Managed Care Program Annual Report – Supplemental Information
Reporting Year 2025 (RY25)

The purpose of this document is to provide background and supplemental information about this report to aid in the interpretation of the data presented in the Department's annual managed care program report submission.

Background

The May 2016 Medicaid and CHIP managed care final rule strengthened state monitoring requirements and added new reporting requirements for states on their managed care programs. CMS has released a series of Informational Bulletins that included reporting templates and toolkits on managed care requirements and programmatic and operational best practices. These Informational Bulletins were published in June 2021, July 2022, November 2023, and June 2024.

The first two Informational Bulletins introduced and provided information on the following report templates: the Managed Care Program Annual Report (MCPAR) required in 42 CFR § 438.66(e), the Medical Loss Ratio (MLR) Summary Report required in 42 CFR § 438.74(a), and the Network Adequacy and Access Assurance Report (NAAAR) required in 42 CFR § 438.207(d) and (e). CMS developed these standardized templates and a web-based reporting portal to create a single submission process and repository for all reporting related to managed care. The templates for these reports can be found on CMS' Medicaid and CHIP Managed Care Reporting website. Additionally, CMS has made efforts to improve transparency by publicly posting Managed Care Program Annual Reports (MCPARs) on a regular basis on Medicaid.gov: Public Access to State Submitted MCPARs | Medicaid.

The third Informational Bulletin provided additional updates on the web-based reporting portal, the reporting requirements for managed care programs, CMS' process for review and approval of managed care contracts, rate certifications, and State directed payments, and announced the release of several new technical assistance toolkits. The fourth Informational Bulletin of the series announced efforts to expand web-based portal use for managed care reporting, contract, and rate submissions, provides reminders on Medicaid managed care and mental health and substance use disorder parity requirements, and outlines CMS' process for review and approval of managed care contracts.

As of August 2025, CMS updated the MCPAR template and the Frequently Asked Questions (FAQs). A link to the FAQ is attached: MCPAR Technical Assistance Resources for States FAQ

MCPAR – Supplemental Information

Excel Workbooks
The Excel template used to populate CMS' online reporting template is not embedded in the PDF of the report. Please note that the information contained in the PDF is the same information required in the MCPAR reporting template. As noted above, the MCPAR reporting template can be found on CMS' Medicaid and CHIP Managed Care Reporting website.

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

Please note that each DHS program submitted its NAAAR prior to the RY 2025 MCPAR submission due date.

Medical Loss Ratio (MLR)
Beginning July 2025, CMS eliminated the Medical Loss Ratio (MLR) percentage, aggregation and population measures, in effort to reduce duplication with MDCT reporting.

Plan Names
The Program Information section collects general program information and the name of each managed care plan that is participating in the program. In order to have information correctly reported in the CMS online reporting portal, DHS had to identify all relevant entities in the plan name field for indicator A.7, *Plan Name*. For Physical HealthChoices this required indicating both the zone level plan name and the statewide plan name because some metrics are reported at the zone level, such as enrollment and complaint and grievance data. Other measures, such as the quality measures and medical loss ratio are reported at the state level by plan. Behavioral Health-HealthChoices plan names include both the MCO name and all the primary contractors because some information is reported at the MCO level while other information is reported at the primary contractor level. All Community HealthChoices information is reported at the contract level.

Section F: Notes
For Reporting Year 2025 (RY25), CMS introduced a new free-text question at the end of the MCPAR, allowing states to provide additional context to their topical area responses.

Please refer to Section F Notes of the PDF reports for additional context provided in the final submission, as well as notes addressing specific CMS Portal entry nuances encountered in the RY25 submission process.

