Instructions

Regulations at 42 C.F.R. § 438.207(a) - (c) require Medicaid managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs)—collectively referred to as "managed care plans"—to submit documentation to the state demonstrating their capacity to serve the expected enrollment of their service areas in accordance with the state's standards for access to care, including the state's network adequacy and availability of services standards under 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206. Managed care plans are required to submit this information to the state no less frequently than:

Scenario 1: At the time the plan enters into a contract with the state;
Scenario 2: On an annual basis;
Scenario 3: At any time there has been a significant change (as defined by the state) in the plan's operations that would affect the adequacy of capacity and services, including (1) changes in the plan's services, benefits, geographic service area, composition of or payments to its provider network, or (2) enrollment of a new population in the plan.

After the state reviews the documentation submitted by a plan, 42 C.F.R. § 438.207(d) requires the state to submit to the Centers for Medicare & Medicaid Services (CMS) an assurance that the plan complies with the state's network adequacy and availability of services standards under 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206. The submission must include documentation of an analysis that the state conducted to support its assurance of compliance for the plan.

This document provides instructions and a template for states to use when submitting this information to CMS under any of the three scenarios described above. States should complete one (1) form with information for applicable managed care plans and their applicable managed care programs. For example, if the state submits this form under scenario 1 above, the state should submit this form only for the managed care plan that entered into a new contract with the state. The state should not report on any other plans or programs. As another example, if the state submits this form under scenario 2, the state should submit this form for all managed care plans. If the state's analysis methods and results are contained in separate documents, please also submit those documents with this form.

Consistent with the Managed Care Program Annual Report (MCPAR) required by 42 C.F.R. § 438.66(e), this report defines a program as having a specified set of benefits, eligibility criteria, and capitation rates that are articulated in a contract between the state and managed care plans.

MMPs are considered both Medicaid and Medicare managed care plans and are not exempt from 42 CFR 438.207. Therefore, states must submit the tool for integrated plans; however, to reduce duplication, states can complete network adequacy sections of the tool (II.A.1-II.A.5) for Medicaid-only covered services.

States do not need to submit the tool for Program of All-Inclusive Care for the Elderly (PACE) programs/plans as states are not required to do so under 42 CFR 438.207.

In the future, this report will be collected through the online MDCT-Managed Care Reporting tool. CMS will notify states when the web-based forms are available and will provide adequate notice prior to requiring submission through the web-based forms. The excel template may be submitted to

mcgdmcoactions@cms.hhs.gov

Organization

This template includes two sections (Section I and Section II). Section I covers descriptive information about the state and all of the managed care programs operating in the state; information for this section is contained in one tab. Section II includes detail on program-level access standards, monitoring methods, and plan-level compliance data. For Section II, states should use **one tab for each program** the state is reporting on and leave unused tabs blank.

Tab topic:	Tab name:	Number of tabs available:
I. State and program-level information	I_State&Prog_Info	1
II. Program-level standards, monitoring methods, and plan-level compliance	II_Prog_X	15

Inputting information

Each tab provides instructions in the "Item Instructions" column. Response types are provided in the "Data Format" columns. Only input values in BEIGE CELLS. Program names and program summary information (i.e., plan types included in a program, services covered under a program) in Section II autopopulates from Section I to reduce burden on states.

After reporting information on each applicable program in the Section II tabs, leave any unused tabs blank. For example, if the state is reporting on plans in five managed care programs, it should enter information in tabs "II_Prog_1" through "II_Prog_5", and leave the remaining tabs blank.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0920 (Expires: June 30, 2024). The time required to complete this information collection is estimated to average 6 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

I. State and program information

A. State information and reporting scenario

States should use this section of the tab to report their contact information, date of report submission, and reporting scenario.

