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*

**DATE:** June 12, 2024

**FROM:** Daniel Tsai, Deputy Administrator and Director

**SUBJECT:** Medicaid and CHIP Managed Care Monitoring and Oversight Tools, including States' Responsibility to Comply with Medicaid Managed Care and Separate CHIP Mental Health and Substance Use Disorder Parity Requirements

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). This guidance also reminds States of Medicaid managed care and separate CHIP mental health and substance use disorder parity requirements.

## Introduction

To improve monitoring and oversight of States' Medicaid and CHIP programs, CMS previously released three CIBs that included reporting templates and toolkits on managed care requirements and programmatic and operational best practices, including on access, quality, program integrity, financial reporting, etc. This CIB is the fourth 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.

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

On November 7, 2023, CMS released the third CIB[3] that provided additional updates and reminders on the web-based reporting portal and the reporting requirements for managed care programs. This guidance also provided an update on 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 on managed care plan transitions, tribal protections, and program integrity, as well as an updated toolkit on validating Medicaid managed care encounter data.

Today, CMS is releasing the fourth CIB that provides updates on efforts to expand web-based portal use for managed care reporting, contract, and rate submissions. The guidance also provides reminders on Medicaid managed care and separate CHIP mental health and substance use disorder parity requirements, additional State reporting requirements, CMS' process for review and approval of managed care contracts, and State responsibilities for managed care program oversight including related to parity.

## State Responsibilities for Managed Care Program Oversight

State Monitoring Requirements

It is essential for States to monitor their managed care plans' compliance with Federal requirements[4] and States are required to have a monitoring system for their managed care programs in accordance with 42 CFR § 438.66. While States have flexibility in how they design their monitoring system, it must demonstrably address all aspects of their managed care program(s) and managed care plan performance for at least the 13 specific program areas enumerated at 42 CFR § 438.66(b), which include appeal and grievance systems, medical management (including utilization management and case management), provider network management, and availability and accessibility of services (including network adequacy standards), and for all other provisions of the managed care contract, as appropriate. The regulations at 42 CFR § 438.66(c) further require that each State uses the data collected from its monitoring activities to improve the performance of its managed care program(s). The 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 managed care programs. States have flexibility in determining how to operationalize their monitoring system. To assist States with these efforts, CMS has issued multiple technical assistance toolkits and resources related to many programmatic areas, including those on access, quality, and program integrity.[5]

Recently the U.S. Department of Health and Human Services Office of Inspector General (OIG) released two reports detailing serious concerns on State and plan compliance with Federal requirements related to mental health (MH) and substance use disorder (SUD) parity[6] and prior

[3] https://www.medicaid.gov/sites/default/files/2023-11/cib11072023.pdf
[4] For this guidance, the term "managed care plan" refers to MCOs, PIHPs, PAHPs, and PCCM entities.
[5] https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-monitoring-and-oversight-initiative/index.html
[6] https://oig.hhs.gov/reports-and-publications/all-reports-and-publications/cms-did-not-ensure-that-selected-states-complied-with-medicaid-managed-care-mental-health-and-substance-use-disorder-parity-requirements/

authorization.[7] Out of a sample of 8 states, the OIG found that 5 States and their MCOs did not conduct required parity analyses by the compliance date established in CMS's regulations, and none of the 8 States made documentation of compliance available to the public by the compliance date. In addition, all 8 of the selected States may not have ensured that all services were delivered to MCO enrollees in compliance with MH/SUD parity requirements. In a separate review, the OIG reviewed data on prior authorization denials and appeals from a total of 115 MCOs and found that the MCOs denied 1 out of every 8 requests for the prior authorization of services in 2019. In addition, of the 115 MCOs reviewed, 12 plans had prior authorization denial rates greater than 25 percent – twice the average rate across all 115 MCOs. The OIG raised concerns that States do not have adequate oversight and monitoring of MCOs' decisions on prior authorization requests. Despite the high number of denials, most of the surveyed State Medicaid agencies reported that they did not routinely review the appropriateness of a sample of MCO denials of prior authorization requests, and many did not collect and monitor data on these decisions.

Medicaid and CHIP provide comprehensive coverage for millions of enrollees and CMS is deeply committed to ensuring timely access to high quality care and takes the OIG's findings very seriously.

