DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMCS Informational Bulletin

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FROM: Dan Brillman
Deputy Administrator, CMS
Director, Center for Medicaid and CHIP Services

SUBJECT: **Medicaid and CHIP Managed Care Monitoring and Oversight**

This Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CIB) provides resources to aid states' monitoring and oversight of managed care in Medicaid and the Children's Health Insurance Program (CHIP) to improve integrity and accountability in managed care programs.[1] CMCS expects that states oversee their managed care plans so that ultimately taxpayer dollars are used effectively and efficiently, beneficiaries realize the value of these financial investments states and the Federal government are making, and ensure rigorous program integrity contractual controls. One of the goals of managed care conceptually is to contain costs while ensuring high quality of care. CMCS expects that states will hold managed care plans accountable.

This CIB focuses on (1) summarizing recently released guidance related to managed care monitoring and oversight; (2) issuing reminders and clarifications on program operations, monitoring and oversight requirements, including notable items identified in findings and recommendations by oversight bodies, including the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) and Government Accountability Office (GAO), to help reduce fraud, waste, and abuse in managed care programs; (3) outlining managed care reporting requirements, including recent changes to reporting templates, to improve transparency; and (4) highlighting key managed care operational and program requirements.

Introduction

It is essential for states to monitor their managed care plans' compliance with federal requirements to ensure program and fiscal integrity in managed care, and states are required to have a monitoring system for their managed care programs. While states have flexibility in how they design their monitoring system, it must demonstrably address all aspects of their managed

[1] Additional CIBs on managed care monitoring and oversight can be found here: https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-monitoring-and-oversight-initiative

care program(s) and plan performance for at least the 14 specific program areas enumerated at 42 CFR § 438.66(b) (applicable in CHIP through a cross-reference at 42 CFR § 457.1285), including claims management, finance, program integrity, availability and accessibility of services, appeal and grievance systems, and quality improvement. Each state is required to use the data collected from its monitoring activities to improve the performance of its managed care program(s).[2] Federal regulations do not include an exhaustive list of performance areas in which data may be used for oversight; however, 42 CFR § 438.66(c) describes several types of data for various performance areas that are fundamental to Medicaid and CHIP managed care programs, such as audited financial and encounter data submitted by each managed care organization (MCO), prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP).

Managed Care Program Oversight

CMS is committed to continuing our work with states to improve access to care, quality, and health outcomes for Medicaid and CHIP beneficiaries while also improving program and fiscal integrity, reducing fraud, waste, and abuse, and ensuring that federal and state oversight is conducted in an efficient and effective manner. To aid states' monitoring and oversight activities in managed care programs, this section outlines recent relevant guidance, reminders and clarifications on program operations, monitoring and oversight based on findings and recommendations identified by oversight bodies, and notifies states of CMS reviews related to Medicaid managed care oversight.

Notable, Recent Guidance Related to Managed Care Monitoring and Oversight

2026-2027 and 2025-2026 Medicaid Managed Care Rate Development Guides
On February 19, 2026, CMS released the 2026-2027 Medicaid Managed Care Rate Development Guide[3] and CMS released the 2025-2026 Medicaid Managed Care Rate Development Guide on August 12, 2025.[4] States use these guides when setting rates with respect to any managed care program subject to federal actuarial soundness requirements during rating periods starting between July 1, 2026 and June 30, 2027, and July 1, 2025 and June 30, 2026 respectively. The guides provide detail on CMS's expectations of information to be included in actuarial rate certifications and are used as a basis for CMS's review.

Working Families Tax Cut Legislation
Public Law 119-21 (which CMS refers to as the Working Families Tax Cut (WFTC) legislation) was signed into law July 4, 2025. On November 18, 2025, CMS released a summary of Medicaid and CHIP related provisions in the WFTC legislation.[5] On February 2, 2026, CMS released revised guidance on section 71116[6] of the WFTC legislation related to state directed payments (SDPs) and rescinded guidance released on September 9, 2025.[7] Section 71116 directed CMS to revise 42 CFR § 438.6(c)(2)(iii) to reduce the total payment rate limit for SDPs for inpatient

