
CMCS Informational Bulletin

DATE: November 8, 2019

FROM: Calder Lynch, Acting Deputy Administrator and Director

SUBJECT: Managed Care Contract Review Redesign Project

The Centers for Medicare & Medicaid Services (CMS) is collaborating with the National Association of Medicaid Directors (NAMD), an organization whose members are state Medicaid directors from all states, the District of Columbia, and U.S territories, to improve CMS' managed care plan contract review process by increasing efficiencies and transparency, and decreasing administrative burden. Both CMS and states have identified the contract review process as an area in need of significant improvement. The volume of state managed care contract submissions has risen steadily over the past several years without significant process improvements to offset the increased workload. Under the current process, contract reviews are taking an average of 254 days to approve, and are consuming a growing proportion of CMS resources. The redesign project will address these issues by expediting the review process so that states and CMS can rebalance their resources, and focus on assuring accessible, high quality health care, and improving health outcomes for Medicaid beneficiaries.

The managed care contract redesign project is one of many CMS initiatives designed to shift the agency's resources away from administrative processes, and toward activities that monitor and improve health outcomes. Like the State Plan Amendment (SPA) and 1915 Waiver Project implemented in 2017, CMS has worked closely with NAMD over the last 9 months to identify changes to the contract review process that are feasible for both CMS and states to implement, and that will improve the overall review process. This effort compliments the process improvements that have already been undertaken by CMS and the Office of the Actuary to reduce the timeframes and administrative burdens associated with managed care rate reviews. The contract redesign will build upon these initiatives to achieve substantial gains throughout the contract and rate review process.

In this bulletin, CMS shares short-term, intermediate and long-term strategies to improve the contract action review process and to reduce the timeframes for approval. This bulletin also introduces a pilot project that CMS has developed to test a risk-based accelerated contract review process for which state participation will be solicited separately. The results of the pilot will inform a long-term strategy for streamlining the contract review process.

Background

Federal regulations at §§ 438.3, 438.4, and 438.7 require CMS to review and approve states' Medicaid managed care contracts and capitation rates paid to managed care plans as actuarially sound. Regulations at §457.1201 require CMS to review CHIP managed care contracts. While CMS works to review contract actions expeditiously, the complexity and variation between contracts often results in a time consuming process for both CMS and states. In addition, the resource intensity of this process has been amplified by the steady growth of managed care programs, the increasing complexity of state delivery system programs, and the increasing number of contract actions submitted by states annually. In Federal Fiscal Year 2018, CMS received 461 contract actions and 259 actuarial certifications. This constituted a 10% increase from the number of contract actions submitted during Federal Fiscal Year 2017. At the same time the number of contract action submissions was increasing, states were expressing concerns about the long review times and administrative burdens associated with CMS' current review process. An internal data analysis found that contract actions were taking an average of 254 days to approve, which prompted CMS to conduct a detailed analysis of contract actions to understand why the reviews were so lengthy and to identify strategies for reducing the approval time.

Managed Care Contract Redesign Framework

To inform the redesign project, CMS collected information from internal and external stakeholders throughout the first six months of 2019. We used multiple mediums to collect data, including a detailed analysis of a sample of approved contract actions; a national survey on states' contracting and rate-setting practices; internal focus groups with analysts from the Center for Medicaid and CHIP Services and the Office of the Actuary (OACT); and technical consultation with states through NAMD. The information collected was used to identify the key variables driving lengthy review times and causing administrative burden.

CMS reviewed a sample of contract actions that included submissions from 40 states and the District of Columbia, representing 15% of the actions submitted and approved between January 1, 2017 and December 31, 2018. To better understand where and why process delays were occurring, we included in the sample a majority of contract actions that had longer review times than the national average, and included an actuarial certification. Each contract action in the sample was examined on a large number of measures, including overall review time, the number of days between states' initial and final contract submissions, the number of questions sent to states, and other additional metrics. The analysis showed four primary factors driving lengthy timeframes: 1) an absence of Federal requirements documented in the contract action; 2) a prior, unapproved contract action (preceding the pending contract action); 3) missing documentation in the state's submission; and 4) approval of the rate certification.

The information CMS collected through state survey responses and internal focus groups further supported the results of the contract analysis. States and analysts identified all four factors as commonly contributing to delayed approvals and identified two additional factors: 5) a non-standardized submission process that can create confusion for states in their understanding of what is needed for CMS review and approval; and 6) a thorough CMS process for evaluating compliance with Federal regulations.

Process Improvements

CMS has developed short-term, intermediate and long-term process improvements to address the factors driving lengthy review times. These process changes were developed in consultation with NAMD and were informed by successful strategies used in previous process improvement projects. In addition to the process improvements proposed for the future, CMS has already begun two reform efforts to expedite the contract and rate approval process.

