The Managed Care Program Annual Report (MCPAR): A requirement of 42 CFR 438.66(e)

MCPAR Overview

Beginning on June 28, 2021, the Centers for Medicare and Medicaid Services (CMS) is requiring that, as part of its monitoring system for all Medicaid managed care programs, 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, regardless of the authority under which the program operates. (For 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 state and managed care plans, and that has associated rate cells.) The initial report will be due for the contract year beginning on or after June 28, 2021; reports are required annually thereafter and aligned with state contract cycles (42 CFR 438.68(e)(1)). (See the Glossary tab for a definition of "reporting year;" see Instructions tab for example reporting timeframes.)

This document provides instructions for data collection and a template for states to use to submit the required information, hereafter referred to as the Managed Care Program Annual Report (MCPAR). States must complete one MCPAR workbook (i.e., complete lettered sheets A-E in this excel file) for each managed care program operating in the state during the year. Data should cover the 12-month period of the contract term during which the state is reporting information to CMS; this is referred to as the "reporting year."

Completed forms should be submitted through an online portal that will be made available on or before June 27, 2022. Questions about this form may be directed to ManagedCareTA@mathematica-mpr.com. This form, or the information contained therein, must also be posted on the state's website as required at 438.66(e)(3)(i), and provided to the Medical Care Advisory Committee as required at 438.66(e)(i) and, if applicable, the MLTSS consultation group as required at 438.66(e)(iii).

MCPAR Template Organization

Consistent with 438.66(e), this template provides space for states to report indicators related to the following ten topics: (I) Program Characteristics and Enrollment; (II) Financial Performance; (III) Encounter Data Reporting; (IV) Grievance, Appeals, and State Fair Hearings; (V) Availability, Accessibility, and Network adequacy; (VI) Quality and Performance Measures; (VII) Sanctions and Corrective Action Plans; (VIII) Beneficiary Support System; and (IX) Program Integrity.

Data on each topic is organized by reporting level: state, program, plan, and other entity (i.e. beneficiary support system). Within this report, states will find data elements with specific drop downs that CMS has pre-selected to standardize data across states, as well as places with instructions for states to report state-specific indicators or free text. Tabs are organized as follows:

Tab topic:	**Tab name**
Reporting instructions	Instructions
A. Cover sheet and identifying information	A_COVER
B. State level, set indicators	B_STATE_set-indc
C1. Program-level, set indicators	C1_PROG_set-indc
C2. Program-level, state-specific indicators: Availability, accessibility, and network adequacy	C2_PROG_free-indc_accs
D1. Plan-level, set indicators	D1_PLAN_set-indc
D2. Plan-level, state-specific indicators: Quality and Performance Measures	D2_PLAN_free-indc_qual
D3. Plan-level, state-specific indicators: Sanctions and Corrective Action Plans	D3_PLAN_free-indc_sanc
E. BSS-entities, set indicators	E_BSS_set-indc
Glossary	Glossary
List of all indicators in the MCPAR, crosswalked to the tab on which they appear	Crosswalk

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0920 (Expires: June 30,2024). The time required to complete this information collection is estimated to average 6 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Reporting Instructions

Item	Instruction or description
Inputting data	Enter information into tabs A-E, and only input values in BEIGE CELLS (white cells with black text provide explanatory text or calculated values). Key terms are defined in the glossary.
Reporting timeframe	The State must submit MPCAR reports to CMS no later than 180 days after each contract year. The initial MCPAR report will be due after the contract year following the release of CMS guidance on the content and form of the report (i.e. after release of this form) (42 CFR 438.68(e)(1). Example timeframe: If CMS releases guidance on the MCPAR in the beginning 2021, states that have contracts on a calendar cycle (for example, states with contracts running from July, 2021 to June, 2022), would have their first required report due December 31, 2022. For states with calendar year contracts, the calendar year following release of the guidance would be 2022, and their first reports would be due June 2023.
Program definition	For purposes of the MCPAR, a program is defined by a distinct set of benefits and eligibilty criteria that is articulated in a contract between the state and managed care plans. "Programs" may also be differentiated from one another based on their associated rate cells.
Exclusion of CHIP from MCPAR	Separate CHIP enrollees and programs should not be reported in the MCPAR. **Please use free text to flag any items for which the state is unable to remove information about Separate CHIP from required reporting for Medicaid-only or Medicaid Expansion CHIP programs.**
Preparing the first MCPAR	CMS acknowledges that states may need to update their contracts with plans to collect some information requested in the MCPAR and that states will need time to create the first MCPAR report. CMS will be available to provide technical assistance to states to help prepare the MCPAR. Requests for technical assistance can be submitted to ManagedCareTA@mathematica-mpr.com.
Overlap with other state reporting requirements	CMS acknowledges that some of the indicators requested in the MCPAR are also reported to CMS through other means. For example, state EQRO reports include measure validation results and measure rates for some or all measures collected by states, although measure rates may not be program specific and may not be reported for all managed care programs operating in the state in a given year. States should consider leveraging existing reports and/or contractors (such as EQROs) to populate the MCPAR. CMS will explore opportunities to align the MCPAR with other data collection efforts in future years.
1115 reports overlap	Per 42 CFR 438.66(e)(1)(ii), states that operate managed care programs under 1115(a) authority **may reference 1115 reports required by its Special Terms and Conditions (STCs) in lieu of entering an indicator into the MCPAR if the report includes the information required by the indicator including the same level of detail (e.g. plan-level data).** However, CMS has worked to ensure that most of the managed care reporting requirements in the MCPAR are not duplicated in STCs; therefore, CMS anticipates few instances where the information required in 1115 quarterly and annual reports will directly overlap with what is required in the MCPAR. If a state would like assistance in determining whether an existing 1115 reporting requirement can be deemed to satisfy requirements of the MCPAR, please request technical assistance via ManagedCareTA@mathematica-mpr.com.
Data lags	If the state does not have data available over the time period with which it is requested in the MCPAR, use the most recent data available and note the reporting period that the data cover.