As mentioned above, States are responsible for effectively monitoring and overseeing their managed care programs and CMS will hold States accountable to ensure that all Medicaid and CHIP beneficiaries receive high quality care in managed care programs. Below we remind States of several Federal requirements and expectations related to MH/SUD parity and forthcoming changes to the prior authorization requirements as part of the Interoperability and Patient Access final rule (CMS-0057-F).[8]

Medicaid and CHIP Mental Health and Substance Use Disorder Parity Requirements

As the largest single source of funding for MH and SUD services in the United States, Medicaid and CHIP fill a critical role in supporting access to services and treatment for millions of individuals living with MH and/or SUD conditions. Managed care is the predominant delivery system for Medicaid with 85 percent of all beneficiaries receiving some or all of their care through a managed care plan in 2021.[9] Ensuring compliance with Federal parity requirements in Medicaid and CHIP is fundamental to improving access to care for enrollees who need MH and/or SUD treatment.

Therefore, CMS reiterates to States that they must effectively oversee their Medicaid managed care and separate CHIP programs and comply with regulatory requirements at 42 CFR §§ 438.3(n) and subpart K and 457.496(d).[10,11] These regulations require States to ensure that all

[7] https://oig.hhs.gov/oei/reports/OEI-09-19-00350.asp

[8] https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

[9] https://www.medicaid.gov/sites/default/files/2023-07/2021-medicaid-managed-care-enrollment-report.pdf

[10] In separate CHIP, parity applies regardless of the type of delivery system.

[11] Parity requirements also apply to Medicaid alternative benefit plans (ABPs) regardless of the type of delivery system. Coverage for Medicaid benefits for beneficiaries that are not enrolled in an MCO and receive non-ABP state plan benefits offered under a fee-for-service delivery system are not subject to these parity standards. See

services delivered to enrollees of an MCO or a separate CHIP program are in compliance with Federal parity requirements, including that financial requirements,[12] such as coinsurance or copayments, and treatment limitations imposed on MH or SUD benefits may not be more restrictive than those applied to substantially all medical or surgical benefits in the same classification of benefits. For purposes of comparing benefits to assess parity, benefits must be mapped to one of four benefit classifications: inpatient, outpatient, emergency care, and prescription drugs as outlined in 42 CFR §§ 438.910(b)(2) and 457.496(d)(2)(ii). Treatment limitations, as defined in 42 CFR §§ 438.900 and 457.496(a), include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limits (QTLs) - which are expressly numerical (such as 50 outpatient visits a year) - and nonquantitative treatment limitations (NQTLs), which otherwise limit the scope or duration of benefits for treatment under a plan or coverage.[13] Common NQTLs, as outlined in 42 CFR §§ 438.910(d)(2) and 457.496(d)(4)(ii), include, but are not limited to, medical management standards, prior authorization, formulary design for prescription drugs, refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols), and standards for provider admission to participate in a network, including reimbursement rates. Application of NQTLs for MH or SUD benefits in a classification are prohibited unless, under the policies and procedures of the State/managed care plan, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH or SUD benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to medical or surgical benefits in the same classification.[14]

To support implementation of the Medicaid and CHIP parity regulations by States, CMS issued a detailed Parity Compliance Toolkit[15] and a Parity Implementation Roadmap,[16] as well as sets of Frequently Asked Questions.[17] CMS also hosted several webinars and provides individualized technical assistance to State Medicaid agencies.[18] CMS is in the process of producing additional resources to assist states with building and maintaining strong monitoring and oversight mechanisms to promote compliance with parity requirements. CMS urges States to ensure that beneficiaries are aware of their rights under mental health parity - consumer information about parity can be found in the Consumer Guide to Disclosure Rights: Making the Most of Your Mental Health and Substance Use Disorder Benefits at https://store.samhsa.gov/sites/default/files/sma16-4992.pdf, and a related brochure entitled Know

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further details on these requirements at: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/parity/index.html.

[12] Financial requirements are defined at 42 CFR §§ 438.900 and 457.496(a).

[13] "Soft limits" or benefit limits that allow for an individual to exceed numerical limits based on medical necessity are also considered NQTLs.

[14] Examples of impermissible NQTLs are outlined in slides from a webinar held on March 9, 2017: https://www.medicaid.gov/sites/default/files/2019-12/parity-webinar-030917.pdf

[15] https://www.medicaid.gov/sites/default/files/2020-07/parity-toolkit.pdf

[16] https://www.medicaid.gov/sites/default/files/2019-12/parity-roadmap.pdf

[17] https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/faq101117.pdf

[18] Webinar #1: https://www.medicaid.gov/sites/default/files/2019-12/parity-webinar.pdf; Webinar #2: https://www.medicaid.gov/sites/default/files/2019-12/parity-webinar-022317.pdf; Webinar #3: https://www.medicaid.gov/sites/default/files/2019-12/parity-webinar-030917.pdf

Your Rights: Parity for Mental Health and Substance Use Disorder Benefits at: https://store.samhsa.gov/sites/default/files/pep21-05-00-003.pdf.[19]