Process Improvements Currently Underway

Non-sequential Approval of Amendments

CMS released a letter to State Medicaid Directors during the week of June 10, 2019, which modified our policy requiring contract amendments to be approved in sequential order. CMS changed this policy to decrease the backlog of contract actions that were held up by a preceding contract action under review. Under the new policy, CMS approves amendments out of sequential order when the following criteria are met: the contract action is amending an approved initial base contract; the amendment meets all applicable Federal regulations; the amendment does not modify the contract in a way that assumes an unapproved amendment has been implemented, nor is the amendment related to or modifying the same provision in an unapproved contract action. This policy change has successfully reduced the backlog of unapproved amendments, and assures that contract actions will not be unnecessarily delayed in the future.

Actuarial Review of Medicaid Capitation Rates

CMS has worked collaboratively with states and NAMD to take significant steps to improve our actuarial review of Medicaid capitation rates to reduce state administrative burden, improve efficiency in our review and ensure fiscal integrity. This effort has resulted in a 39% reduction in CMS review time to-date. In 2018, the average CMS review time was 130 days, which represented a strong improvement from the 193 day average for CMS review in 2015. Some examples of the process improvements, include: (1) creating a central CMS mailbox for submission and communication with states on Medicaid rate reviews to eliminate internal CMS processing time; (2) implementing a cover sheet to accompany state submissions to allow CMS's contract and rate review processes to begin more quickly; (3) focusing our actuarial review on the most significant issues to reduce the number and rounds of questions with states; (4) utilizing more technical assistance calls with states to work through complex issues; and (5) pilot testing an accelerated rate review process. CMS also issues an annual rate development guide outlining our documentation expectations for actuarial rate certifications so that states know which documentation to gather and submit in order to avoid requests for expected documentation.

CMS is committed to continuing our work with states to further fine-tune this process. CMS is currently gathering state feedback and evaluating the accelerated rate review pilot conducted in 2018 to further improve our review process. Once CMS completes our evaluation of the pilot, we will be communicating changes, if any, to our rate review process in the annual Medicaid managed care rate development guide.

Short-Term Process Improvements

Short-term process improvements will become effective over the next several months. They are designed to be implemented quickly with minimal effort and little, if any, disruption to states' internal processes. While the short-term process changes are currently voluntary, CMS strongly encourages states to implement them as we believe the short-term improvements will significantly streamline the review process.

15 Day Call

CMS will be asking states to participate in a call within 15 days of submitting a contract action. The call will provide states the opportunity to review the intent of the submission and any critical timelines, and will allow CMS the opportunity to request missing documentation and identify known major policy issues. This strategy has been used to successfully reduce SPA and 1915 waiver processing times, as discussed in a [CMS Informational Bulletin](#) issued in August 2018.

Contract & Rate Certification Submission Cover Sheet

On October 3, 2017, CMS and NAMD released a cover sheet for states to complete when submitting a contract action. The cover sheet provides general information about the states' managed care program and its contracted entities; the name and type of documents included in the submission; and detailed information on the scope and purpose of the amendment submitted for approval. When completed accurately and comprehensively, the cover sheet streamlines the review process by ensuring CMS has the necessary information at the outset to begin an efficient review of the submission.

Clear Identification of Contract Modifications

States are encouraged to identify the modifications implemented by contract amendments through submission of a red-lined version of the contract or other mechanism that clearly identifies the contract language that is being changed. The marked-up version should be submitted along with a clean copy of the contract action.

Tip Sheet for Complete Contract Action Submissions

CMS is often delayed in finalizing the review of states' contract submissions due to missing documents necessary for approval. Based on technical consultation with states through NAMD, CMS is providing the appended tip sheet to assist states in providing complete contract action submissions. The tip sheet provides guidance on requirements for a complete contract submission, including when approval of a contract action requires submission of additional documentation such as a rate certification, medical loss ratio (MLR) summary report, mental health/substance use disorder (MH/SUD) parity analysis, and/or readiness review results.

Intermediate and Long-Term Process Improvements

CMS' long-term goal is to reduce the amount of resources spent on contract review, so that states and CMS can rebalance their efforts, and focus on producing meaningful health outcomes. The intermediate process improvements are intended to substantially change the contract review process by modifying the submission process and developing a new approach to contract compliance. Within the next several months, CMS will be piloting a risk-based review of managed care contracts that focuses on a subset of managed care provisions. Under this approach, CMS anticipates spending significantly less time evaluating only written contract compliance and instead focus on outcomes-based oversight. In the meantime, CMS also will prioritize development of state and CMS resources for additional outcomes-based oversight, including toolkits on MLR reporting and annual oversight reporting. Such resources are in addition to existing toolkits on provider network adequacy and encounter data. Our goal is to implement a new review process nationally. CMS also hopes to supplement its contract monitoring with activities that strengthen our support of states' oversight activities. As part of this effort, CMS will be developing toolkits, disseminating best practices, and increasing data transparency to provide states with additional resources designed to improve state oversight of managed care delivery systems.