A. Cover sheet and identifying information

Item or entity	Instructions and definition	Data format	Input data in beige cells in this column. These values will autopopulate other tabs. Response
State name	Enter the name of state submitting the report.	Set value (select one)	
Contact name	Enter the name and email address of the person or position to contact with questions regarding information reported in the MCPAR. 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.	Free text	
Contact email address	Enter the email address of the individual filling out this document.	Free text	
Date of report submission	Enter the date on which this document is being submitted to CMS.	Date (MM/DD/YYYY)	
Reporting period start date	Enter the start date of the reporting period represented in this document.	Date (MM/DD/YYYY)	
Reporting period end date	Enter the end date of the reporting period represented in this document.	Date (MM/DD/YYYY)	
Program name	Enter the name of the program for which the state is reporting data in the MCPAR. For purposes of the MCPAR, a program is defined by a contract between the state and a managed care plan (or group of plans), which articulates a standard set of benefits, eligibility criteria, reporting requirements, and has a set of rate cells specific to that program.	Free text	
Plan 1	Enter the name of each plan that participates in the program for which the state is reporting data. If the program contracts with fewer than 35 plans, leave unused fields blank.	Free text	
Plan 2		Free text	
Plan 3		Free text	
Plan 4		Free text	
Plan 5		Free text	
Plan 6		Free text	
Plan 7		Free text	
Plan 8		Free text	
Plan 9		Free text	
Plan 10		Free text	
Plan 11		Free text	
Plan 12		Free text	
Plan 13		Free text	
Plan 14		Free text	
Plan 15		Free text	
Plan 16		Free text	
Plan 17		Free text	
Plan 18		Free text	
Plan 19		Free text	
Plan 20		Free text	
Plan 21		Free text	

Plan 22		Free text	
Plan 23		Free text	
Plan 24		Free text	
Plan 25		Free text	
Plan 26		Free text	
Plan 27		Free text	
Plan 28		Free text	
Plan 29		Free text	
Plan 30		Free text	
Plan 31		Free text	
Plan 32		Free text	
Plan 33		Free text	
Plan 34		Free text	
Plan 35		Free text	
BSS entity 1	Enter the names of the beneficiary support system (BSS) entities that support enrollees in the program for which the state is reporting data. If the program contracts with fewer than 10 BSS entities, leave unused fields blank. **If the program includes more than 10 BSS entities, states may contact CMS for guidance.**	Free text	
BSS entity 2		Free text	
BSS entity 3		Free text	
BSS entity 4		Free text	
BSS entity 5		Free text	
BSS entity 6		Free text	
BSS entity 7		Free text	
BSS entity 8		Free text	
BSS entity 9		Free text	
BSS entity 10		Free text	

B. State-level indicators

#	Indicator	Instructions and definition	Data format	Input data only in beige cells in this column [STATE]
Topic I. Program Characteristics and Enrollment				
B.I.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.	Count	
B.I.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.	Count	
Topic III. Encounter Data Reporting				
B.III.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 defintion for more information.)	Set values (select multiple) or use free text for "other" response	
B.III.2	HIPAA compliance of proprietary system(s) for encounter data validation	If state selected “proprietary system(s)” in indicator B.III.1, indicate whether the system(s) utilized are fully HIPAA compliant.	Set values (select one)	
Topic X. Program Integrity				
B.X.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 (such as 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.	Free text	
B.X.2	Contract standard for overpayments	Indicate whether the state allows plans to retain overpayments, requires the return of overpayments, or has established a hybrid system.	Set values (select one)	
B.X.3	Contract locations of overpayment standard	Identify where the overpayment standard in indicator B.X.2 is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Free text	
B.X.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	Free text	
B.X.5	State overpayment reporting monitoring	Describe how the state monitors plan performance in reporting overpayments to the state. For example, does the state track compliance with this requirement and/or timeliness of reporting?	Free text	

B.X.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).	Free text	
B.X.7.a	Changes in provider circumstances: Part 1	Indicate if the state monitors whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4).	Set values (select one)	
B.X.7.b	Changes in provider circumstances: Part 2	If the state monitors whether plans report provider “for cause” terminations in a timely manner in indicator B.X.7.a, indicate whether the state uses a metric or indicator to assess plan reporting performance.	Set values (select one)	
B.X.7.c	Changes in provider circumstances: Part 3	If the state uses a metric or indicator to assess plan reporting performance in indicator B.X.7.b, describe the metric or indicator that the state uses.	Free text	
B.X.8a	Federal database checks: Part 1	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. In the course of the state's federal database checks, did the state find any person or entity excluded?	Set values (select one)	
B.X.8b	Federal database checks: Part 2	If in the course of the state's federal database checks the state found any person or entity excluded, please 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 in Tab D3 as applicable. Enter N/A if not applicable.	Free text	
B.X.9a	Website posting of 5 percent or more ownership control [Y/N]	Report whether the state posts 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 following §455.104 and required by 42 CFR 438.602(g)(3).	Set values (select one)	
B.X.9b	Website posting of 5 percent or more ownership control [link]	If the state posts on its website the names of the plan individuals with 5% or more ownership or control, under 42 CFR 602(g)(3), provide a link to the website. Enter N/A if not applicable.	Free text	
B.X.10	Periodic audits [link]	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 under 42 CFR 438.602(e), provide the link(s) to the audit results.	Free text	

C1. Program-level, set indicators

#	Indicator	Instructions and definition	Data format	Input data only in beige cells in this column [Program]
Topic I. Program Characteristics and Enrollment				
C1.I.1	Program contract	Enter the title and date of the contract between the state and plans participating in the managed care program.	Free Text	
C1.I.2	Contract URL	Enter the hyperlink to the model contract or landing page for executed contracts for the program being reported in the MCPAR.	Free Text (hyperlink)	
C1.I.3	Program type	Select the type of MCPs that contract with the state to provide the services covered under the program. Select one of the allowed values.	Set values (select one)	
C1.I.4.a	Special program benefits	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 should not be listed here.)	Set values (select multiple)	
C1.I.4.b	Variation in special benefits	Please note any variation in the availability of special benefits within the program (e.g. by service area or population). Enter "N/A" if not applicable.	Free text	
C1.I.5	Program enrollment	Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	Count	
C1.I.6	Changes to enrollment or benefits	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.	Free text	
Topic III. Encounter Data Reporting				
C1.III.1	Uses of encounter data	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)). Select purposes for which the state uses encounter data collected from managed care plans (MCPs).	Set values (select multiple) or use free text for "other" response	
C1.III.2	Criteria/ measures used to evaluate MCP performance	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). Select types of measures used by the state to evaluate managed care plan performance in encounter data submission and correction.	Set values (select multiple) or use free text for "other" response	
C1.III.3	Encounter data performance criteria contract language	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.	Free text	
C1.III.4	Financial penalties contract language	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. Use contract section references, not page numbers.	Free text	