[2] 42 CFR § 438.66(c); 42 CFR § 457.1285
[3] https://www.medicaid.gov/medicaid/managed-care/downloads/2026-2027-medicaid-rate-guide-022026.pdf
[4] https://www.medicaid.gov/medicaid/managed-care/downloads/2025-2026-medicaid-rate-guide-082025.pdf
[5] https://www.medicaid.gov/federal-policy-guidance/downloads/cib11182025.pdf
[6] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-letter-02022026.pdf
[7] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-ltr-09092025.pdf

hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center effective for rating periods beginning on or after July 4, 2025. Section 71116 also included a provision temporarily grandfathering certain SDPs until the rating period beginning on or after January 1, 2028. More details on the WFTC legislation, including other guidance released by CMS, can be found on Medicaid.gov.[8]

Medicaid Managed Care Payments and Emergency Medicaid
On September 30, 2025, CMS issued a State Medicaid Director (SMD) letter (25-003)[9] announcing an updated interpretation of section 1903(v) of the Social Security Act (the Act), which authorizes federal financial participation for care and services necessary for treatment of an emergency medical condition for aliens ineligible for full Medicaid benefits (often referred to as "emergency Medicaid"). Specifically, CMS announced a change in the agency's interpretation of how section 1903(v) of the Act applies to Medicaid managed care payments to improve program and fiscal integrity in the Medicaid program. Beginning with rating periods starting on or after September 30, 2026, aliens ineligible for full Medicaid benefits may not be included in risk-based Medicaid managed care, including risk-based capitation rate development or payments, SDPs, in lieu of services and settings (ILOSs), or in managed care contracts with primary care case managers (PCCMs) or primary care case management entities (PCCM entities). Additional details on these restrictions and state options for providing coverage for emergency Medicaid are outlined in the SMD letter.

State Directed Payment Quality Evaluations
On September 10, 2025, CMS issued a CIB outlining our expectations and existing regulatory requirements for state design and submission of SDP quality evaluation plans and findings.[10] This guidance explains that CMS will no longer deem an SDP preprint submission to be complete and eligible for federal review unless it includes minimum quality evaluation elements. Minimum documentation requirements for SDP preprints are outlined below in further detail in the section entitled "Minimum Documentation Standards for CMS to Begin Review." On September 10, 2025, CMS also published an optional template for states to report evaluation findings to CMS.[11]

Medical Loss Ratio (MLR) Plan-to-State Reporting Template
On July 28, 2025, CMS released a customizable template for states to optionally utilize with their MCOs, PIHPs, and PAHPs when plans report MLRs to states for Medicaid and CHIP managed care programs.[12] States can use this template to gather MLR information from plans that states need to fulfill their responsibility to submit summary MLR reports to CMS.[13] States and plans have previously requested that CMS develop a template to reduce their administrative burden, and the HHS-OIG recommended a template.[14]

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[8] https://www.medicaid.gov/working-families-tax-cut-legislation
[9] https://www.medicaid.gov/federal-policy-guidance/downloads/smd25003.pdf
[10] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/cib09102025.pdf
[11] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-ltr-evltn-findng-tmplte.pdf
[12] https://www.medicaid.gov/medicaid/managed-care/downloads/mlr-toolkit-template.xlsx
[13] 42 CFR § 438.74; 42 CFR § 457.1203(e)
[14] HHS-OIG. CMS Has Opportunities to Strengthen States' Oversight of Medicaid Managed Care Plans' Reporting of Medical Loss Ratios. September 2022.

MLR Toolkit
On September 30, 2024, CMS published an MLR toolkit[15] that provides states with practical information to support states' review, validation, and oversight of plans' Medicaid MLR reporting. The toolkit also includes recommendations for the collection, validation, and use of MLR data, guidance for key MLR policy areas as well as state examples for creating an effective financial monitoring system.

Reminders and Clarification on Managed Care Operations, Monitoring, and Oversight

Tailoring Network Adequacy Standards to Address Maternal Health Care Needs
In September 2024, the HHS-OIG released a report outlining ways states could better leverage coverage and access requirements to promote improved maternal health care access in Medicaid managed care.[16] Adopting network adequacy standards that are more specific to provider type, service, and/or level of care can provide states and their plans with clearer information to ensure enrollees are receiving appropriate services from appropriate providers to prevent unnecessary costs and duplicative services in line with right service, right provider, right time.