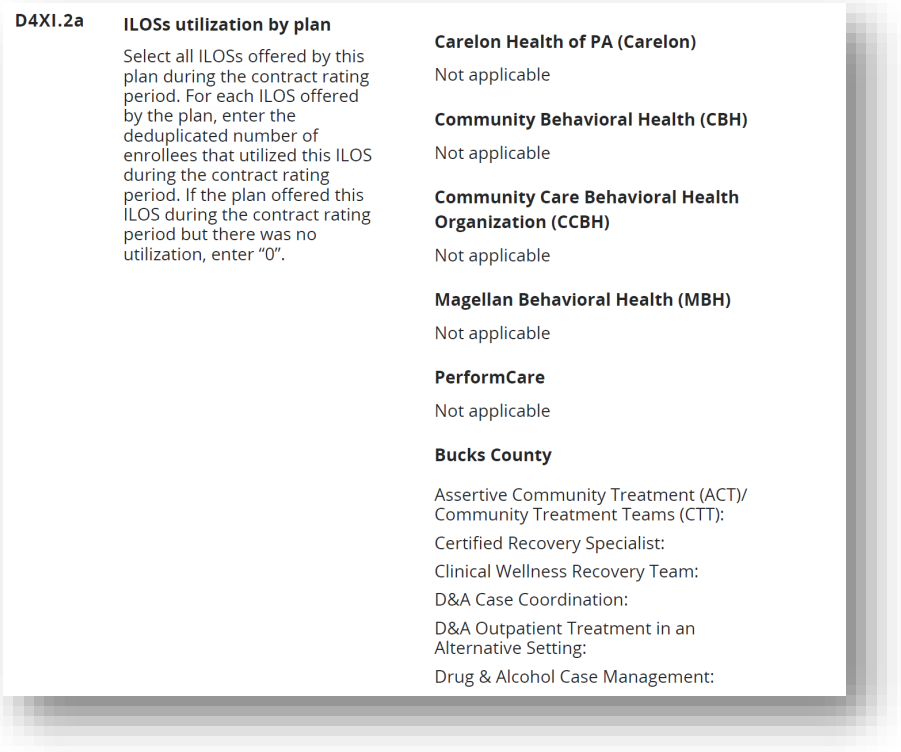
CMS Portal Entry Nuances
When DHS submitted data to CMS, the following portal entry nuances were identified:

Topic IV: Appeals, State Fair Hearings & Grievances
Note: The federal term "appeal" may include Pennsylvania "complaints" and "grievances". The federal term "grievance" is termed "complaints" in Pennsylvania.

- Use of Not Applicable or "N/A" when it does not apply to the respective program
    - PA used the "N/A" when it did not apply to the program. For example, PHC and BHC do not cover LTSS, so the report states "N/A".

Discrepancies
When DHS compared the RY25 data submitted to CMS against the PDF reports generated from the web-based reporting portal, DHS identified the following discrepancies:

Topic XI: In Lieu of Service (ILOS)
- The RY25 report posted for Behavioral Health-HealthChoices reflects a noted data entry nuance to measure D4.XI.2a, *ILOS Utilization by Plan*.
    - Where utilization data was provided in the CMS Portal, it is not reflected in the PDF extract pulled from the site, resulting in a "blank" response.
    - For example, in snippet below, Bucks County ILOS utilization appears "blank" on the PDF even though data was entered and submitted in the CMS Portal.



D4XI.2a	**ILOSs utilization by plan** Select all ILOSs offered by this plan during the contract rating period. For each ILOS offered by the plan, enter the deduplicated number of enrollees that utilized this ILOS during the contract rating period. If the plan offered this ILOS during the contract rating period but there was no utilization, enter "0".	**Carelon Health of PA (Carelon)** Not applicable **Community Behavioral Health (CBH)** Not applicable **Community Care Behavioral Health Organization (CCBH)** Not applicable **Magellan Behavioral Health (MBH)** Not applicable **PerformCare** Not applicable **Bucks County** Assertive Community Treatment (ACT)/ Community Treatment Teams (CTT): Certified Recovery Specialist: Clinical Wellness Recovery Team: D&A Case Coordination: D&A Outpatient Treatment in an Alternative Setting: Drug & Alcohol Case Management:

Topic XIII: Prior Authorization

- The RY25 reports posted for each program reflect a noted PDF extract discrepancy
    - Where data was provided in the CMS Portal, it is not reflected on the PDF extract pulled from the site, resulting in a “blank” response.

Topic XIV: Patient Access API Usage

- The RY25 reports posted for each program reflect a noted PDF extract discrepancy
    - Where data was provided in the CMS Portal, it is not reflected on the PDF extract pulled from the site, resulting in a “blank” response.