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CMCS Informational Bulletin

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SUBJECT: Medicaid and CHIP Managed Care Monitoring and Oversight Tools

The purpose of this Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CIB) is to provide additional tools for States and the Centers for Medicare & Medicaid Services (CMS) to improve the monitoring and oversight of managed care in Medicaid and the Children's Health Insurance Program (CHIP).

Introduction

To improve monitoring and oversight of States' Medicaid and CHIP programs, we have released two CIBs that included reporting templates and toolkits. This CIB is the third in this series.

On June 28, 2021, CMS released the first CIB[1] that introduced a reporting template for the Managed Care Program Annual Report (MCPAR), announced the development of a web-based reporting portal for the collection of all required managed care reports, and announced release of two technical assistance toolkits for State use on behavioral health access and the Medicaid and CHIP managed care quality strategy. In this guidance, CMS committed to developing additional tools for monitoring and oversight of managed care.

On July 6, 2022, CMS published the second CIB[2] that provided an update on the web-based reporting portal and introduced two additional reporting templates for the Medical Loss Ratio (MLR) Report and the Network Adequacy and Access Assurances Report (NAAAR). Additionally, this guidance announced release of a new technical assistance toolkit for States on managed long-term services and supports (MLTSS) and published initial recommended practices and strategies for ensuring timely and accurate payment to Indian health care providers.

Today, CMS is releasing the third CIB that provides additional updates and reminders on the web-based reporting portal and the reporting requirements for managed care programs. This guidance also provides an update on CMS' process for review and approval of managed care contracts, rate certifications, and State directed payments, and announces the release of several new technical assistance toolkits.

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/cib06282021.pdf
[2] https://www.medicaid.gov/federal-policy-guidance/downloads/cib07062022.pdf

Required 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: the MCPAR required in 42 CFR § 438.66(e) for Medicaid only, the MLR Summary Report required in 42 CFR §§ 438.74(a) and 457.1203(e) for Medicaid and CHIP respectively, and the NAAAR required in 42 CFR §§ 438.207(d) and 457.1230(b), respectively. Specific information on each of these reports is available on Medicaid.gov.[3]

CMS previously published Excel templates for each report. However, CMS has since launched a web-based submission portal, known as the Medicaid Data Collection Tool for Managed Care Reporting (MDCT-MCR), which can now collect both MCPAR and MLR reports from States. For both reports, the MDCT-MCR collects the same information included in the Excel templates, creating a single submission process and repository for these State reporting requirements. CMS expects to incorporate all required managed care reports into the MDCT-MCR system over time. The structured data captured by this system will allow CMS to generate and analyze State-specific and nationwide data across all managed care programs and requirements. CMS will use these data to identify areas that need improvement and target technical assistance to help States improve their managed care programs and comply with managed care statutory and regulatory requirements.

Medical Loss Ratio (MLR) Summary Reporting in the MDCT-MCR

Federal regulations at 42 CFR §§ 438.74(a) and 457.1203(e) require that States 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 managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) under contract with the State. CMS released the Excel template for this reporting as part of the CIB published on July 6, 2022.

CMS is pleased to announce that the MLR Summary Report is now available for States to submit through the MDCT-MCR. States that are ready to submit their MLR Summary Reports through the online portal can begin immediately. MLR Summary Reports required as part of the rate certification submission for rating periods beginning on or after July 1, 2024, must be submitted through the MDCT-MCR.

MDCT-MCR access is limited to State employees authorized by their State leadership. CMS has been in contact with each State's representative to the Managed Care Technical Advisory Group (MC-TAG) to explain the process to authorize and apply for access. Each State must follow the instructions to gain access to the system.[4] While States can still use the Excel template internally to gather the necessary information, States must enter and submit the report through the MDCT-MCR by the deadline outlined above.

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[3] https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html

[4] Instructions for gaining access to MCDT-MCR are located here: https://www.medicaid.gov/resources-for-states/medicaid-and-chip-program-portal/medicaid-data-collection-tool-mdct-portal/index.html#MCR

Managed Care Reporting Reminders

CMS would also like to remind States of the submission requirements for the MCPAR and NAAAR.