If obstetrical/gynecological (OB/GYN) care is covered under the contract between the state and plan, the state must develop and enforce at least one quantitative network adequacy standard for this provider type per 42 CFR § 438.68(b), cross-referenced for CHIP at 42 CFR § 457.1218.[17] The HHS-OIG found that many states had OB/GYN standards specific to physicians while others had standards that included a range of providers and noted that these differences among states may indicate that the requirement is not clearly or consistently understood. The HHS-OIG recommended that CMS clarify the OB/GYN network adequacy standard requirement and support states in tailoring their standards to better address maternal health care.

In response to these HHS-OIG recommendations, CMS is clarifying that states have flexibility to specify the provider types that MCOs, PIHPs, and PAHPs can use to meet the OB/GYN network adequacy standard. This existing requirement permits states to establish standards for providers of OB/GYN services generally, rather than for obstetricians and gynecologists only. States may include any providers who are authorized in their states to provide OB/GYN services, such as obstetricians and gynecologists (including maternal-fetal medicine specialists), family medicine physicians, certified nurse-midwives (CNMs), and other types of midwives. States have the option, but are not required, to cover services from professionals such as doulas, community health workers, and lactation consultants.

Many states may be missing opportunities to identify gaps in maternal health care access in managed care through their network adequacy standards. States may tailor their OB/GYN network adequacy standard(s) for maternal health care services by choosing to develop more detailed requirements, such as:

- Measuring availability of maternal health providers individually by provider type, which could help identify gaps for specific provider types.

[15] https://www.medicaid.gov/medicaid/managed-care/downloads/mlr-toolkit-sep-2024.pdf
[16] HHS-OIG. States Could Better Leverage Coverage and Access Requirements To Promote Maternal Health Care Access in Medicaid Managed Care. September 2024.
[17] 42 CFR §§ 438.68(b)(1)(ii), 438.68(a), 438.206, and 438.207; 42 CFR §§ 457.1218 and 457.1230(a) and (b)

- Developing multiple types of network adequacy standards, such as travel time and provider-to-enrollee ratios, to provide a more comprehensive assessment of access.
- Tailoring OB/GYN standards by service type, stage of pregnancy, and/or risk level, so that the stringency of the standard aligns with the most time-sensitive health factors.

Prior Authorization Decisions

In recent years, prior authorization has been a subject of increased scrutiny because of its pivotal role in the coverage of services. Both the HHS-OIG and GAO have released reports detailing concerns regarding state oversight of prior authorization decisions by MCOs, PIHPs, or PAHPs.

The HHS-OIG reviewed data on prior authorization denials and appeals from a total of 115 MCOs. It found that most surveyed state agencies did not routinely review the appropriateness of a sample of prior authorization denials, even for managed care plans with very high denial rates.[18] The HHS-OIG recommended that CMS issue guidance to states on the use of managed care plans' use of prior authorization data for oversight and work with states on actions to identify and address plans that may be issuing inappropriate prior authorization denials.

The GAO reviewed a sample of 5 states and found that less than half of states in their study reviewed any denials or appeals for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.[19] The GAO recommended CMS issue guidance (see SHO 24-005)[20] to clarify plans' ability to require prior authorization for EPSDT services and outline CMS's expectations on how states should monitor the appropriateness of managed care plans' prior authorization decisions.

States should monitor plans' prior authorization decisions in Medicaid and CHIP and have specific processes in place to ensure compliance with EPSDT requirements. States should analyze managed care plans' prior authorization metrics,[21] and other applicable data (e.g., data on enrollee grievances and appeals), to aid efforts to identify issues and take appropriate action to ensure program integrity in managed care programs and monitor plan performance. States should consider paying particular attention to:

- Trended or abrupt changes in prior authorization denial rates, including rates following an appeal.
- Outliers exceeding state-established thresholds that may indicate inappropriate denial practices (e.g., denial rates that are significantly above the average rate across the state's other plans).
- Comparing denial rates between plans in the same program or for the same plan contracted for multiple managed care programs in the state.