States must provide documentation of how services to Medicaid MCO enrollees and separate CHIP beneficiaries are delivered in compliance with the requirements of 42 CFR subpart K and 42 CFR § 457.496. CMS reiterates that, for Medicaid managed care, States are required to provide documentation to CMS in accordance with 42 CFR § 438.3(n)(2) when any medical, surgical, MH, or SUD benefits are not included in an MCO's Medicaid contract and are provided using another delivery system or through a different managed care plan. Additionally, CMS reinforces our expectation that when the State's contract requires an MCO to provide all medical, surgical, MH, and SUD benefits for a Medicaid population, States analyze the MCOs' analyses of Medicaid parity in MH and SUD benefits to comply with 42 CFR § 438.920(b)(2), and submit these to CMS. As CMS stated in the 2016 final Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans rule: "When the MCO provides all medical/surgical and MH/SUD benefits, the statute imposes the parity compliance on the MCO. It is implicit in our final rule, at § 438.920(a), that the MCO perform the analysis in those circumstances. We believe that states should be aware of the timeframe for completing the parity analysis and the outcomes when the MCO does it to be sure the state oversees the delivery of benefits in a manner that is compliant with these rules, including implementing any appropriate contract changes." (81 FR 18414) For separate CHIPs, parity analysis and supporting documentation must be submitted as part of the State plan amendment (SPA) review process regardless of type of delivery system.

Additionally, all Medicaid managed care[20] and separate CHIP analyses must be updated when necessary, including when benefits, QTLs or NQTLs or financial requirements change, or deficiencies are corrected, or when new managed care plans are added to a managed care program (i.e., new MCOs, or PIHPs or PAHPs providing services to MCO enrollees). For separate CHIPs, States will also have to submit revised analyses if there is a delivery system change. Parity analyses should be submitted to CMS as part of the Medicaid managed care plan contract submissions and CHIP SPA submissions that CMS reviews and approves in accordance with 42 CFR §§ 438.3(a) and 457.60.

States must also effectively monitor parity requirements as part of their Medicaid managed care program monitoring activities as required in 42 CFR § 438.66 and to enable compliance with § 438.920(b). As part of States' monitoring efforts, States should ensure that their policies include written procedures for regularly reviewing compliance with MH/SUD parity requirements such as contract renewals for managed care plans and amendments to the State plan and, as outlined above, other events can trigger review of parity compliance. States can also leverage existing oversight and plan assessment tools to monitor plan performance and compliance, including plan reporting requirements, network adequacy and access requirements, Healthcare Effectiveness

[19] Additional resources on parity compliance are found at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity

[20] 42 CFR § 438.920(b)(1)

Data and Information Set (HEDIS) submissions, beneficiary complaint processes, etc.[21] State oversight of parity requirements in commercial plans found that it is useful to review consumer complaints, compliance surveys, market conduct examinations, and/or network adequacy assessments in this review to identify potential areas of noncompliance.[22]

States must conduct timely follow-up with plans that have identified parity compliance issues to verify that corrective actions have been fully implemented. We also reiterate that CMS expects that States have clear contract provisions to hold their plans accountable for compliance with the parity requirements, including specific potential enforcement actions by the state for continued non-compliance. In light of the OIG's finding that some States did not make these parity analyses available to the public, CMS reiterates that States should provide documentation of compliance with these requirements, including the States' and MCOs' parity analyses, to the general public and post this information on the State Medicaid website in accordance with 42 CFR § 438.920(b)(1). To facilitate State reporting of plan performance and increase transparency on this vital topic, CMS is updating the MCPAR to include fields to collect data related to these parity requirements.

Prior Authorizations, Interoperability and Patient Access

CMS is very concerned about recent OIG findings regarding the high prior authorization denial rates by some MCOs, and OIG's concern that States did not have adequate oversight in this area. Plans' use of prior authorization processes is often a core component of enrollees' access to services. As such, States must ensure that they exercise rigorous oversight of plans' prior authorization processes and performance to ensure that Medicaid and CHIP enrollees receive medically necessary services without inappropriate delays or obstacles. This oversight is a State responsibility in accordance with 42 CFR § 438.66 and CMS expects robust and comprehensive state activity and documentation to fulfill these obligations.