C1.III.5	Incentives for encounter data quality	Describe the types of incentives that may be awarded to managed care plans for encounter data quality	Free text	
C1.III.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.	Free text	
Topic IV. Grievance, Appeals, and State Fair Hearings				
C1.IV.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, provide the definition that the state uses for "critical incidents" within the managed care program. If the managed care program does not cover LTSS, the state should respond "N/A."	Free text or N/A	
C1.IV.2	State definition of "timely" resolution for standard appeals	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. Describe the state's definition of timely resolution for standard appeals in the managed care program.	Free text	
C1.IV.3	State definition of "timely" resolution for expedited appeals	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. Describe in the state's definition of timely resolution for expedited appeals in the managed care program.	Free text	
C1.IV.4	State definition of "timely" resolution for grievances	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. Describe the state's definition of timely resolution for grievances in the managed care program.	Free text	
Topic V. Availability, Accessibility, and Network Adequacy				
C1.V.1	Gaps/challenges in network adequacy	Describe any challenges to maintaining adequate networks and meeting standards. What are the state's biggest challenges?	Free text	
C1.V.2	State response to gaps in network adequacy	Describe how the state works with MCPs to address these gaps.	Free text	
Topic IX. Beneficiary Support System (BSS)				
C1.IX.1	BSS website	Indentify the website and/or email address that beneficiaries use to seek assistance from the BSS through electronic means.	Free text	
C1.IX.2	BSS auxiliary aids and services	42 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. Describe how 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)).	Free text	
C1.IX.3	BSS LTSS program data	Describe how 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, as required by 42 CFR 438.71(d)(4).	Free text	
C1.IX.4	State evaluation of BSS entity performance	Describe steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance.	Free text	
Topic X. Program Integrity				

C1.X.3	Prohibited affiliation disclosure	Did any plans disclose prohibited affiliations? If the state took action, as required under 42 CFR 438.610(d), please enter interventions on Tab D3 Sanctions and Corrective Action Plans.	Set values (select one)	

C2. Program-level, state-specific indicators: Availability, accessibility, and network adequacy

Context: 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.

Instructions: Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level, with each indicator on a separate row. Select drop downs or enter information in the beige cells in columns B-I >>

	Domain or standard type	Standard	Standard type	Provider type	Applicable region(s)	Population	Monitoring methods	Frequency of oversight methods
Data format:	Set values (select one)	Free text	Set values (select one) or use free text for "other" response	Set values (select one) or use free text for "other" response	Set values (select one) or use free text for "other" response	Set values (select one) or use free text for "other" response	Set values (allow multiple) or use free text for "other" response	Set values (select one) or use free text for "other" response
Topic V. Availability, Accessibility, and Network Adequacy								
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D1. Plan-level, set indicators