If data indicate a potential performance issue, the state and managed care plans should analyze the root cause(s) driving the problematic trend(s) and take appropriate action to remediate the issue. States should also explore methods to strengthen their monitoring and oversight of prior

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[18] HHS-OIG. High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care. July 2023.
[19] GAO. Managed Care Plans' Prior Authorization Decisions for Children Need Additional Oversight. April 2024.
[20] State Health Official (SHO) Letter 24-005 includes information on EPSDT requirements and prior authorizations.
[21] 42 CFR § 438.210(f); 42 CFR § 457.1230

authorization processes when necessary. For example, states could consider:

- Increasing specificity and accountability in contract language.
- Ensuring that process improvements are implemented by managed care plans in a timely manner, including recommendations by the external quality review organization.
- Reviewing a sample of prior authorization decisions, including reviewing data for children and adults separately, to identify trends or barriers to care that may be EPSDT-specific.
- Offering independent, external medical reviews for managed care enrollees when an enrollee appeals a managed care plan's prior authorization denial.

Medicaid Managed Care Oversight Reviews

Pursuant to CMS's oversight authority,[22] CMS implemented Medicaid Managed Care Oversight Reviews (MCORs) in 2025 as part of CMS's efforts to develop a broader range of monitoring and oversight tools that address complex managed care issues and fraud, waste, and abuse in managed care delivery systems. MCORs are an ongoing, structured method to improve compliance, assess potential changes to CMS managed care policy and operations, identify areas where states may benefit from enhanced technical assistance and/or corrective action. CMS will leverage data collected from standardized reporting tools (e.g., Managed Care Program Annual Report (MCPAR), Network Adequacy and Access Assurances report (NAAAR), Medical Loss Ratio (MLR) Summary Report) to inform MCOR selection and reviews, and may also collect additional information from the state(s) selected for each MCOR prior to developing recommendations. The first MCOR, in four select states notified in December 2025, analyzes (1) how states are using sanctions on managed care plans to address areas in need of improvement, and (2) whether states are reporting sanctions to CMS and returning the federal share of financial sanctions.

Managed Care Reporting

The managed care regulations require states to submit reports to CMS about their managed care programs on an annual or periodic basis, including:[23]

- MCPAR, required under 42 CFR § 438.66(e) (Medicaid only);
- MLR Summary Report, required under 42 CFR §§ 438.74(a) and 457.1203(e) (Medicaid and CHIP); and
- NAAAR, required under 42 CFR §§ 438.207(d) and 457.1230(b) (Medicaid and CHIP).

CMS initially published Excel templates for each report but has since launched a web-based submission portal, known as the Medicaid Data Collection Tool for Managed Care Reporting (MDCT-MCR), which now collects all three reports. The structured data captured by this system enables CMS to generate and analyze state-specific and nationwide data across managed care programs and requirements. Along with assessing compliance with federal requirements, CMS will use these data to identify areas for improvement and target technical assistance to help states

[22] Section 1903(m)(2)(A) and 1902(a)(4) of the Act

[23] Additional reporting information is available at: https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html

improve their managed care programs, plan performance, and program integrity.

Required Managed Care Reporting in MDCT-MCR

Managed Care Annual Program Report

States must annually submit a MCPAR to CMS for each Medicaid managed care program administered by the state, no later than 180 days after each contract year.[24] To improve transparency, CMS publicly posts MCPARs on Medicaid.gov.[25, 26]

The first MCPARs were submitted to CMS beginning in December 2022, and since that time CMS has conducted significant outreach and engagement with states to improve MCPAR reporting and data quality. Over the last eighteen months, CMS has made several MCPAR updates to revise questions and functionality to ensure that the report collects useful information, streamline the report to reduce state burden, and further standardize responses to promote reporting consistency and improve data quality. Key changes include:

- On August 15, 2024, additional questions were added related to mental health parity compliance, ILOSs, and appeals outcomes.
- On December 16, 2024, additional questions were added related to Patient Access Application Programming Interface usage and prior authorization.
- On September 3, 2024, CMS published technical guidance on MCPAR reporting of appeals and grievances to address data quality issues that CMS identified.[27]
- In early 2025, CMS began sending standardized feedback to states on data quality issues identified in their MCPAR submissions to aid reporting improvements.
- On July 30, 2025, a new functionality was added allowing states to select the managed care program for a MCPAR from a prepopulated list, and opt out of MCPAR questions related to availability, accessibility, and network adequacy if they submit a NAAAR in MDCT-MCR for the same reporting period.
- On February 19, 2026, questions were refined to capture enrollment for risk-based managed care programs and remove content that is captured in the MLR Summary Report and NAAAR.