Managed Care Annual Program Report (MCPAR)

Federal regulations at 42 CFR § 438.66(e) require States to submit a MCPAR. Each State must submit to CMS, no later than 180 days after each contract year, a report on each Medicaid managed care program administered by the State. The report is collected through the MDCT-MCR. The requirement to submit the annual report was triggered by the CIB published on June 28, 2021, and the deadline for State submission is dependent upon the contract year of each managed care program. The due dates for the next round of reports are listed below and reports are required each year thereafter.

Contract Year of the Managed Care Program	Contract Period of Next Report	Next Report Due
July through June	7/1/2022 – 6/30/2023	December 27, 2023
September through August	9/1/2022 – 8/31/2023	February 27, 2024
October through September	10/1/2022 – 9/30/2023	March 28, 2024
January through December	1/1/2023 – 12/31/2023	June 28, 2024
February through January	2/1/2023 – 1/31/2024	July 29, 2024
April through March	4/1/2023 – 3/31/2024	September 27, 2024

Network Adequacy and Access Assurances Report (NAAAR)

Federal regulations at 42 CFR §§ 438.207(d) and 457.1230(b) require that States must:

- Submit an assurance of compliance to CMS that each MCO, PIHP, and PAHP meets the State's requirement for availability of services; and
- Include documentation of an analysis that supports the assurance of the adequacy of the network for each contracted MCO, PIHP, or PAHP related to its provider network.

The information is required to be submitted:

- At the time the State enters into a contract with each MCO, PIHP, or PAHP;
- On an annual basis; and
- Any time there is a significant change in the operations that would affect the adequacy of capacity and services of an MCO, PIHP, or PAHP.

Note: CMS recommends that the report be submitted at the same time a State submits the associated managed care contract to CMS for review and approval, including a new contract, a renewal, or an amendment.

The CIB published on July 6, 2022, announced the release of the Excel template[5] for the NAAAR. In the future, this report will be collected through the MDCT-MCR, though this reporting functionality is not yet available. CMS will notify States when the web-based NAAAR form is available. Until that time, States are required to submit the Excel template of the report to MCGDMCOActions@cms.hhs.gov.

[5] https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html

Comprehensive information about all managed care reporting requirements is available on Medicaid.gov.[6]

CMS Review of Managed Care Contracts, Rate Certifications, and State Directed Payments

Federal regulations at 42 CFR §§ 438.3, 438.4, and 438.7 require CMS to review and approve States' Medicaid managed care contracts and rate certifications. Regulations at 42 CFR § 457.1201(a) require CMS to review separate CHIP managed care contracts. In accordance with 42 CFR § 438.6(c), most State directed payments in Medicaid also require prior CMS approval through a preprint form. Medicaid and CHIP capitation rates must be documented in executed MCO, PIHP, and PAHP contracts as required at 42 CFR §§ 438.3(c)(1)(ii) and 457.1201(c), and any changes to the capitation rates must be documented in executed contract amendments. State directed payments must also be documented in executed Medicaid managed care contracts and incorporated into Medicaid rate certifications.

In a CIB published on November 8, 2019,[7] CMS outlined process improvements to CMS' review of managed care contracts and rate certifications and included a tip sheet for a complete contract action submission. CMS has published several pieces of guidance on State directed payments, including SMD# 21-001 on January 8, 2021, which released a revised preprint template.[8][9] On November 23, 2021, CMS published a CIB outlining revisions to the submission process for managed care contracts, rate certifications, and State directed payment preprints.[10]

CMS continues to experience delays in State submission of complete Medicaid managed care contract actions, rate certifications, and State directed payment preprints; these delays prevent timely CMS review of these actions. Therefore, CMS is publishing this guidance on the components of a complete submission. CMS will not begin formal review of contracts, rate certifications, and State directed payment preprints until we receive a complete submission of the contracts, rate certifications, and State directed payment preprints. Below we outline the process for each of these.