Input plan-level data in beige cells in these columns >>

#	Indicator	Instructions and definition	Data format	[Plan 1]	[Plan 2]	[Plan 3]	[Plan 4]	[Plan 5]	[Plan 6]	[Plan 7]	[Plan 8]	[Plan 9]	[Plan 10]	[Plan 11]	[Plan 12]	[Plan 13]	[Plan 14]	[Plan 15]	[Plan 16]	[Plan 17]	[Plan 18]	[Plan 19]	[Plan 20]	[Plan 21]	[Plan 22]	[Plan 23]	[Plan 24]	[Plan 25]	[Plan 26]	[Plan 27]	[Plan 28]	[Plan 29]	[Plan 30]	[Plan 31]	[Plan 32]	[Plan 33]	[Plan 34]	[Plan 35]
Topic I: Program Characteristics and Enrollment																																						
D1.I.1	Plan enrollment	Enter total number of individuals enrolled in each plan as of the first day of the last month of	Count																																			
D1.I.2	Plan share of Medicaid	Sum of enrollment in the plan (within the specific program) as a percentage of total Medicaid enrollment in the state • Numerator: Plan enrollment (indicator D1.I.1)	Percentage (calculated) *Note: No data entry required; this cell is*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D1.I.3	Plan share of any Medicaid managed care	Sum of enrollment in a given plan (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care. • Numerator: Plan enrollment (indicator D1.I.1)	Percentage (calculated) *Note: No data entry required; this cell is*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Topic II. Financial Performance																																						
D1.II.1a	Medical Loss Ratio (MLR): Aggregate value	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. Indicate below in D1.II.1b the level of aggregation of the reported MLR. 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.4 below. See glossary for the regulatory definition of MLR.	Percentage																																			
D1.II.1b	Aggregate MLR value: Level of aggregation	As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations. Select the aggregation level that best describes	Set values (select one) or use free text for "other"																																			
D1.II.2	Population specific MLR description	If the state requires plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees, describe the populations here. If the state does not require this, write "N/A." See glossary for the	Free text																																			
D1.II.3	MLR reporting period	If the data reported in item D1.II.1a covers a different time period than the MCPAR report, use	Free text																																			
Topic III. Encounter Data																																						
D.1.III.1	Definition of timely encounter data submissions	Describe the state's standard for timely encounter data submissions.	Free text																																			
D1.III.2	Share of encounter data submissions that met state's timely submission requirements	Enter the percentage of the plan's encounter data file submissions (submitted during the reporting period) that 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	Percentage																																			
D1.III.3	Share of encounter data submissions that were HIPAA compliant	Enter the percentage of the plan's encounter data submissions (submitted during the reporting period) that 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.	Percentage																																			
Topic IV. Grievance, Appeals, and State Fair Hearings																																						
Subtopic: Appeals																																						
D1.IV.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.	Count																																			
D1.IV.2	Active appeals	Enter the total number of appeals still pending or in process (not yet resolved) as of the first	Count																																			
D1.IV.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. 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	Count																																			
D1.IV.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. 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. If the managed care plan does not cover LTSS, the state should write "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 write "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 an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	Count																																			
D1.IV.5a	Standard appeals for which timely resolution was provided	Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. (See 42 CFR §438.408(b)(2) for requirements related to timely	Count																																			
D1.IV.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	Count																																			
D1.IV.6a	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	Count																																			
D1.IV.6b	Appeals related to reduction, suspension, or termination of a	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.	Count																																			
D1.IV.6c	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	Count																																			
D1.IV.6d	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).	Count																																			
D1.IV.6e	Appeals related to lack of timely plan response to an appeal or	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)	Count																																			
D1.IV.6f	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	Count																																			
D1.IV.6g	Appeals related to denial of an enrollee's request to dispute	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.	Count																																			
Number of appeals resolved during the reporting period related to the following services: *(A single appeal may be related to multiple service types and may therefore be counted in multiple categories below.)*			(none)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)
D1.IV.7a	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. Please 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	Count																																			
D1.IV.7b	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	Count																																			
D1.IV.7c	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	Count																																			
D1.IV.7d	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	Count																																			
D1.IV.7e	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	Count																																			
D1.IV.7f	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,	Count																																			
D1.IV.7g	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	Count																																			
D1.IV.7h	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	Count																																			
D1.IV.7i	Appeals related to non-emergency medical transportation	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".	Count																																			
D1.IV.7j	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".	Count																																			
Subtopic: State Fair Hearings and External Medical Reviews By Originating Plan																																						
D1.IV.8a	State Fair Hearing requests	Enter the total number of requests for a State Fair Hearing filed during the reporting year by or on behalf of enrollees from the plan that issued the adverse benefit determination.	Count																																			
D1.IV.8b	State Fair Hearings resulting in a favorable decision for the	Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	Count																																			
D1.IV.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.	Count																																			
D1.IV.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	Count																																			
D1.IV.9a	External Medical Reviews resulting in a favorable decision for the enrollee	External medical review is defined and described at 42 CFR §438.402(c)(i)(B). If your state does not offer an external medical review process, please enter "N/A". If your state does offer an external medical review process, provide the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to	Count or N/A																																			
D1.IV.9b	External Medical Reviews resulting in an adverse decision for the enrollee	External medical review is defined and described at 42 CFR §438.402(c)(i)(B). If your state does not offer an external medical review process, please enter "N/A". 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.	Count or N/A																																			
Subtopic: Grievances																																						
D1.IV.10	Grievances resolved	Enter the total number of grievances resolved by the plan during the reporting year. A	Count																																			
D1.IV.11	Active grievances	Enter the total number of grievances still pending or in process (not yet resolved) as of the	Count																																			
D1.IV.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	Count																																			
D1.IV.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 an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	Count																																			
D1.IV.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	Count																																			
Number of grievances resolved by plan during the reporting period related to the following services: *(A single grievance may be related to multiple service types and may therefore be counted in multiple categories below.)*			(none)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)
D1.IV.15a	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. Please 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	Count																																			
D1.IV.15b	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. Please 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	Count																																			
D1.IV.15c	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	Count																																			
D1.IV.15d	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	Count																																			
D1.IV.15e	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	Count																																			
D1.IV.15f	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	Count																																			
D1.IV.15g	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	Count																																			
D1.IV.15h	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,	Count																																			
D1.IV.15i	Grievances related to non-emergency medical transportation	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".	Count																																			
D1.IV.15j	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".	Count																																			
Number of grievances resolved by plan during the reporting period related to the following reasons: *(A single grievance may be related to multiple reasons and may therefore be counted in multiple categories below.)*			(none)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)	(header/blank cell)
D1.IV.16a	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.	Count																																			
D1.IV.16b	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.	Count																																			
D1.IV.16c	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.	Count																																			
D1.IV.16d	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	Count																																			
D1.IV.16e	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.	Count																																			
D1.IV.16f	Grievances related to payment or	Enter the total number of grievances resolved during the reporting period that were filed for a	Count																																			
D1.IV.16g	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 state Ombudsman or Office of the Inspector General.	Count																																			
D1.IV.16h	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	Count																																			
D1.IV.16i	Grievances related to lack of timely plan response to a service authorization or appeal request (including requests to expedite or	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).	Count																																			
D1.IV.16j	Grievances related to plan denial of request for an 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 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	Count																																			
D1.IV.16k	Grievances filed for other	Enter the total number of grievances resolved during the reporting period that were filed for a	Count																																			
Topic X. Program Integrity																																						
D1.X.1	Dedicated program integrity staff	Report the number of dedicated program integrity staff for routine internal monitoring and	Count																																			
D1.X.2	Count of opened program	Enter the count of program integrity investigations opened by the plan in the past year.	Count																																			
D1.X.3	Ratio of opened program integrity investigations	Enter 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.	Ratio																																			
D1.X.4	Count of resolved program	Enter the count of program integrity investigations resolved by the plan in the past year.	Count																																			
D1.X.5	Ratio of resolved program	Enter the ratio of program integrity investigations resolved by the plan in the past year per	Ratio																																			
D1.X.6	Referral path for program integrity referrals to the state	Select the referral path that the plan uses to make program integrity referrals to the state: - If the plan makes referrals to the Medicaid Fraud Control Unit (MFCU) only. - If the plan makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently.	Set value (select one)																																			

D1.X.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 using the referral path selected in indicator D1.X.6 · If the plan makes referrals to the MFCU only, enter the count of referrals made. · If the plan makes referrals to the SMA and MFCU concurrently, enter the count of unduplicated referrals. · If the plan makes some referrals to the SMA and others directly to the MFCU, enter the count of referrals made to the SMA and the MFCU in aggregate.	Count																																			
D1.X.8	Ratio of program integrity referrals to the state	Enter the ratio of program integrity referrals listed in indicator D1.X.7 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.	Ratio																																			
D1.X.9	Plan overpayment reporting to the state	Summarize 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 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)	Free text																																			
D1.X.10	Changes in beneficiary circumstances	Select the frequency the plan reports changes in beneficiary circumstances to the state.	Set values (select one)																																			

D2. Plan-level, state-specific indicators: Quality and Performance Measures

Guidance: Per 42 CFR 438.340(c)(3), the Management and Program Annual Report must provide information on and an assessment of the operation of the managed care program including an update on items, PIHP- or MAP-specific issues as needed. Please refer to the specific requirements listed in the Table for further clarification/examples of specific issues.