Network Adequacy and Access Assurances Report

States are required to submit an assurance of compliance to CMS that each Medicaid and CHIP MCO, PIHP, and PAHP meets the state's requirements for availability of services and include documentation of an analysis that supports the assurance of network adequacy for each contracted MCO, PIHP, or PAHP.[28] Collectively, CMS refers to this as the NAAAR.[29]

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[24] 42 CFR § 438.66(e)

[25] https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/public-access-state-submitted-mcpars

[26] MCPARs are also available on state websites and subject to transparency requirements in 42 CFR § 438.66(e)(3).

[27] https://www.medicaid.gov/medicaid/managed-care/downloads/mcpar-appeals-grievances-tech-guidance.pdf

[28] 42 CFR § 438.207(d); 42 CFR § 457.1230(b)

[29] The submission timeframes for the NAAAR are outlined in 42 CFR §§ 438.207(d), 438.207(g), and 457.1230(b)

On July 30, 2025, CMS launched NAAAR in MDCT-MCR.[30] States may optionally submit the NAAAR in MDCT-MCR for rating periods beginning before July 9, 2025, and are required to complete the NAAAR in MDCT-MCR for rating periods beginning on or after July 9, 2025. The new NAAAR form in MDCT-MCR differs from the Excel reporting template in the following key ways, each intended to streamline and reduce unnecessary burden:

- Reuse of submission details: MDCT-MCR allows states to reuse submission details from prior NAAARs completed in MDCT-MCR (such as network adequacy standards for each provider type), greatly reducing data entry in subsequent submissions.
- Streamlined reporting of standards and deficiencies: MDCT-MCR standardizes and better organizes data fields for network standards, analyses, and findings to facilitate easier and faster completion.
- Elimination of duplicate reporting: States can skip MCPAR network adequacy questions by providing the specific date when they submitted, or will submit, a NAAAR through MDCT-MCR for the same reporting period.

On February 19, 2026, a new functionality was added to reduce administrative burden by allowing states to select the managed care program for a NAAAR from a prepopulated list, and CMS began requiring additional specificity from states related to network adequacy.

Medical Loss Ratio Summary Report

For both Medicaid and CHIP, states are required to submit annually (with their rate certification required in 42 CFR § 438.7 for Medicaid) a summary description of the MLR report(s) received from the MCOs, PIHPs, and PAHPs under contract with the state.[31]

CMS has undertaken several efforts to improve public transparency and state oversight of plans' MLRs. CMS began publicly posting MLR public use files annually.[32] As referenced above, CMS published an optional MLR plan-to-state reporting template that states may utilize with their plans to gather the detail necessary for the MLR Summary Reports,[33] and an MLR toolkit to aid state monitoring and oversight of plans' MLR reporting.[34]

Reporting in Transformed Medicaid Statistical Information System (T-MSIS)

States must ensure that MCOs, PIHPs, and PAHPs maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of 42 CFR Part 438; this data is critical for effective program management.[35] States' contracts with these plans must provide for the submission of enrollee encounter data to the state at a frequency and level of detail specified by CMS and the state, based on program administration, oversight, and program integrity needs.[36] The enrollee encounter data must include allowed amounts and paid

[30] https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting
[31] 42 CFR § 438.74(a); 42 CFR § 457.1203(e)
[32] https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/mlr-summary-reports
[33] https://www.medicaid.gov/medicaid/managed-care/downloads/mlr-toolkit-template.xlsx
[34] https://www.medicaid.gov/medicaid/managed-care/downloads/mlr-toolkit-sep-2024.pdf
[35] 42 CFR §§ 438.242 and 457.1233(d)
[36] 42 CFR §§ 438.242(c)(2)-(3)

amounts.[37] CMS updated its data guide[38] to include a version 4 file layout, which specifies the T-MSIS reporting requirements for SDP-specific data fields,[39] including the plan's negotiated payment amount, the amount of the SDP in the payment, and any other amounts included in the total amount paid to the provider. States should begin reporting these T-MSIS fields as soon as possible, but no later than September 2026.