CMS also recently took action to expand plans' accountability for prior authorization processes. The Interoperability and Patient Access final rule (CMS-0057-F), which appeared in the Federal Register on February 8, 2024,[23] includes several provisions that impact Medicaid and CHIP managed care plans. CMS strongly encourages States to begin planning efforts with their managed care plans now to ensure timely and effective implementation. For rating periods starting on or after January 1, 2026, Medicaid and CHIP managed care plans will be required to (1) provide standard prior authorization decisions within state-established timeframes that cannot exceed **7** calendar days for non-expedited matters;[24] (2) provide a specific reason for every

[21] An Implementation Roadmap for State Policymakers Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Program. Centers for Medicare and Medicaid Services. 2017. https://www.medicaid.gov/sites/default/files/2019-12/parity-roadmap.pdf

[22] Substance Abuse and Mental Health Services Administration. Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States. Rockville, MD: U.S. Department of Health and Human Services; 2016. https://store.samhsa.gov/sites/default/files/sma16-4983.pdf

[23] https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

[24] 42 CFR §§ 438.210(d) and 457.1230(d). This is a reduction from the current maximum of 14 days. Expedited prior authorization decisions remain unchanged as part of the Interoperability and Patient Access final rule (CMS-0057-F); the maximum standard for expedited prior authorization decisions is "no later than 72 hours." 42 CFR § 438.210(d)(1) and (2) do not apply to covered outpatient drugs.

denial;[25] and (3) post annual prior authorization metrics on their public website including the number of requests approved, denied, approved after appeal, and the average time between submission and decision.[26] For rating periods starting on or after January 1, 2027, there are new requirements for managed care plans' Patient, Provider, and Payer-to-Payer Application Programming Interfaces (APIs) to include prior authorization information. There is also a requirement for Medicaid and CHIP managed care plans to have a Prior Authorization API that will (1) identify all services that require prior authorization; (2) specify the documentation requirements for each; and (3) enable prior authorization requests and responses to be exchanged.[27] For a comprehensive summary of all Federal requirements related to this final rule, we encourage States, plans, and other stakeholders to review this final rule and the resources published by CMS.[28] To facilitate State reporting of plan performance, CMS is updating the MCPAR to include fields to collect data related to the prior authorization requirements.

**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), for Medicaid and CHIP respectively. Specific information on each of these reports is available on Medicaid.gov.[29]

CMS initially 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 now collects both MCPAR and MLR reports from States. MDCT-MCR collects the same information included in the Excel templates, creating a single submission process and repository for these State reporting requirements. CMS is working to incorporate the NAAAR into the MDCT-MCR system next. 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. Along with assessing compliance with managed care statutory and regulatory requirements, CMS will use these data to identify areas for improvement and target technical assistance to help States improve their managed care programs and plan performance. CMS continues to update fields in the MCPAR, NAAAR and MLR summary reporting to facilitate State reporting of plan performance and increase transparency including to address regulatory requirements and audit findings. We encourage all States to assess contract changes necessary to ensure necessary plan reporting for these efforts.

<u>Managed Care Reporting Reminders</u>
CMS would also like to remind States of the submission requirements for the MCPAR, NAAAR, and MLR Summary Report.

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[25] 42 CFR §§ 438.242(b)(8) (cross-referencing § 431.80(a)) and 457.1233(d) (cross-referencing § 438.242(b)).
[26] 42 CFR §§ 438.210(f) and 457.1230(d).
[27] 42 CFR §§ 438.242(b)(7) (cross-referencing § 431.80(b)) and 457.1233(d) (cross-referencing § 438.242(b)).
[28] https://www.cms.gov/priorities/key-initiatives/burden-reduction/policies-and-regulations/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f
[29] https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html

*Medicaid Managed Care Program Annual 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 |
|---|---|---|
| January through December | 1/1/2023 – 12/31/2023 | June 28, 2024 |
| April through March | 4/1/2023 – 3/31/2024 | September 27, 2024 |
| July through June | 7/1/2023 – 6/30/2024 | December 27, 2024 |
| September through August | 9/1/2023 – 8/31/2024 | February 27, 2025 |
| October through September | 10/1/2023 – 9/30/2024 | March 29, 2025 |
| January through December | 1/1/2024 – 12/31/2024 | June 29, 2025 |

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. Based on these in-depth efforts with States, CMS also published Frequently Asked Questions (FAQs) as a technical assistance resource for States in March 2024.[30] These FAQs are structured into three categories: (1) general questions on reporting; (2) operational questions on submission through the web-based portal; and (3) questions on the content included in the MCPAR.