Managed Care Plan Contracts

A complete managed care plan[11] contract action submission includes many components, including contract actions signed and dated by all parties which include all pages, appendices, and attachments, as well as any documents that are incorporated into the contract by reference,[12] and additional required documentation, when applicable, such as rate certifications, MLR

[6] https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html

[7] https://www.medicaid.gov/federal-policy-guidance/downloads/cib110819.pdf

[8] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf

[9] https://www.medicaid.gov/sites/default/files/2022-12/sdp-4386c-preprint-template-12192022.pdf

[10] https://www.medicaid.gov/federal-policy-guidance/downloads/cib112321.pdf

[11] The term "managed care plan" refers to MCOs, PIHPs, PAHPs and PCCM entities when utilized.

[12] States may choose to utilize additional documentation outside of managed care plan contracts to apply standards and provide guidance on what the contract requires; however, any new requirements or those that make changes to payment, or the work performed under the contract should be included in the managed care plan contract.

Summary Reports, etc. See Appendix 1 for details on the components of a complete managed care plan contract submission. This appendix has been updated from the addendum included in the CIB published on November 8, 2019, to provide additional clarity to States.

Historically, CMS has begun its review of managed care plan contracts once it is received, even in cases where components of the managed care plan contract were missing or other key documents such as rate certifications were absent. This approach has led to inefficiencies in our review process and resulted in increasingly long review times. For example, in some cases, CMS has asked States questions regarding an incomplete contract submission that were then subsequently answered in missing contractual documentation; these questions could have been avoided if the States submitted all relevant documentation concurrently. We are concerned about the unnecessary administrative burden that this causes for both States and CMS. We are also concerned that these inefficiencies appear to be growing. In 2020, CMS waited an average of 79 days between receiving States' initial submissions and complete contract packages. By 2023, that number had increased substantially to 232 days.

We believe it is vital for States to submit complete managed care plan contracts in a timely and efficient manner to CMS for our review and approval of these contracts as required in 42 CFR §§ 438.3 and 457.1201(a), and consistent with authority in section 1902(a)(4) of the Social Security Act to establish methods for proper and efficient operation in Medicaid and section 2101(a) of the Act for establishing efficient and effective health assistance in CHIP. Therefore, CMS is now outlining the minimum documentation standards that must be met within a managed care plan contract submission before CMS will begin review. CMS is implementing this new requirement in two phases, to allow States time to make internal operational changes, if necessary, to comply with these documentation standards. Phase 1 will begin for any managed care plan contract effective on or after July 1, 2024, and Phase 2 will begin for managed care contracts effective on or after July 1, 2025. See Appendix 2 for further details on this approach.

With the recent reorganization in CMCS to create the Managed Care Group, the current mailbox that States are expected to submit managed care contracts to has changed. States should submit all managed care plan contracts to CMCS at: MCGDMCOActions@cms.hhs.gov. Additionally, States should continue to submit all State contract actions with Medicaid managed care plans, including associated rate certifications, to the MMCratesetting@cms.hhs.gov mailbox to ensure timely review of Medicaid managed care rate development.

Medicaid Rate Certifications

If a contract submission is for a risk-based managed care plan contract and includes a rate certification, the rate certification must meet certain documentation standards to be considered complete before CMS will begin review of the rate certification. 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.[13] As noted in this guide, the rate certification must include both the letter or attestation from the actuary that specifically certifies that the capitation rates or rate ranges are actuarially sound and meets applicable Federal requirements, and all supporting documentation that relates to the letter or attestation, including the actuarial report,

[13] https://www.medicaid.gov/medicaid/managed-care/guidance/rate-review-and-rate-guides/index.html

other reports, letters, memorandums, other communications, and other workbooks or data.

Medicaid State Directed Payments

For those State directed payments that require written prior approval, CMS must receive a complete preprint before CMS will begin review. A complete State directed payment preprint submission requires a State directed payments preprint form[14] as well as the preprint addendum tables[15] in an Excel workbook, as necessary. State directed payments granted prior written approval on or after February 1, 2023, pursuant to 42 CFR § 438.6(c), are published on Medicaid.gov.[16] As such, all preprint submissions must comply with Section 508 of the Rehabilitation Act (Section 508) and the preprint has been made compliant to enable timely posting.

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.

For those State directed payments that require written prior approval, CMS strongly recommends that States submit preprints to CMS at least 90 calendar days before the start of the applicable rating period. To request technical assistance or submit a State directed payment preprint for review, States should use the following mailbox: StateDirectedPayment@cms.hhs.gov.