CMS Review of Medicaid Managed Care Actions

CMS is required to review and approve states' Medicaid managed care authorities, contracts, rate certifications, and SDP preprints (when written prior approval is required).[40] CMS will not begin review of these actions until CMS receives a complete submission for the respective action as noted below. Additionally, CMS provides an update on the single web-based system, entitled Managed Care Review (MC-Review), for state submission and CMS review of Medicaid managed care contracts and rates.

Minimum Documentation Standards for CMS to Begin Review

Medicaid Managed Care Authorities
There are several different Medicaid managed care authorities that states can utilize to implement a Medicaid managed care delivery system. Each of these authorities requires CMS review and approval. In order for CMS to begin our review of a managed care authority, the state must submit a complete application, such as a state plan amendment for authority under section 1932(a) of the Act or waiver application for a waiver under section 1915(b) of the Act.[41]

Historically, states have been required to submit an independent assessment for the first two renewals of a managed care section 1915(b) waiver as required minimum documentation for CMS to begin review of the waiver application.[42] Additionally, as part of the section 1915(b) waiver application, states complete a section on monitoring, which includes strategies for assessing program impact, access, and quality. As part of the waiver renewal process, states report the results of their monitoring strategies. Over the last few years, CMS has imposed reporting requirements on all Medicaid managed care programs to improve transparency on program operations and plan performance, including through the collection of required reporting through the MCPAR, NAAAR, and MLR Summary Report as described further above.[43] At this time, CMS believes the requirements for an independent assessment for the first two renewals of managed care section 1915(b) waivers and the reporting of monitoring results as a requirement of the waiver renewal process are no longer necessary as minimum documentation requirements. Data on access, quality, and program impact are now collected via standardized managed care reporting, and CMS will use this information to inform our review and action on managed care section 1915(b) waiver requests in accordance with 42 CFR § 431.55(b)(2). CMS believes this

[37] 42 CFR § 438.242(c)(3)
[38] https://www.medicaid.gov/tmsis/dataguide/v4/
[39] 42 CFR § 438.6(c)(4)
[40] Sections 1915(b) and 1932(a) of the Act; 42 CFR §§ 431.55, 438.3, 438.4, 438.6(c)(2)(i), and 438.7
[41] Further details are available at: https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities
[42] SMD letter published on December 22, 1998; Section 2111(B) of the State Medicaid Manual
[43] 42 CFR §§ 438.8, 438.66(e), 438.74(a), and 438.207(d)

policy change will help ensure that CMS and states efficiently utilize standardized data collection and remove unnecessary duplication and associated administrative burden. Therefore, CMS will no longer expect an independent assessment to be submitted as part of the minimum documentation required to initiate review of section 1915(b) waiver renewals, or require states to report on monitoring as part of the section 1915(b) waiver request process as long as the state continues to meet their existing MCPAR, NAAAR, and MLR reporting obligations mentioned above.

Medicaid State Directed Payment Preprints

As noted in guidance issued on November 7, 2023,[44] for SDPs that require written prior approval,[45] CMS must receive a complete preprint before CMS will begin review. A complete SDP preprint submission requires an SDP preprint[46] and, if needed, a preprint addendum[47] to expand upon existing tables. The preprint and addendum, when needed, must be fully completed by a state.[48] For example, the preprint must include the total payment rate comparison outlined in Table 2 of the preprint, which is required by CMS to ensure the total payment rate for each service and provider class included in the SDP is reasonable, appropriate, and attainable.[49] Additionally, any SDP that requires written prior approval and is for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center must provide a demonstration of the total payment rate. This demonstration must be updated at least once every 3 years thereafter.[50]

As noted above, on September 10, 2025, CMS issued guidance[51] requiring states to submit certain quality evaluation elements before CMS will begin review of an SDP preprint. These elements are: (1) a description of how the SDP explicitly ties to goals and objectives in the state's managed care program quality strategy;[52] (2) an evaluation plan with specific evaluation measures and, for each of those measures, baseline statistics, the baseline year, and a measurable performance target for improvement or attainment against the baseline measure;[53] and (3) the evaluation results based on the evaluation plan provided in the prior preprint submission(s) (required when the state is requesting renewal of an SDP that has been in place for at least two rating periods). For the third element, CMS understands that states are sometimes unable to provide complete annual evaluation results at the time of preprint submission due to claims lag or measure reporting specifications. In those instances, the state is expected to submit interim