Describe the measures the state uses to monitor quality and performance by collecting data related to utilization and access to care, outcomes, and other aspects of performance for the managed care program. Please include any measures that are required by the state, as well as any measures that are tracked by the state's managed care plans. Please note that the measures listed in this table are not intended to be exhaustive. Please add rows as needed.

Please refer to the Table Guidance tab for additional information and examples.

Domain	NQF #	Measure name	Measure steward (i.e., organization that collects and reports measure)	Measure is a(n)	Measure description	[Plan 1]	[Plan 2]	[Plan 3]	[Plan 4]	[Plan 5]	[Plan 6]	[Plan 7]	[Plan 8]	[Plan 9]	[Plan 10]	[Plan 11]	[Plan 12]	[Plan 13]	[Plan 14]	[Plan 15]	[Plan 16]	[Plan 17]	[Plan 18]	[Plan 19]	[Plan 20]	[Plan 21]	[Plan 22]	[Plan 23]	[Plan 24]	[Plan 25]	[Plan 26]	[Plan 27]	[Plan 28]	[Plan 29]	[Plan 30]	[Plan 31]	[Plan 32]	[Plan 33]	[Plan 34]	[Plan 35]
Text values (enter one or two from list) or "Other" (specify)	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text	Free text
Access, timeliness, and efficiency of care																																						
Behavioral health services																																						
Care coordination																																						
Health care quality outcomes																																						
Health care utilization																																						

D3. Plan-level, state-specific indicators: Sanctions and Corrective Action Plans

Context: 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.

Describe sanctions and corrective action plans that the state has issued to the plan by selecting drop downs or entering information in the beige cells in columns A-J. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Use one row per action.

Domain	Intervention type	Intervention topic	Plan name	Reason for intervention	Instances (#) of noncompliance	Amount	Date assessed	Remediation date non-compliance was corrected	Has plan had CAP or had an intervention for similar reasons within the previous two years
Set values (select one) or use free text for "other" response	Set values (select one) or use free text for "other" response	Set values (select multiple) or use free text for "other" response	Set values (select one) *Note: list will autopopulate with plan names listed on the cover*	Free text	Count	Dollar	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Set values (select one)
Topic VIII. Sanctions and Corrective Action Plans									

E. Beneficiary support system (BSS) entities, set indicators

Context: 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 reported in tab C1, Topic IX.

#	Indicator	Instructions and definition	Data format	Input data in the beige cells in these columns >> [BSS Entity 1]	[BSS Entity 2]	[BSS Entity 3]	[BSS Entity 4]	[BSS Entity 5]	[BSS Entity 6]	[BSS Entity 7]	[BSS Entity 8]	[BSS Entity 9]	[BSS Entity 10]
Topic IX. Beneficiary Support System													
E.IX.1	BSS entity type	Select type of entity contracted to perform each BSS activity specified at 42 CFR 438.71(b).	Set values (select multiple) or use free text for "other" response										
E.IX.2	BSS entity role	Select roles that the contracted BSS entity performs, specified at 42 CFR 438.71(b).	Set values (select multiple) or use free text for "other" response										

Glossary

This tab defines key terms used in the workbook. DO NOT INPUT INFORMATION INTO THIS TAB.

Term	Acronym	Definition/ specification
Beneficiary Support System	BSS	As defined at 42 CFR 438.71, a BSS provides support to beneficiaries both prior to and after enrollment in a MCO, PIHP, PAHP, PCCM or PCCM entity. The BSS must provide at a minimum: (i) Choice counseling for all beneficiaries, (ii) Assistance for enrollees in understanding managed care. (iii) Assistance as specified for enrollees who use, or express a desire to receive, LTSS in paragraph (d) of this section. (2) The beneficiary support system must perform outreach to beneficiaries and/or authorized representatives and be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested....(d) Functions specific to LTSS activities: (1) An access point for complaints and concerns about plan enrollment, access to covered services, and other related matters. (2) Education on enrollees' grievance and appeal rights; the State fair hearing process; enrollee rights and responsibilities; and additional resources outside of the MCO, PIHP or PAHP. (3) Assistance, upon request, in navigating the plan grievance and appeal process, as well as appealing adverse benefit determinations by a plan to a State fair hearing. (4) Review and oversight of LTSS program data to provide guidance to the State Medicaid Agency on identification, remediation and resolution of systemic issues.
Corrective action plan	CAP	A corrective action plan is a step by step plan of action that is developed to achieve targeted outcomes for resolution of identified errors in an effort to: (1) identify the most cost-effective actions that can be implemented to correct error causes; (2) develop and implement a plan of action to improve processes or methods so that outcomes are more effective and efficient; (3) achieve measureable improvement in the highest priority areas; and (4) eliminate repeated deficient practices.
Critical incident	--	CMS uses the term "critical incident" to refer to events that adversely impact enrollee health and welfare and the achievement of quality outcomes identified in the person centered plan. However, the exact definition of "critical incident" and the categories that managed care plans are required to report is defined by each state.
Encounter data validation	--	The act of 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 the 2019 State Toolkit for Validating Medicaid Encounter Data for examples of intrafield, interfield, interfile and intersource validation tests that states can use to evaluate encounter data quality. The toolkit is available at: https://www.medicaid.gov/medicaid/downloads/ed-validation-toolkit.pdf.
LTSS user	--	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 filed).
Managed care organization	MCO	Consistent with 42 CFR 438.2, Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is (1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or (2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions: (i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity, (ii) Meets the solvency standards of § 438.116.
Managed care plan	MCP	Consistent with 42 CFR 438.66, this document uses the term “managed care plan” to refer to MCO, PIHP, PAHP, and PCCM entities
Managed care program	--	Consistent with 42 CFR 438.2, Managed care program means a managed care delivery system operated by a State as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act. For purposes of the MCPAR, a program is defined by a specified set of benefits and eligibilty criteria that is articulated in a contract between the state and managed care plans, and that has associated rate cells.
Managed long-term services and supports	MLTSS	Managed Long Term Services and Supports (MLTSS) refers to the delivery of long term services and supports through capitated Medicaid managed care programs.
Medical Loss Ratio	MLR	As specified under 42 CFR 438.8(d)-(h), MLR is the sum of an MCP’s incurred claims, quality expenditures, and fraud prevention expenditures divided by its adjusted premium revenue. The MCP’s adjusted premium revenue is its aggregated premium revenue minus taxes, licensing, and regulatory fees. For states that mandate minimum MLR values for MCPs, minimum values must be at least 85 percent under 42 CFR 438.8(c).
Non-emergency medical transportation	NEMT	Medicaid agencies are reqired to ensure necessary transportation for beneficiaries to and from providers. For situations that do not involve an immediate threat to the life or health of an individual, this requirement is usually called “non-emergency medical transportation,” or NEMT.
Premium deficiency reserve	PDR	Premium deficiency reserve (PDR) indicates whether future premiums plus current reserves are enough to cover future claim payments and expenses for the remainder of a contract period.
Prepaid ambulatory health plan	PAHP	Consistent with 42 CFR 438.2, Prepaid ambulatory health plan (PAHP) means an entity that (1) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates; (2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract.
Prepaid inpatient health plan	PIHP	Consistent with 42 CFR 438.2, Prepaid inpatient health plan (PIHP) means an entity that (1) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates; (2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract.
Primary care case management	PCCM	Consistent with 42 CFR 438.2, Primary care case management means a system under which: (1) A primary care case manager (PCCM) contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries; or (2) A PCCM entity contracts with the State to provide a defined set of functions.