Additionally, for each State directed payment, the risk-based managed care plan contracts must include a description of providers entitled to the payment, how it is authorized, how the State is directing the plans to pay the providers, and any reporting requirements the managed care plans must meet to show they have met those requirements. Requirements for each payment should be sufficiently detailed in the contracts to enable the plans to consistently operationalize each payment arrangement in alignment with CMS approval of the State directed payment preprint(s).

Technical Assistance Toolkits for States[17]

In the CIB published June 28, 2021, CMS committed to developing a series of technical assistance toolkits to assist States in complying with various managed care standards and regulations and to help improve State monitoring and oversight of their managed care programs. Today, CMS is releasing several new toolkits, described below.

[14] https://www.medicaid.gov/sites/default/files/2022-12/sdp-4386c-preprint-template-12192022.pdf

[15] The preprint addendum is an Excel document, entitled "Section 438.6(c) Preprint Addendum Tables" which can be downloaded from here.

[16] https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints

[17] Most toolkits can be found at the CMS Medicaid and CHIP Managed Care Monitoring and Oversight Initiative webpage: https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-monitoring-and-oversight-initiative/index.html

Medicaid Managed Care Plan Transitions

Today, CMS is releasing a toolkit entitled, "Medicaid Managed Care Plan Transitions: A Toolkit for States on Promoting Continuity of Care When Plans Enter, Leave, or Merge or are Acquired." As the MCOs, PIHPs, and PAHPs operating in States' Medicaid managed care programs change, States and plans must ensure there are no disruptions in enrollees' access to care. States can mitigate the risk of disruption through planning, implementation, and monitoring of plan transitions, as well as developing associated managed care contractual requirements. This toolkit provides steps that States can take during each phase of a transition to support successful movement of enrollees from one plan to another, clear communications with enrollees about the impact of a transition and their rights and options, and facilitation of continuity of care with established and new providers. The toolkit is available on Medicaid.gov.[18]

Tribal Protections in Medicaid and CHIP Managed Care

Today, CMS is releasing a toolkit entitled, "Tribal Protections in Medicaid and CHIP Managed Care Oversight." To assist states in complying with the statutory and regulatory Indian managed care protections, CMS met with States, Tribes, Indian health care providers (IHCPs), and managed care plans to identify and resolve implementation and compliance issues on a State-by-State basis. To address implementation of the Indian managed care protections from a national perspective, the National Indian Health Board (NIHB) and CMS convened a Tribal Medicaid Managed Care Virtual Roundtable in May 2021. The Roundtable panelists included Tribal health directors, State Medicaid staff, and managed care plan staff who gathered to discuss strategies and identify recommended practices and resources that could be used to aid States and managed care plans in implementing the statutory and regulatory Indian Medicaid managed care protections. In July 2022, NIHB produced a Roundtable Report that memorialized the recommended practices and strategies for addressing Medicaid and CHIP managed care issues in Indian Country.[19] This toolkit builds upon the Roundtable Report by providing more detail on these recommendations. The toolkit provides an overview of the Indian health delivery system, statutory and regulatory protections, and recommended implementation practices. The toolkit is available on Medicaid.gov.[20]

Validating Medicaid Managed Care Encounter Data

In August 2019, CMS published a toolkit, entitled "Validating Medicaid Managed Care Encounter Data," that provides practical information States can use to validate and improve the Medicaid encounter data they receive from their managed care plans. The toolkit describes activities that all States should perform to ensure high quality data, and includes examples of current State practices, checklists to assist State staff who conduct validation, and resources that provide helpful tips and tools. We have updated this toolkit to incorporate guidance about the periodic audit process for encounter data, as required at 42 CFR § 438.602(e). This toolkit provides techniques to help states ensure robust audits of their encounter data validation processes to assess the accuracy, truthfulness, and completeness of their encounter data and the sufficiency of their validation processes. The toolkit is available on Medicaid.gov.[21]

[18] https://www.medicaid.gov/sites/default/files/2023-10/mmcp-transtons-tolkit.pdf
[19] https://www.nihb.org/docs/phrc-uploads/08152022/medicaid-managed-care-report_final_08102022.pdf
[20] https://www.medicaid.gov/sites/default/files/2023-10/trbl-protcns-medcd-chip-mngd-care-ovrsght-tolkt.pdf
[21] https://www.medicaid.gov/sites/default/files/2023-10/mmce-data-valdtn-tolkit.pdf

