This communication was printed, published, or produced and disseminated at U.S. taxpayer expense. The information provided in this document is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance that it is based upon. This document summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.
Agenda

• Medicaid and CHIP Managed Care Monitoring and Oversight Tools Center Informational Bulletin
• Timing for Medicaid Budget and Expenditure System (MBES) American Rescue Plan Changes
• Open Mic Q and A
Medicaid and CHIP
Managed Care Monitoring and Oversight Initiative
The increased prevalence of managed care underscores the need for strong federal and state oversight of managed care in Medicaid and CHIP.

- 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.
Over the last year, several factors have brought Medicaid and CHIP Managed Care Monitoring and Oversight to the forefront:

- Requirements in the 2016 and 2020 Medicaid and CHIP managed care final rules.

- Requests from states, stakeholders, and oversight bodies to improve technical assistance and federal oversight of Medicaid and CHIP managed care programs.
This CIB introduce a series of tools for states and CMS to utilize to improve the monitoring and oversight of managed care in Medicaid and CHIP.

Provides guidance setting the content and format of the Annual Managed Care Program Report required by CMS regulations.

Provides Information on an appeals and grievances data collection tool being piloted with states completing the readiness review process in the next 18 months.


Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib06282021.pdf
The Managed Care Program Annual Report (MCPAR) is required under 42 C.F.R. § 438.66(e).

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 CIB provides that guidance and releases an excel based template with instructions to show the exact measures collected by the report.

<table>
<thead>
<tr>
<th>Contract Year of the Managed Care Program</th>
<th>Contract Period of First Report</th>
<th>First Report Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>July through June</td>
<td>7/1/2021 – 6/30/2022</td>
<td>December 27, 2022</td>
</tr>
<tr>
<td>September through August</td>
<td>9/1/2021 – 8/31/2022</td>
<td>February 27, 2023</td>
</tr>
<tr>
<td>October through September</td>
<td>10/1/2021 – 9/30/2022</td>
<td>March 29, 2023</td>
</tr>
<tr>
<td>January through December</td>
<td>1/1/2022 – 12/31/2022</td>
<td>June 29, 2023</td>
</tr>
<tr>
<td>February through January</td>
<td>2/1/2022 – 1/31/2023</td>
<td>July 30, 2023</td>
</tr>
<tr>
<td>April through March</td>
<td>4/1/2022 – 3/31/2023</td>
<td>September 27, 2023</td>
</tr>
</tbody>
</table>
Content of the Managed Care Program Annual Report (MCPAR)

- Consistent with 42 C.F.R. § 438.66, the template covers the following topics:
  1. Program characteristics and enrollment
  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
  10. Program integrity

- All topics apply to MCOs, PIHPs, and PAHPs; only certain topics apply to PCCMs.
- States will submit one MCPAR per managed care program.
Form of the Managed Care Program Annual Report (MCPAR)

- The report will be collected electronically through a web-based submission portal that will collect exactly the information that is included in the excel template.

- 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. This portal will work workbook.
The Managed Care Program Annual Report (MCPAR): A requirement of 42 CFR 438.66(e)
## C1. Program-level, set indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Instructions and definition</th>
<th>Data format</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1.1.1 Program contract</td>
<td>Enter the title and date of the contract between the state and plans participating in the managed care program.</td>
<td>Free Text</td>
</tr>
<tr>
<td>C1.1.2 Contract URL</td>
<td>Enter the hyperlink to the model contract or landing page for executed contracts for the program being reported in the MCCPN.</td>
<td>Free Text (hyperlink)</td>
</tr>
<tr>
<td>C1.1.3 Program type</td>
<td>Select the type of MCPs that contract with the state to provide the services covered under the program. Select one of the allowed values.</td>
<td>Set values (select one)</td>
</tr>
<tr>
<td>C1.1.4 Special program benefits</td>
<td>CMS is interested in knowing whether one or more of the following four special benefit types are 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 of the allowed values. (Note: 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 programs are not to be included.)</td>
<td>Set values (select multiple)</td>
</tr>
<tr>
<td>C1.1.4.b Variation in special benefits</td>
<td>Please note any variation in the availability of special benefits within the program on a quarterly, semi-annual, or annual basis if applicable.</td>
<td>Free text</td>
</tr>
<tr>
<td>C1.1.5 Program enrollment</td>
<td>Enter the total number of individuals enrolled in the managed care program as of the last day of the reporting year.</td>
<td>Count</td>
</tr>
<tr>
<td>C1.1.6 Changes to enrolment or benefits</td>
<td>Provide a brief explanation of any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.</td>
<td>Free text</td>
</tr>
<tr>
<td>C1.3.1 Uses of encounter data</td>
<td>Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 C.F.R. 438.542(d)(1)). The data sets used for this data are encounter data collected from managed care plans (MCPs).</td>
<td>Set values (select multiple) or use free text for “otherwise” responses</td>
</tr>
<tr>
<td>C1.3.2 Critical measures used to evaluate MCP performance</td>
<td>Enter 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.</td>
<td>Free text</td>
</tr>
<tr>
<td>C1.3.3 Encounter data performance criteria contract language</td>
<td>Enter reference to the contract section that describes the types of failures to meet encounter data submission standards for which states may impose financial sanction(s) related to encounter data quality.</td>
<td>Free text</td>
</tr>
<tr>
<td>C1.3.4 Financial penalties contract language</td>
<td>Use contract section references, not page numbers.</td>
<td>Free text</td>
</tr>
<tr>
<td>C1.3.5 Incentives for encounter data quality</td>
<td>Describe the types of incentives that may be awarded to managed care plans for encounter data quality.</td>
<td>Free text</td>
</tr>
</tbody>
</table>
CMS is also developing standard content and a web-based submission platform for the following required new reports:

- Medical Loss Ratio (MLR) Summary Report required under 42 C.F.R. § 438.74(a).
- Access Standards Certification pursuant to 42 C.F.R. § 438.207(d).