Input state-level data in this column

#	Item	Item Instructions	Data Format	Hawaii
I.A.1	Contact name	Enter the name of the individual(s) filling out this document.	Free text	Grant Shiira
I.A.2	Contact email address	Enter the email address(es) of the individual(s) filling out this document.	Free text	gshiira@dhs.hawaii.gov
I.A.3	State or territory	Enter the state or territory represented in this document.	Set values (select one)	Hawaii
I.A.4	Date of report submission	Enter the date on which this document is being submitted to CMS.	Date (MM/DD/YYYY)	6/16/2025
I.A.5	Reporting scenario	Enter the scenario under which the state is submitting this form to CMS. Under 42 C.F.R. § 438.207(c) - (d), the state must submit an assurance of compliance after reviewing documentation submitted by a plan under the following three scenarios: - Scenario 1: At the time the plan enters into a contract with the state; - Scenario 2: On an annual basis; - Scenario 3: Any time there has been a significant change (as defined by the state) in the plan's operations that would affect its adequacy of capacity and services, including (1) changes in the plan's services, benefits, geographic service area, composition of or payments to its provider network, or (2) enrollment of a new population in the plan. As described in the instructions tab, states should complete one (1) form with information for applicable managed care plans and programs. For example, if the state submits this form under scenario 1 above, the state should submit this form only for the managed care plan (and the applicable managed care program) that entered into a new contract with the state. The state should not report on any other plans or programs under this scenario. As another example, if the state submits this form under scenario 2, the state should submit this form for all managed care plans and managed care programs.	Set values (select one)	Scenario 2: Annual report
I.A.6	Reporting scenario - other	If the state is submitting this form to CMS for any reason other than those specified in I.A.5, explain the reason.	Free text	No

B. Program information

States should use this section of the tab to report information on applicable managed care programs under the scenario selected in I.A.5, including reporting periods and providers covered under the programs.

Input program-level data in beige cells

#	Item	Item Instructions	Data Format	QUEST Integration
I.B.1	Program name	Enter the name of each managed care program in the state in columns E - S. After entering each managed care program name, leave any unused columns in E - S blank. A program is defined by a specified set of benefits, eligibility criteria, and capitation rates that are articulated in a contract between the state and managed care plans. If more than one program is included in a single contract, enter one program per column, starting with column E. Each program entered into these fields will auto-populate program fields in the remaining tabs of this document.	Free text	QUEST Integration
I.B.2	Statutory authority	Enter the statutory authority(ies) (e.g. Section 1115, 1915(b), etc.) for each managed care program in the state in columns E - S. After entering the authority(ies) for each program, leave any unused columns in E - S blank.	Free text	1115 Waiver
I.B.3	Plan type included in program	Indicate the managed care plan type (MCO, PIHP, PAHP, or MMP) that contracts with the state in each program.	Set values (select one) or use free text for "other" response	MCO
Reporting Period		*For items I.B.4 and I.B.5, indicate the reporting period for the analysis and compliance information entered into this report. CMS expects states to enter a reporting period end date that is no more than one year prior to the submission of this report.* *Under scenario 1 (new contract) and 3 (significant change in plan operations), the reporting period may cover less than one year.* *Under scenario 2 (annual report), the reporting period should cover one year.*	(none)	(header/blank cell)
I.B.4	Reporting period start date	For each program, enter the start date of the reporting period for the analysis and compliance information entered into this report.	Date (MM/DD/YYYY)	1/1/2023
I.B.5	Reporting period end date	For each program, enter the end date of the reporting period for the analysis and compliance information entered into this report.	Date (MM/DD/YYYY)	12/31/2023
Providers		*For items I.B.6.a - k, indicate whether the program covers each 42 C.F.R. § 438.68 provider type specified.* *For MMPs, only enter providers of Medicaid-only covered services. Do not enter providers of Medicaid and Medicare or Medicare-only covered services.*	(none)	(header/blank cell)
I.B.6.a	Adult primary care	Indicate whether the program covers adult primary care providers.	Set values (select one)	Covered
I.B.6.b	Pediatric primary care	Indicate whether the program covers pediatric primary care providers.	Set values (select one)	Covered
I.B.6.c	OB/GYN	Indicate whether the program covers Ob/Gyn providers.	Set values (select one)	Covered
I.B.6.d	Adult behavioral health	Indicate whether the program covers adult behavioral health providers.	Set values (select one)	Covered
I.B.6.e	Pediatric behavioral health	Indicate whether the program covers pediatric behavioral health providers.	Set values (select one)	Covered
I.B.6.f	Adult specialist	Indicate whether the program covers adult specialist providers.	Set values (select one)	Covered
I.B.6.g	Pediatric specialist	Indicate whether the program covers pediatric specialist providers.	Set values (select one)	Covered
I.B.6.h	Hospital	Indicate whether the program covers hospital providers.	Set values (select one)	Covered
I.B.6.i	Pharmacy	Indicate whether the program covers pharmacy providers.	Set values (select one)	Covered
I.B.6.j	Pediatric dental	Indicate whether the program covers pediatric dental providers.	Set values (select one)	Not covered
I.B.6.k	LTSS	Indicate whether the program covers long-term services and supports (LTSS) providers.	Set values (select one)	Covered
I.B.6.l	Other (optional field for the state)	Indicate (1) any notes for items I.B.6.a - k and/or (2) other provider types relevant to the state's network adequacy standards (42 C.F.R. § 438.68) or availability standards (42 C.F.R. § 438.206) covered under the program not listed in items I.B.6.a - k.	Free text (optional field for the state)	None

