

Instructions

Regulations at 42 C.F.R. § 438.207(a) - (c) require Medicaid managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs)—collectively referred to as “managed care plans”—to submit documentation to the state demonstrating their capacity to serve the expected enrollment of their service areas in accordance with the state’s standards for access to care, including the state’s network adequacy and availability of services standards under 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206. Managed care plans are required to submit this information to the state no less frequently than:

Scenario 1: At the time the plan enters into a contract with the state;

Scenario 2: On an annual basis;

Scenario 3: At any time there has been a significant change (as defined by the state) in the plan’s operations that would affect the adequacy of capacity and services, including (1) changes in the plan’s services, benefits, geographic service area, composition of or payments to its provider network, or (2) enrollment of a new population in the plan.

After the state reviews the documentation submitted by a plan, 42 C.F.R. § 438.207(d) requires the state to submit to the Centers for Medicare & Medicaid Services (CMS) an assurance that the plan complies with the state’s network adequacy and availability of services standards under 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206. The submission must include documentation of an analysis that the state conducted to support its assurance of compliance for the plan.

This document provides instructions and a template for states to use when submitting this information to CMS under any of the three scenarios described above. States should complete one (1) form with information for applicable managed care plans and their applicable managed care programs. For example, if the state submits this form under scenario 1 above, the state should submit this form only for the managed care plan that entered into a new contract with the state. The state should not report on any other plans or programs. As another example, if the state submits this form under scenario 2, the state should submit this form for all managed care plans. If the state’s analysis methods and results are contained in separate documents, please also submit those documents with this form.

Consistent with the Managed Care Program Annual Report (MCPAR) required by 42 C.F.R. § 438.66(e), this report defines a program as having a specified set of benefits, eligibility criteria, and capitation rates that are articulated in a contract between the state and managed care plans.

MMPs are considered both Medicaid and Medicare managed care plans and are not exempt from 42 CFR 438.207. Therefore, states must submit the tool for integrated plans; however, to reduce duplication, states can complete network adequacy sections of the tool (II.A.1-II.A.5) for Medicaid-only covered services.

States do not need to submit the tool for Program of All-Inclusive Care for the Elderly (PACE) programs/plans as states are not required to do so under 42 CFR 438.207.

Please submit the completed form through an online portal that will be made available. Questions about this form may be directed to

ManagedCareTA@mathematica-mpr.com.

Organization

This template includes two sections (Section I and Section II). Section I covers descriptive information about the state and all of the managed care programs operating in the state; information for this section is contained in one tab. Section II includes detail on program-level access standards, monitoring methods, and plan-level compliance data. For Section II, states should use **one tab for each program** the state is reporting on and leave unused tabs blank.

Tab topic:	Tab name:	Number of tabs available:
I. State and program-level information	I_State&Prog_Info	1
II. Program-level standards, monitoring methods, and plan-level compliance	II_Prog_X	15

Inputting information

Each tab provides instructions in the “Item Instructions” column. Response types are provided in the “Data Format” columns. Only input values in BEIGE CELLS. Program names and program summary information (i.e., plan types included in a program, services covered under a program) in Section II autopopulates from Section I to reduce burden on states.

After reporting information on each applicable program in the Section II tabs, leave any unused tabs blank. For example, if the state is reporting on plans in five managed care programs, it should enter information in tabs “II_Prog_1” through “II_Prog_5”, and leave the remaining tabs blank.