Over the last eighteen months, CMS has made several updates to the MCPAR to ensure the report is functioning correctly, to add functions to make the template work better for States, and to revise questions to ensure the report collected useful information. For example, CMS revised the MCPAR to align the reporting period for all appeals, State fair hearings, and grievance questions, as well as the enrollment questions, so that States report all values for the full reporting years. CMS updated the MCPAR web-based form in MDCT-MCR to reduce State administrative burden by allowing certain responses, such as quality performance measure descriptions, to carry over to the next year's MCPAR, and implemented a shorter MCPAR for programs reporting solely on primary care case management entities (PCCM entities) that is limited to two required sections. CMS also resolved MDCT-MCR system issues that impacted MCPAR reporting, such as removing the limit on the number of quality measures that could be submitted in the MCPAR. CMS expects that the need for MCPAR updates will decline over time as the MCPAR reporting process matures, and we intend to move to update the MCPAR on standard cycles.

CMS is also undertaking efforts to improve transparency by publicly posting MCPARs in the

[30] https://www.medicaid.gov/sites/default/files/2024-03/mcpar-faq-march-2024.pdf

next year on a regular basis on Medicaid.gov. CMS reminds States that they must post MCPARs on the State's website in accordance with 42 CFR § 438.66(e)(3)(i).[31] Additionally, States must provide the MCPAR to the Medical Care Advisory Committee and, if the program includes MLTSS, to the stakeholder consultation group specified in 42 CFR § 438.70.

*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 managed care organization (MCO), prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (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 no less frequently than:

- 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[32] for the NAAAR. CMS anticipates this report will be collected through the MDCT-MCR in the future, though this reporting functionality is not yet available. CMS will notify States when the web-based NAAAR form is available, as this effort is in development. Until that time, States are required to submit the Excel template of the report to MCGDMCOActions@cms.hhs.gov.

*Medical Loss Ratio (MLR) Summary Report*
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 MCOs, PIHPs, and PAHPs under contract with the State. CMS announced the implementation of the MLR template in MDCT-MCR as part of the CIB published on November 7, 2023. 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. CMS is also undertaking efforts to improve transparency by publicly posting public use files for MLR Summary Reports in the next year on a regular basis on Medicaid.gov.

Comprehensive information about all managed care reporting requirements is available on

[31] In the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality final rule (CMS-2439-F) that was published on May 10, 2024, CMS revised 42 CFR § 438.66(e)(3)(i) to require that the MCPAR be posted on the state's Web site within 30 calendar days of submitting it to CMS. This will be required as of the effective date of the final rule (i.e., July 9, 2024.)
[32] A link to the template is available at https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html

Medicaid.gov.[33] If States require additional technical assistance on these reports, please reach out to CMS at ManagedCareTA@cms.hhs.gov.

## CMS Review of Managed Care Contracts

Minimum Documentation Standards for Medicaid Managed Care Plan Contracts

Federal regulations at 42 CFR § 438.3 require CMS to review and approve States' Medicaid managed care contracts. CMS is not able to consider a contract action for approval until a complete managed care plan contract action submission includes all required components. See Appendix 1 of the CIB published on November 7, 2023, for details on the components of a complete managed care plan contract submission, including executed contract actions, a parity analysis, etc.[34]

Historically, CMS began our review of Medicaid managed care plan contracts once a submission was received from a State, even in cases where components of the managed care plan contract were missing, or other key documents were absent. This approach has led to inefficiencies in our review process and resulted in increasingly long review times. 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 consistent with authority in section 1902(a)(4) of the Social Security Act to establish methods for proper and efficient operation in Medicaid. Therefore, the CIB published on November 7, 2023, announced a change to our review of Medicaid managed care plan contracts. Beginning with contract actions effective July 1, 2024, CMS will not begin review of Medicaid managed care plan contracts until minimum document standards for the contract submission are met. These changes will occur in two phases. Phase 1 will begin for any managed care plan contracts 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 of the CIB published on November 7, 2023, for further details on this approach.[35]

Managed Care Review (MC-Review)

CMS is currently developing a web-based system, entitled Managed Care Review (MC-Review), for State submission and CMS review of Medicaid managed care contracts and rates, and CMS continues to expand functionality of this system. CMS believes a single web-based system for submission and review of Medicaid managed care contracts and rates will lead to increased efficiencies in our review process, increase transparency of our expectations by utilizing structured data fields to aid State submission of these actions, and reduce State administrative burden. The 14 States currently utilizing MC-Review have provided positive feedback about the system's efficiencies and ease of use. CMS strongly encourages States to consider early adoption of this system to improve efficiencies. If your State is interested in participating in MC-Review, please reach out to CMS at ManagedCareTA@cms.hhs.gov.

## Closing

CMS is committed to strengthening the monitoring and oversight of Medicaid and CHIP

[33] https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html
[34] https://www.medicaid.gov/sites/default/files/2023-11/cib11072023.pdf
[35] https://www.medicaid.gov/sites/default/files/2023-11/cib11072023.pdf

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.