Primary care case management entity	PCCM entity	Consistent with 42 CFR 438.2, Primary care case management entity (PCCM entity) means an organization that provides any of the following functions, in addition to primary care case management services, for the State: (1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line; (2) Development of enrollee care plans; (3) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program; (4) Provision of payments to FFS providers on behalf of the State; (5) Provision of enrollee outreach and education activities; (6) Operation of a customer service call center; (7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement; (8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers; (9) Coordination with behavioral health systems/providers; (10) Coordination with long-term services and supports systems/providers.
Reporting period /Reporting year	--	The 12-month period of the contract term (i.e. the contract year) for which the state is reporting information to CMS. Reporting year may also correspond to “rating period.”
Risk-based capital	RBC	Risk-based capital (RBC) measures the percentage of the required minimum capital that the MCP is holding. The MCP’s minimum capital is calculated using a standard formula that measures the risk of insolvency.
Sanction		Sanctions are enforcement actions taken against a managed care plans. Such actions include monetary and other forms of remedies, such as suspending all or part of new member enrollments, and suspending or terminating all or part of the contract.

Crosswalk of MCPAR indicators by tab

				Tab identifier ➤	A	B	C1	C2	D1	D2	D3	E
				Reporting level ➤	Cover sheet	State-level	Program-level		Plan-level			BSS-level
				Indicator type* ➤	Set	Set	Set	Free	Set	Free		Set
#	**Indicator**	**Instructions and definition**	**Data format**									
n/a	**Identifying information on the state, program, plan, and BSS being reported**				**X**							
n/a	Point of contact and email address	(see Tab A)			X							
n/a	Date of report submission	(see Tab A)			X							
n/a	Reporting period start and end date	(see Tab A)			X							
n/a	Name of the state, program, plans, and BSS entities being reported on	(see Tab A)			X							
I	**Program Characteristics and Enrollment****					**X**	**X**		**X**			
B.I.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.	Count			X						
B.I.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.	Count			X						
C1.I.1	Program contract	Enter the title and date of the contract between the state and plans participating in the managed care program.	Free Text				X					
C1.I.2	Contract URL	Enter the hyperlink to the model contract or landing page for executed contracts for the program being reported in the MCPAR.	Free Text (hyperlink)				X					
C1.I.3	Program type	Select the type of MCPs that contract with the state to provide the services covered under the program. Select one of the allowed values.	Set values (select one)				X					
C1.I.4.a	Special program benefits	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 should not be listed here.)	Set values (select multiple)				X					
C1.I.4.b	Variation in special benefits	Please note any variation in the availability of special benefits within the program (e.g. by service area or population). Enter "N/A" if not applicable.	Free text				X					
C1.I.5	Program enrollment	Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	Count				X					
C1.I.6	Changes to enrollment or benefits	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.	Free text				X					
D1.I.1	Plan enrollment	Enter total number of individuals enrolled in each plan as of the first day of the last month of the reporting year.	Count						X			
D1.I.2	Plan share of Medicaid	Sum of enrollment in the plan (within the specific program) as a percentage of total Medicaid enrollment in the state • Numerator: Plan enrollment (indicator D1.I.1) • Denominator: Statewide Medicaid enrollment (indicator B.I.1)	Percentage (calculated) *Note: No data entry required; this cell is autopopulated*						X			
D1.I.3	Plan share of any Medicaid managed care	Sum of enrollment in a given plan (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care. • Numerator: Plan enrollment (indicator D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (indicator B.I.2)	Percentage (calculated) *Note: No data entry required; this cell is autopopulated*						X			
II	**Financial Performance**								**X**			
D1.II.1a	Medical Loss Ratio (MLR): Aggregate value	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. Indicate below in D1.II.1b the level of aggregation of the reported MLR. 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.4 below. See glossary for the regulatory definition of MLR.	Percentage						X			
D1.II.1b	Aggregate MLR value: Level of aggregation	As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations. Select the aggregation level that best describes the MLR being reported in indicator D1.II.1a for each plan.	Set values (select one) or use free text for "other" response						X			