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[44] https://www.medicaid.gov/federal-policy-guidance/downloads/cib11072023.pdf
[45] 42 CFR § 438.6(c)(2)(i)
[46] SDP preprint template published on December 22, 2022
[47] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-4386c-preprint-addendum.xlsx
[48] The preprint must be completed in full, and all information must be provided only in the fillable sections of the preprint and the addendum tables. No additions or markings, including comments, are permitted in order to maintain Section 508 compliance. When possible, the State should use the addendum tables, rather than provide separate supporting documentation. The preprint, addendum tables, and any other supporting documents must be submitted as separate files, without merging or reformatting.
[49] 42 CFR § 438.6(c)(1)(ii)(I)
[50] 42 CFR § 438.6(c)(2)(iii)
[51] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/cib09102025.pdf
[52] 42 CFR § 438.340; Table 7 of the preprint template published on December 20, 2022
[53] Table 8 in the preprint template published on December 20, 2022

annual evaluation results. CMS also published an optional template that states may use to report evaluation findings to CMS.[54]

To promote transparency into how states are directing Medicaid MCO, PIHP, and PAHP expenditures in connection with SDPs, CMS publishes all SDP preprints approved on or after February 1, 2023, and CMS updates this public posting regularly.[55]

Medicaid Managed Care Plan Contracts
In guidance issued on November 7, 2023,[56] CMS outlined the minimum documentation requirements necessary before CMS would begin review of a managed care plan contract. States should also consult the State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval,[57] which outlines the standards CMS applies when reviewing and approving state contracts with Medicaid managed care plans.

Medicaid Rate Certifications
This November 7, 2023 guidance also outlined the minimum documentation requirements for Medicaid rate certifications, including that the rate certification must be signed by an actuary meeting the qualifications in 42 CFR § 438.2, and developed in accordance with the rate development standards and documentation expectations outlined in the Medicaid Managed Care Rate Development Guide[58] that is released annually by CMS. As referenced above, on August 12, 2025, CMS released the Medicaid Managed Care Rate Development Guide for rating periods starting between July 1, 2025 and June 30, 2026.[59]

Medicaid MC-Review
In 2024, CMS launched the MC-Review state portal, a web-based system for state submission and CMS review of Medicaid managed care contracts and rates, to implement efficiencies and reduce administrative burden related to the submission and review process. CMS has supported 45 states in onboarding and using MC-Review to transmit their contracts and rates. States have reported a 39 percent reduction in the time required to conduct a submission and have found that use of the system increases efficiencies in the review process and increases transparency.

Consistent with CMS's authority under 42 CFR § 438.3(a) to specify the form and manner of contract and rate submissions, beginning July 1, 2026, CMS will require that all Medicaid managed care contract and rate submissions transmitted to CMS after this date must use the MC-Review state portal.[60] Please visit the MC-Review landing page found here: https://mc-review.onemac.cms.gov/ for more details on how to access the system. CMS encourages the few states that have not yet adopted the system to do so ahead of this date.

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[54] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-ltr-evltn-findng-tmplte.pdf
[55] https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints
[56] https://www.medicaid.gov/federal-policy-guidance/downloads/cib11072023.pdf
[57] https://www.medicaid.gov/medicaid/downloads/mce-checklist-state-user-guide.pdf
[58] https://www.medicaid.gov/medicaid/managed-care/guidance/rate-review-and-rate-guides
[59] https://www.medicaid.gov/medicaid/managed-care/downloads/2025-2026-medicaid-rate-guide-082025.pdf
[60] Submissions received prior to 7/1/26 will be accepted via email and will remain an email submission throughout the review and approval process which may impact review timeframes.

Closing

CMS is committed to strengthening the monitoring and oversight of Medicaid and CHIP managed care programs, continuing to improve the program and fiscal integrity of these programs, and addressing fraud, waste, and abuse in managed care. If you have any questions or need additional information, please contact ManagedCareTA@cms.hhs.gov.