Once Complete, the web-based submission will help CMS:

- Generate and analyze state-specific and nationwide data across the universe of managed care programs and requirements
- Identify and target efforts to assist states in improving their managed care programs
- Ensure compliance with managed care statutes and regulations, such as ensuring access to care
To assist states in meeting the readiness review requirement, and to monitor new programs or program expansions, CMS is developing the following tools that will also be submitted in a web-based platform.

- Enhanced Readiness Review Reporting Tool.
- New Appeals and Grievances Reporting Tool to be used during the first year of program implementation (after completion of the 18 month pilot).
New Technical Assistance Toolkits for State Compliance and Oversight

- CMS is developing a series of toolkits to assist states with various managed care regulatory provisions that will provide important Technical Assistance to states to improve state monitoring and oversight of managed care programs.

  - Behavioral Health Access
  - Managed Care Quality Strategies
Overview of the Behavioral Health (BH) Provider Network Adequacy Toolkit

- Aims to help state Medicaid agencies and managed care partners meet network adequacy requirements for BH providers.
- Highlights promising practices and strategies from state Medicaid agencies and managed care plans in three main areas:
  - Incorporating BH services into comprehensive managed care arrangements.
  - Expanding BH workforce and participation in Medicaid managed care.
  - Oversight and monitoring strategies to assess managed care plan compliance with state network standards and encourage innovation to improve networks.
- Informed by multiple sources and methods:
  - National experts and staff from ten states, a series of virtual forums, review of literature, and state documents.
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Overview of the 2021 Managed Care Quality Strategy Toolkit

- Per 42 CFR 438.340(a) and 457.1240(e), state Medicaid and CHIP agencies that contract with MCOs, PIHPs, PAHPs, and certain PCCM entities are required 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.

- The purpose of this toolkit is to provide technical assistance to states to support them in implementing the quality strategy requirements and to provide considerations for states to improve their strategies.

- This toolkit replaces the 2013 Quality Strategy Toolkit; some key features of the 2021 Toolkit includes:
  - resources, examples, and best practices for states to consider
  - addressing common challenges identified during the CMS review and feedback process, and during technical assistance calls with states
  - going beyond compliance to help states to leverage their quality strategy for quality improvement

Medicaid and CHIP Managed Care Quality Strategy Toolkit Table of Contents

I. Introduction
This chapter provides a brief description of quality strategy requirements, how quality strategies relate to other managed care quality tools, and the purpose of this toolkit.

II. Developing a Quality Strategy
This chapter describes steps a state can take to develop its quality strategy, requirements that the state must address in its quality strategy, and considerations for how to improve its quality strategy. The chapter contains seven sections:

A. Steps for developing the quality strategy.
   This section describes nine steps that the state can use to create its quality strategy.

B. Cross-cutting considerations.
   This section describes five cross-cutting considerations that the state should take into account when developing its quality strategy.

C. Drafting and implementing the quality strategy.
   This section describes what is required of states and provides considerations for drafting and implementing the quality strategy.

D. Goals and objectives.
   This section describes what is required of states and provides considerations for developing measurable goals and objectives for continuous quality improvement.

E. Quality of care.
   This section describes what states are required to include with regard to quality of care information, such as quality metrics and performance targets, Medicaid Managed Care Long-Term Services and Supports (MLTSS) measures, and transition of care policies.

F. Monitoring and compliance.
   This section describes what is required of states and provides considerations for presenting monitoring and compliance information, such as network adequacy standards and intermediate sanctions.

G. External quality review (EQR) arrangements.
   This section describes what is required of states and provides considerations for presenting EQR arrangements, such as the EQR non-duplication option.

III. Updating the Quality Strategy
This chapter describes what is required of states and provides considerations for updating the quality strategy, such as the quality strategy review and evaluation process.

IV. Quality Strategy Submission Process
This chapter provides guidance for states on the quality strategy submission process, including public and Tribal comment periods and submitting the state’s initial and revised quality strategies to the Centers for Medicare & Medicaid Services (CMS).

Appendices
This toolkit includes the following three appendices. Use the clickable links “Go now!” buttons to navigate to the appendices.

Appendix A. Acronyms
This appendix defines acronyms used in the toolkit.

Appendix B. Glossary of Terms
This appendix defines terms used in the toolkit.

Appendix C. Non-Duplication for EQR-Related Activities
Quality strategy regulations require the state to describe its EQR arrangements. This appendix describes the EQR non-duplication option for the state when Medicare or accreditation review standards are comparable to the EQR protocols.
Upcoming Toolkits

- CMS intends to make additional toolkits available to states over the next two years. They will continue to provide critical Technical Assistance to State. Topics will include:
  - Managed Long-Term Services and Supports
  - Managing Plan Transitions
  - Provider Screening and Enrollment
  - Program Integrity
  - Tribal Protections in Medicaid and CHIP Managed Care
Managed Care Monitoring and Oversight Collaboration

Next Steps:
In order to continue improving CMS’ monitoring and oversight of managed care:

► CMS will release new tools, including standard reporting templates in a web-based platform and additional toolkits, periodically over the next 2 years.

► CMS will continue engaging with states and stakeholders to determine what additional support and resources states need to improve their monitoring and oversight of managed care programs.
Questions