D1.II.2	Population specific MLR description	If the state requires plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees, describe the populations here. If the state does not require this, write "N/A." See glossary for the regulatory definition of MLR.	Free text					X			
D1.II.3	MLR reporting period discrepancies	If the data reported in items D1.II.1a covers a different time period than the MCPAR report, use this space to note the start and end date for that data.	Free text					X			
III	**Encounter Data Reporting**				**X**	**X**		**X**			
B.III.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 defintion for more information.)	Set values (select multiple) or use free text for "other" response		X						
B.III.2	HIPAA compliance of proprietary system(s) for encounter data validation	If state selected “proprietary system(s)” in indicator B.III.1, indicate whether the system(s) utilized are fully HIPAA compliant.	Set values (select one)		X						
C1.III.1	Uses of encounter data	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)). Select purposes for which the state uses encounter data collected from managed care plans (MCPs).	Set values (select multiple) or use free text for "other" response			X					
C1.III.2	Criteria/ measures used to evaluate MCP performance	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). Select types of measures used by the state to evaluate managed care plan performance in encounter data submission and correction.	Set values (select multiple) or use free text for "other" response			X					
C1.III.3	Encounter data performance criteria contract language	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.	Free text			X					
C1.III.4	Financial penalties contract language	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. Use contract section references, not page numbers.	Free text			X					
C1.III.5	Incentives for encounter data quality	Describe the types of incentives that may be awarded to managed care plans for encounter data quality	Free text			X					
C1.III.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.	Free text			X					
D.1.III.1	Definition of timely encounter data submissions	Describe the state's standard for timely encounter data submissions.	Free text					X			
D1.III.2	Share of encounter data submissions that met state’s timely submission requirements	Enter the percentage of the plan’s encounter data file submissions (submitted during the reporting period) that 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.	Percentage					X			
D1.III.3	Share of encounter data submissions that were HIPAA compliant	Enter the percentage of the plan’s encounter data submissions (submitted during the reporting period) that 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.	Percentage					X			
IV	**Grievance, Appeals, and State Fair Hearings**					**X**		**X**			
C1.IV.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, provide the definition that the state uses for "critical incidents" within the managed care program. If the managed care program does not cover LTSS, the state should respond "N/A."	Free text or N/A			X					
C1.IV.2	State definition of "timely" resolution for standard appeals	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. Describe the state's definition of timely resolution for standard appeals in the managed care program.	Free text			X					
C1.IV.3	State definition of "timely" resolution for expedited appeals	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. Describe in the state's definition of timely resolution for expedited appeals in the managed care program.	Free text			X					

C1.IV.4	State definition of "timely" resolution for grievances	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. Describe the state's definition of timely resolution for grievances in the managed care program.	Free text				X					
	Subtopic: Appeals								**X**			
D1.IV.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.	Count						X			
D1.IV.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.	Count						X			
D1.IV.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. 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). If not applicable, write "N/A."	Count						X			
D1.IV.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. 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. If the managed care plan does not cover LTSS, the state should write "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 write "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 an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	Count or N/A						X			
D1.IV.5a	Standard appeals for which timely resolution was provided	Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. (See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.)	Count						X			
D1.IV.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.)	Count						X			
D1.IV.6a	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)	Count						X			
D1.IV.6b	Appeals related to reduction, suspension, or termination of a previously authorized service	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.	Count						X			
D1.IV.6c	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.	Count						X			
D1.IV.6d	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).	Count						X			
D1.IV.6e	Appeals related to lack of timely plan response to an appeal or grievance	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.	Count						X			
D1.IV.6f	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)	Count						X			
D1.IV.6g	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.	Count						X			
(A single appeal may be related to multiple service types and may therefore be counted in multiple categories below.)									X			

D1.IV.7a	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. Please 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".	Count					X			
D1.IV.7b	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".	Count					X			
D1.IV.7c	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".	Count					X			
D1.IV.7d	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".	Count					X			
D1.IV.7e	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 oupatient prescription drugs, enter "N/A".	Count					X			
D1.IV.7f	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".	Count					X			
D1.IV.7g	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".	Count					X			
D1.IV.7h	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".	Count					X			
D1.IV.7i	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".	Count					X			
D1.IV.7j	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".	Count					X			
	Subtopic: State Fair Hearings and External Medical Reviews By Originating Plan							**X**			
D1.IV.8a	State Fair Hearing requests	Enter the total number of requests for a State Fair Hearing filed during the reporting year by or on behalf of enrollees from the plan that issued the adverse benefit determination.	Count					X			
D1.IV.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.	Count					X			
D1.IV.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.	Count					X			
D1.IV.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	Count					X			
D1.IV.9a	External Medical Reviews resulting in a favorable decision for the enrollee	External medical review is defined and described at 42 CFR §438.402(c)(i)(B). If your state does not offer an external medical review process, please enter N/A. If your state does offer an external medical review process, provide the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	Count or N/A					X			
D1.IV.9b	External Medical Reviews resulting in an adverse decision for the enrollee	External medical review is defined and described at 42 CFR §438.402(c)(i)(B). If your state does not offer an external medical review process, please enter N/A. 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.	Count or N/A					X			
	Subtopic: Grievances							**X**			
D1.IV.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.	Count					X			

D1.IV.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.	Count					X							
D1.IV.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 filed).	Count					X							
D1.IV.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 an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	Count					X							
D1.IV.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.)	Count					X							
(A single grievance may be related to multiple service types and may therefore be counted in multiple categories below.)			(none)					X							
D1.IV.15a	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. Please 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".	Count					X							
D1.IV.15b	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. Please 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".	Count					X							
D1.IV.15c	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".	Count					X							
D1.IV.15d	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".	Count					X							
D1.IV.15e	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".	Count					X							
D1.IV.15f	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".	Count					X							
D1.IV.15g	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".	Count					X							
D1.IV.15h	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".	Count					X							
D1.IV.15i	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".	Count					X							
D1.IV.15j	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".	Count					X							
(A single grievance may be related to multiple reasons and may therefore be counted in multiple categories below.)			(none)					X							

D1.IV.16a	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.	Count					X			
D1.IV.16b	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.	Count					X			
D1.IV.16c	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.	Count					X			
D1.IV.16d	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.	Count					X			
D1.IV.16e	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.	Count					X			
D1.IV.16f	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.	Count					X			
D1.IV.16g	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 state Ombudsman or Office of the Inspector General.	Count					X			
D1.IV.16h	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.	Count					X			
D1.IV.16i	Grievances related to lack of timely plan response to a service authorization or appeal request (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).	Count					X			
D1.IV.16j	Grievances related to plan denial of request for an 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 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.)	Count					X			
D1.IV.16k	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.	Count					X			
V	**Availability, Accessibility, and Network adequacy**					**X**	**X**				
C1.V.1	Gaps/challenges in network adequacy	Describe any challenges to maintaining adequate networks and meeting standards. What are the state's biggest challenges?	Free text			X					
C1.V.2	State response to gaps in network adequacy	Describe how the state works with MCPs to address these gaps.	Free text			X					
C2	State-specific measures used to monitor availability, accessibility, and network adequacy.	(see Tab C2)					X				
VII	**Quality and Performance Measures**								**X**		