Program Integrity

On November 1, 2023, CMS released four program integrity toolkits to provide States and managed care plans with guidance on optimizing program accountability and transparency. The topics for these toolkits were identified as the most pressing challenges for States based on 42 CFR 438 Subpart H (adopted in CHIP via cross-reference at 42 CFR § 457.1285) regulatory requirements, State technical assistance requests raised in the Fraud, Waste, and Abuse Technical Advisory Group, and State educational requests in Medicaid Integrity Institute (MII) trainings.[22] These program integrity toolkits provide information and examples regarding oversight practices that States should consider to ensure that effective program integrity measures are in place. The program integrity toolkits are described below.

Compliance Program Requirements

The Compliance Program Requirements toolkit discusses the compliance program requirements that States must follow when entering into contracts with managed care plans. Specifically, CMS regulations at 42 CFR § 438.608(a)(1) require that States, through contracts with managed care plans, must require managed care plans to implement and maintain arrangements or procedures designed to detect and prevent fraud, waste, and abuse. These arrangements or procedures must include a compliance program that meets several minimum elements. The toolkit is available on Medicaid.gov.[23]

Prompt Referrals of Potential Fraud, Waste, or Abuse

The Prompt Referrals of Potential Fraud, Waste, or Abuse toolkit outlines the requirements of managed care plans to promptly report and establish clear timelines for referrals of potential fraud, waste, or abuse to the State Medicaid Program Integrity (PI) Unit or Medicaid Fraud Control Unit (MFCU), as required in 42 CFR § 438.608(a)(7). When referring potential fraud, waste, or abuse, States have the discretion to stipulate the ways managed care plans can report potential fraud. The toolkit is available on Medicaid.gov.[24]

Treatment of Overpayments and Recoveries

The Treatment of Overpayments and Recoveries toolkit discusses how recoveries of network provider overpayments may be treated under requirements found in 42 CFR §§ 438.608(d) and (a)(2). These regulations provide States with flexibility on how to handle recoveries made by managed care plans to create incentives for managed care plans to proactively oversee network provider billing practices and identify fraud, waste, and abuse. The toolkit is available on Medicaid.gov. [25]

Payment Suspensions Based on Credible Allegations of Fraud

This Payment Suspensions Based on Credible Allegations of Fraud toolkit discusses managed care-related payment suspensions and the procedures in place to suspend payment when there is

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[22] Learn more about MII trainings at: https://www.cms.gov/medicaid-integrity-institute.

[23] https://www.cms.gov/files/document/managed-care-compliance.pdf

[24] https://www.cms.gov/files/document/managed-care-fraud-referral.pdf

[25] https://www.cms.gov/files/document/managed-care-overpayment-recoveries.pdf

a credible allegation of fraud, consistent with requirements found in 42 CFR § 438.608(a)(8). States have an important oversight responsibility when implementing payment suspensions for network providers, and CMS encourages States and managed care plans to collaborate throughout this process. The toolkit is available on Medicaid.gov.[26]

Closing

CMS is committed to strengthening the monitoring and oversight of Medicaid and CHIP managed care programs and looks forward to continuing to collaborate with States on the implementation of these tools. CMS anticipates issuing additional tools in the future to improve monitoring and oversight activities in Medicaid and CHIP managed care. If you have any questions or need additional information, please contact ManagedCareTA@cms.hhs.gov.

[26] https://www.cms.gov/files/document/managed-care-payment-suspensions.pdf

Appendix 1: Components of a Complete Managed Care Plan Contract Submission

Before CMS can approve Medicaid managed care plan contracts in accordance with 42 CFR § 438.3(a) and finalize our review of CHIP managed care contracts in accordance with § 457.1201(a), all contract submission packages must include:

1. Contract action(s) signed and dated by all parties which include all pages, appendices, and attachments, as well as any documents that are incorporated into the contract by reference, and
2. The following additional documentation, as described in the chart below.