Pilot Project: Risk-Based Accelerated Contract Review Process

CMS acknowledges that we do not currently utilize a consistent timeline for review and approval of Medicaid managed care contracts. One key factor impacting CMS' ability to review contracts is a large variability in state submissions. CMS is committed to working in partnership with states to move toward a standardized submission and review process, including a clear timeline that assures adequate oversight in CMS' review and approval of states' contracts with managed care plans. As CMS works in partnership with states to move toward this goal, CMS is interested in piloting a risk-based accelerated contract review process. Our goal is to use the results of this pilot to inform CMS' implementation of a more streamlined and standardized contract review process that, potentially, can be implemented on a national level. CMS will pilot the risk-based accelerated review process with 7-10 states who are interested in testing and evaluating the new process. Pilot states operating multiple managed care programs may opt to include only contracts pertaining to a specific program(s) in the pilot. To be considered for the pilot, a state's most recently approved contract action must comply with all applicable Federal requirements, and the state cannot have any significant compliance or capitation rate development issues that are known to CMS.

Under the pilot, volunteer states will commit to utilizing a standardized contract submission process that aligns with the short-term process improvements discussed in the previous section, completing a streamlined checklist that documents compliance with key Federal requirements, and providing an assurance that the contract action is compliant with all applicable federal requirements. CMS and OACT will then conduct a review of the contract action under the risk-based accelerated review process, and send initial questions to the state within 30-45 days of receiving a contract amendment or initial base contract. For purposes of the pilot, CMS will not be accepting contract actions that authorize a new managed care program, a new managed care plan into an existing program, or a new population or benefit that is considered complex or high

risk. We will share additional information about the pilot through an upcoming solicitation directed to State Medicaid Directors

The pilot project will address the absence of Federal requirements in the contract action, missing documentation in the state's submission, the non-standardized submission process and the time-consuming process for evaluating compliance with Federal regulations. Additionally, this strategy increases transparency and efficiency related to CMS approval of managed care contracts; acknowledges the crucial, frontline role states currently play in the operation and oversight of managed care programs; ensures appropriate Federal oversight; and focuses Federal oversight on high risk areas that are critical to the fiscal integrity and delivery of quality and accessible Medicaid and CHIP benefits.

Oversight Tools for States and CMS

As CMS rebalances its oversight strategy, we will expand our efforts to develop resources that states can use to strengthen their own oversight mechanisms. Federal regulations require states to have robust oversight activities, several of which have recently gone into effect, or will soon go into effect. To meet these new requirements, CMS will be developing external toolkits for states; some examples include toolkits on creating medical loss ratio reports, annual oversight reporting, and other new tools focused on managed long-term services and supports. This work will build upon other resources CMS has developed for states, including a toolkit outlining state strategies for ensuring provider network adequacy and service availability, and an encounter data toolkit for collecting, validating and reporting Medicaid managed care data. CMS will also be developing internal toolkits to ensure CMS is reviewing the new information and data required under the Medicaid managed care regulations in a standardized and consistent manner across all states.

Increased Transparency in Program Administration

CMS has recently begun tracking a significant number of managed care metrics, with the aim of quantifying our progress toward greater efficiency and effectiveness. These data will help inform further enhancements to the managed care contract review process and enable CMS to provide external data on contract review timeframes as part of our Medicaid and CHIP Scorecard.

Next Steps for Managed Care Contract Review Process Redesign Project

The managed care contract review and approval processes represent a substantial workload for both states and CMS, and we are invested in continuing to collaborate with states to identify additional ways to enhance efficiency and reduce administrative burden. We look forward to receiving feedback from states as we move forward to implement the short-term and intermediate strategies. If you have questions or need additional information, please contact Hye Sun Lee, Regional Operations Group, or Alissa Deboy, Disabled and Elderly Health Programs Group.

Addendum: Tip Sheet for Complete Contract Action Submissions

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

1. 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, and
2. The following additional documentation, as described in the chart below.

When the Contract Action:	Additional documentation required	Regulatory Reference
Implements Medicaid capitation rates	Rate certification and all supporting documentation, when required	Medicaid: §438.7
Implements capitation rates for the state’s annual rating period	In addition to documentation noted elsewhere for Medicaid capitation rates: Annual summary of managed care plan medical loss ratio (MLR) reports	Medicaid: §438.74(a) CHIP: §457.1203(e)
Provides any services to MCO enrollees using a delivery system other than the MCO and 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)	MH/SUD parity analysis	Medicaid: §438.3(n)(2), §438.920 CHIP: §457.496(f), §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)