D2	State-specific measures used to monitor quality and performance across 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.	(see Tab D2)							X		
VIII	**Sanctions and Corrective Action Plans****									**X**	
D4	List of sanctions, administrative penalties, and corrective action plans that the state has issued to plans.	(see Tab D4)								X	
IX	**Beneficiary Support System (BSS)**			**X**	**X**	**X**					**X**
n/a	Name of the BSS entities being reported on	(see Tab A)	Free text	X							
C1.IX.1	BSS website	Indentify the website and/or email address that beneficiaries use to seek assistance from the BSS through electronic means.	Free text			X					
C1.IX.2	BSS auxiliary aids and services	42 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. Describe how 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)).	Free text			X					
C1.IX.3	BSS LTSS program data	Describe how 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, as required by 42 CFR 438.71(d)(4).	Free text			X					
C1.IX.4	State evaluation of BSS entity performance	Describe steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance.	Free text			X					
E.IX.1	BSS entity type	Select type of entity contracted to perform each BSS activity specified at 42 CFR 438.71(b).	Set values (select multiple) or use free text for "other" response								X
E.IX.2	BSS entity role	Select roles that the contracted BSS entity performs, specified at 42 CFR 438.71(b).	Set values (select multiple) or use free text for "other" response								X
X	**Program Integrity**				**X**	**X**		**X**			
B.X.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 (such as 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.	Free text		X						
B.X.2	Contract standard for overpayments	Indicate whether the state allows plans to retain overpayments, requires the return of overpayments, or has established a hybrid system.	Set values (select one)		X						
B.X.3	Contract locations of overpayment standard	Identify where the overpayment standard in indicator B.X.2 is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Free text		X						
B.X.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	Free text		X						
B.X.5	State overpayment reporting monitoring	Describe how the state monitors plan performance in reporting overpayments to the state. For example, does the state track compliance with this requirement and/or timeliness of reporting?	Free text		X						
B.X.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).	Free text		X						

B.X.7.a	Changes in provider circumstances: Part 1	Indicate if the state monitors whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4).	Set values (select one)		X						
B.X.7.b	Changes in provider circumstances: Part 2	If the state monitors whether plans report provider “for cause” terminations in a timely manner in indicator B.X.7.a, indicate whether the state uses a metric or indicator to assess plan reporting performance.	Set values (select one)		X						
B.X.7.c	Changes in provider circumstances: Part 3	If the state uses a metric or indicator to assess plan reporting performance in indicator B.X.7.b, describe the metric or indicator that the state uses.	Free text		X						
B.X.8a	Federal database checks: Part 1	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. In the course of the state's federal database checks, did the state find any person or entity excluded?	Set values (select one)		X						
B.X.8b	Federal database checks: Part 2	If in the course of the state's federal database checks the state found any person or entity excluded, please 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 in Tab D3 as applicable. Enter N/A if not applicable.	Free text		X						
B.X.9a	Website posting of 5 percent or more ownership control [Y/N]	Report whether the state posts 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 following §455.104 and required by 42 CFR 438.602(g)(3).	Set values (select one)		X						
B.X.9b	Website posting of 5 percent or more ownership control [link]	If the state posts on its website the names of the plan individuals with 5% or more ownership or control, under 42 CFR 602(g)(3), provide a link to the website. Enter N/A if not applicable.	Free text		X						
B.X.10	Periodic audits [link]	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 under 42 CFR 438.602(e), provide the link(s) to the audit results.	Free text		X						
C1.X.3	Prohibited affiliation disclosure	Did any plans disclose prohibited affiliations? Y/N. If the state took action, as required under 42 CFR 438.610(d), please enter interventions on Tab D3 Sanctions and Corrective Action Plans.	Set values (select one)			X					
D1.X.1	Dedicated program integrity staff	Report the number of dedicated program integrity staff for routine internal monitoring and compliance risks as required under 42 CFR 438.608(a)(1)(vii).	Count					X			
D1.X.2	Count of opened program integrity investigations	Enter the count of program integrity investigations opened by the plan in the past year.	Count					X			
D1.X.3	Ratio of opened program integrity investigations	Enter 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.	Ratio					X			
D1.X.4	Count of resolved program integrity investigations	Enter the count of program integrity investigations resolved by the plan in the past year.	Count					X			
D1.X.5	Ratio of resolved program integrity investigations	Enter 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.	Ratio					X			
D1.X.6	Referral path for program integrity referrals to the state	Select the referral path that the plan uses to make program integrity referrals to the state: · If the plan makes referrals to the Medicaid Fraud Control Unit (MFCU) only. · If the plan makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently. · If the plan makes some referrals to the SMA and others directly to the MFCU.	Set value (select one)					X			
D1.X.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 using the referral path selected in indicator D1.X.6 · If the plan makes referrals to the MFCU only, enter the count of referrals made. · If the plan makes referrals to the SMA and MFCU concurrently, enter the count of unduplicated referrals. · If the plan makes some referrals to the SMA and others directly to the MFCU, enter the count of referrals made to the SMA and the MFCU in aggregate.	Count					X			
D1.X.8	Ratio of program integrity referrals to the state	Enter the ratio of program integrity referrals listed in indicator D1.X.7 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.	Ratio					X			

D1.X.9	Plan overpayment reporting to the state	Summarize 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 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).	Free text					X			
D1.X.10	Changes in beneficiary circumstances	Select the frequency the plan reports changes in beneficiary circumstances to the state.	Set values (select one)					X			

* Standardized or pre-set indicators cover specific information that CMS would like reported consistently across all programs and plans (for example, enrollment count). State-specific or free indicators cover information that will vary based on what a state collects from its plans (for example, access measures).

** Denotes sections that are required for PCCM entities, per 438.66(e)(2).