When the Contract Action:	Additional Documentation Required	Regulatory Reference
Implements or amends Medicaid capitation rates[27]	Rate certification and all supporting documentation, when required[28]	Medicaid: § 438.7
Implements capitation rates for the state's annual rating period	MLR Summary Reports[29]	Medicaid: § 438.74(a) CHIP: § 457.1203(e)
Provides any services to MCO enrollees using a delivery system other than the MCO and there is (1) a change in benefits provided by the MCO, PIHP, PAHP, or FFS is occurring; or (2) the State is contracting with a new MCO(s)	Parity analysis in mental health and substance use disorder (SUD) benefits	Medicaid: §§ 438.3(n)(2) and 438.920 CHIP: §§ 457.496(f) and 457.1201(l)
Implements in Medicaid (1) a new managed care program; (2) a new managed care plan not previously contracted with the State; or (3) the provision of covered benefits to new eligibility groups.	Readiness review results	Medicaid: § 438.66(d)(2)(iii)

Additionally, CMS recommends that the NAAAR be submitted when a State submits the associated managed care plan contract to CMS. See the section entitled, Required Managed Care Reporting, for further details.

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[27] The only exception is when States are permitted to either use the rate range option under 42 CFR §§ 438.4(c)(1) or use the de minimis rate adjustment under 438.7(c)(3), but States are not permitted to use both mechanisms in combination. Note that CMS' documentation expectations for these State flexibilities are outlined in Section I.1 of the Medicaid Managed Care Rate Development Guide.

[28] Rate development standards and CMS's documentation expectations for rate certifications are outlined in the Medicaid Managed Care Rate Development Guide.

[29] As outlined in the section entitled, Medical Loss Ratio (MLR) Summary Reporting in the MDCT-MCR, States will be expected to submit these reports within MDCT-MCR by the outlined deadline. As such, a State should confirm that it completed this respective submission in MDCT-MCR when a State submits the associated managed care plan contract action via email to the respective mailboxes outlined above.

Appendix 2: CMS Process for Reviewing Managed Care Plan Contracts

As outlined in the chart below, CMS will not begin review of managed care plan contracts submitted by States until minimum documentation standards are met as outlined in the below chart. These changes to CMS' review process will occur in two phases to allow States time to make internal operational changes. CMS strongly encourages States to submit contract actions consistent with all applicable documentation standards before the effective date of the managed care plan contract to facilitate timely and efficient review by CMS.

Minimum Documentation Standards Necessary for CMS to Begin Review of Managed Care Plan Contracts

Phase 1: Contract actions with an effective date on or after 7/1/2024	Phase 2: Contract actions with an effective date on or after 7/1/2025
1. Base contract(s) or contract amendment(s) (during Phase 1 these can be unsigned, but should include final language); 2. All appendices, attachments and any documents incorporated by reference into the contract; and 3. Rate certification, if applicable CMS also recommends that States submit a complete contract inclusive of prior amendments highlighting all current changes. This additional documentation will likely result in fewer CMS questions and any submission that includes this detail will be prioritized for more expeditious review.	1. Executed base contract(s) or contract amendment(s), signed and dated by all parties; 2. All appendices, attachments, and any documents incorporated by reference into the contract; 3. Rate certification, if applicable And, when applicable: 4. MLR Summary Report; 5. Parity analysis in mental health and SUD benefits; 6. Readiness review results; and 7. Submission of associated Medicaid/CHIP authority (e.g., State plan amendment, waiver under sections 1915(b) or 1915(c) of the Social Security Act, State directed payment preprint) for applicable contractual requirements.[30] CMS also recommends that States submit a complete contract inclusive of prior amendments highlighting all current changes. This additional documentation will likely result in fewer CMS questions and any submission that includes this detail will be prioritized for more expeditious review.

[30] As a reminder for States, CMS will not approve managed care plan contracts until all necessary Medicaid authority is approved that is associated with the contractual requirements. For example, if a contract action includes a programmatic change to require a managed care plan to deliver a new Medicaid benefit to Medicaid managed care enrollees, the associated Medicaid State plan or waiver authority must be approved before CMS can consider the managed care plan contract action for approval. As such, we believe that these necessary Medicaid authorities should at least be submitted to CMS before CMS will begin review of the associated managed care plan contracts.