entity reports in MDCT MCR:

- On the MCPAR dashboard, select the "Add / copy a MCPAR" button
- A modal will appear and when asked "Is your program a Primary Care Case Management (PCCM) entity?" — select "yes'"
- The system will guide you through the required questions for PCCM entity
- If throughout the process you have questions, click the "Get Help" in the upper right corner of the screen.

9. NEW: Why is CMS changing how States select program names for reporting?

As part of CMS' efforts to streamline and make program names consistent across managed care reporting, users can now select a program name from a list of existing program names, add a new program, or rename a program. The program name list in MDCT MCR was compiled and reconciled from official program names submitted to CMS by States.

10. NEW: If I don't find the name of a program on the drop-down list, what do I do?

If the program name is not on the drop-down list, or the name needs revision, States can add or update a program name through the MCPAR.

11. NEW: When I update, delete, or add a new program name to the MCPAR, how will that change get incorporated for future program name selections and MCPAR reporting?

When a State has a new program or updates a program, CMS will incorporate that information into the subsequent program name list for future use. CMS may follow up with the State to validate the change or address any discrepancies from other reports or contract documents to ensure we have the most accurate official name of the program.

12. NEW: If I rebrand an existing program by changing its name, can I still copy an earlier program report to take advantage of the copy over function?

Yes. You may copy over the contents of an existing report from any program in your State for any reason. As before, copying a program's MCPAR will retain the structure of your program but

allow you to enter updated responses for the new reporting period, including the name of the program.

13. Can we report multiple Beneficiary Support System (BSS) entities in the MCPAR?

Yes. You can enter multiple BSS entities in section E.IX.1 of the MCPAR web-form.

14. Do we need to report each Aging and Disability Resource Center (ADRC) location as a unique BSS entity?

If ADRCs perform largely the same functions, you can report them as a single BSS entity called a Multi-Location ADRC. When prompted to enter information describing the functions performed by ADRCs, also note the number of locations where the ADRC operates.

15. If a State does not have managed LTSS (MLTSS), can "N/A" be used to respond to questions about data for a BSS Long-Term Services and Supports (LTSS) program?

Yes, States that do not have any MLTSS programs can enter "N/A" when prompted for BSS LTSS data **[Question C1.IX.3]**.

16. How should appeals and grievances data related to enrollees who use LTSS be reported?

As a first step, States should identify any enrollee who uses LTSS in the program they are reporting on. Then, States should report all appeals and grievances filed by or on behalf of these enrollees who use LTSS in section D.1.IV of the MCPAR web-form. If LTSS is not a part of the program you are reporting on, answer "N/A" to all LTSS-related questions. In addition, there are several questions that require LTSS-specific reporting.

17. NEW: Are there resources to help us report our appeals and grievances data?

Yes. In August 2024, CMS published the MCPAR Technical Guidance, Topic: Appeals and Grievances on Medicaid.gov to help States report more accurate, complete, and consistent data.

18. What is the level of detail required for reporting quality and performance measures?

States should report all managed care plan-level measures that the State uses to monitor managed care quality and performance. The MCPAR collects measures under the following 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) LTSS

States with measures that do not align with these domains should use free text to describe the domain and associated measures. All quality and performance measure results should be reported based on the managed care populations specifically identified in the associated MCPAR.

19. What is the scope of sanctions reported in the MCPAR?

As required in 42 CFR 438.66(e)(2)(viii), a State must report in the MCPAR all sanctions or corrective actions imposed by the State or other formal or informal intervention with a contracted managed care plan to improve performance, including those issued, in progress, or completed during the contract year. This includes, but is not limited to, financial penalties, corrective action plans, suspension of enrollment, written warnings, and other formal or informal intervention with a contracted plan to improve performance. The State should include any sanction-related action taken during the contract year, regardless of when the issue was identified and regardless of what entity identified the non-compliance (e.g., the State, an auditing body, the plan, EQRO).

20. For Question D1.X.10 on the frequency of plans reporting changes in enrollee circumstances, how should states report "on occurrence?"

You should select the option that most closely reflects the frequency with which each managed care plan in your program reports changes in beneficiary circumstances to the State. CMS added an additional response option to this question with the phrasing, "Promptly when plan receives information about the change"; States should select this response option if it aligns with their processes.

21. What do we do if our program started or ended partway through a reporting year? How do we report a partial year of data?

CMS understands that program start and end dates do not always align to a 12-month period. Please contact our technical assistance team at ManagedCareTA@cms.hhs.gov to discuss your State's specific circumstance. CMS may advise you to report a partial year of data or more than 12 months of data in one MCPAR. Any time a MCPAR contains more or less than 12 months of data, the State should indicate that in MCPAR section A in the Reporting period start date and Reporting period end date fields.

22. How often do the MCPAR reporting requirements and template change? Will States be notified when there is a change?

CMS aims to update the MCPAR no more than twice a year. CMS will notify States of these semi-annual changes to the MCPAR web-form and template and the effective date of the changes.

23. NEW: When CMS updates the MCPAR template, how can we tell what changes have been made?

The Excel template posted on Medicaid.gov lists recent MCPAR updates with their effective dates on the "Instructions" tab. A banner at the top of the MCPAR web-form where States select the MCPAR radio button to go into their dashboard also lists this information.

24. NEW: We started using a version of the Excel template before the MCPAR web-form was updated before our submission date. Now, our data do not match what is in the new web-form. How can we ensure that the versions are the same?

It is best practice to initiate a MCPAR report in MDCT at the same time that you start filling out the most recent version of the Excel template. This will lock in the web-form version in MDCT and ensure that both versions are the same.

25. NEW: How can we add State staff to the MCPAR mailing list to get updated MCPAR information and technical assistance resources?

CMS maintains a list of MCPAR contacts who receive MCPAR updates for each State. To add or edit your State's contacts, please email ManagedCareTA@cms.hhs.gov.

Section 4: Questions on MCPAR Enrollment Indicators

1. NEW: What count should be used for the Statewide Medicaid enrollment (Question B.I.1)?

States must report the average number of individuals (unduplicated) enrolled per month in the State's Medicaid program. Include all Medicaid enrollees, whether they are in fee-for-service (FFS) or managed care. Each person should only be counted once, even if they access services across multiple delivery systems.

2. NEW: How should Statewide Medicaid managed care enrollment (Question B.I.2) be reported?

Question B.I.2 represents the average number of unduplicated individuals enrolled in any managed care program per month. Each person should be counted once, even if they participate in more than one managed care program. Do not sum enrollment across managed care programs without de-duplicating.

3. NEW: What is the relationship between Questions B.I.1 and B.I.2?

Question B.I.1 (Statewide Medicaid enrollment) should always be greater than or equal to B.I.2 (Statewide managed care enrollment). B.I.1 and B.I.2 would only be equal if 100 percent of a State's Medicaid beneficiaries are enrolled in some form of managed care.

4. NEW: Can the values for Questions B.I.1 and B.I.2 vary across MCPARs submitted for the same reporting year?

No. Because Questions B.I.1 (Statewide Medicaid enrollment) and B.I.2 (Statewide managed care enrollment) are Statewide values, they should be consistent across all MCPAR submissions for the same reporting year.

5. NEW: What is the relationship between Statewide managed care enrollment and program enrollment (Questions B.I.2 and C1.I.5)?

Question B.I.2 (Statewide managed care enrollment) must be greater than or equal to C1.I.5 (program enrollment). Program enrollment is usually a subset of the Statewide total, and a single managed care program should be less than or could be equal (e.g., dental managed care covering all managed care enrollees) to the total Statewide Medicaid managed care enrollment. Program enrollment would never be greater than the total Statewide managed care enrollment. For

example, a State could not report the total for C1.I.5 (program enrollment) as 1.5 million, but B.I.2 (Statewide managed care enrollment) as 1.3 million.

6. NEW: What is the relationship between plan and program enrollment (Questions C1.I.5 and D1.I.1)?

Question D1.I.1 (plan enrollment) represents the average number of individuals enrolled per month in a particular plan within a program. When summed across all plans in a program, the total should closely match C1.I.5 (program enrollment). Minor discrepancies may occur due to member movement between plans, but large differences should be reviewed to determine if the numbers are valid.

7. NEW: How can we ensure accurate enrollment numbers reporting before submitting the MCPAR?

Step 1 Validate that B.I.1 ≥ B.I.2.

Step 2 Validate that B.I.2 ≥ C1.I.5.

Step 3 Ensure that C1.I.5 closely approximates SUM (D1.I.1) with any variance only related to movement between plans.

Step 4 Confirm that B.I.1 and B.I.2 are the same across all MCPARs for the same reporting period.