C. Separate analysis and results documents

States should use this section of the tab to report on separate documents submitted with this form that contain the state's analysis and results information requested in tabs "II_Prog_X".

Input program-level data in beige cells

#	Item	Item Instructions	Data Format	QUEST Integration
		For item I.C.1, indicate for each program in columns E-S whether the state's analysis methods and results regarding plan compliance with the state's 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206 standards are contained in a separate document(s). Before indicating "yes", ensure that the document(s) contains the information requested in tabs "II_Prog_X". If the state reports "yes" in I.C.1 , indicate in items I.C.2 - I.C.4 the name and date of the document(s) as well as the page/section numbers for where the program is addressed in the document(s). Submit the document(s) with this form. For any program for which the state reports "no" in I.C.1 (meaning that the state does not report analysis methods and results in a separate document[s]), the state must enter data in Sections B and C in tabs "II_Prog_X".	(none)	(header/blank cell)
I.C.1	Analysis and results in separate documents	For each program in columns E-S, indicate whether the state's analysis methods and results regarding plan compliance with the state's 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206 standards are contained in a separate document(s). If yes, submit the document(s) with this form.	Set values (select one)	No, analysis methods and results are not contained in a separate document(s)
I.C.2	Name of analysis and results documents	If the state indicated that analysis methods and results are contained in a separate document(s) for any program in columns E-S, indicate the name of the document(s). If analysis methods and results are not contained in a separate document(s), write "N/A."	Free text	
I.C.3	Date of analysis and results documents	If the state indicated that analysis methods and results are contained in a separate document(s) for any program in columns E-S, indicate the date of the document(s). If analysis methods and results are not contained in a separate document(s), write "N/A."	Free text	
I.C.4	Page/section references in analysis and results documents	If the state indicated that analysis methods and results are contained in a separate document(s) for any program in columns E-S, indicate the page/section numbers for where the program is addressed in the document(s). If analysis methods and results are not contained in a separate document(s), write "N/A."	Free text	

II. Program-level standards, monitoring methods, and plan compliance

Enter the state's standards and results from the 1. Program Summary.

Program Summary	QUEST Integration	
Plan type included in program/contract	All MCOs	
Services included in managed care/program	Adult primary care, Pediatric primary care, OB/GYN, Adult behavioral health, Pediatric behavioral health, Adult specialist, Pediatric specialist, Hospital, Pharmacy, LTSS, other services	
Analytic approach used to manage/monitor	Analytic methods and results are not contained in a separate file (unless specified below)	BETA OK: analysis and results correctly reported in EB-1.0
Name of analysis and results document	<Placeholder for separate analysis and results document>	
Date of analysis and results document	<Placeholder for separate analysis and results document>	

Context: Regulations at 42 C.F.R. § 438.358(b)(1)(ii) require states that contract with MCOs, PAHPs, and PIHPs to submit to CMS information on the state's network adequacy and availability of services standards under 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206. Review the states network adequacy and availability of services standards under 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206 to ensure that the state has adequate information to report to CMS to support its assurance of compliance for each plan. The state must submit this information to CMS after receipt of approval/notification from the state that the plan is in compliance with 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206. The Table below provide a template for states to submit this information for the program listed at the top of the tab.

A. Access and network adequacy standards required for plans participating in the program

Instr: Instruct use this section of the tab to report each standard included in managed care program contracts; report each unique standard in columns B – J.

| | | | | <= Input program-level data in columns for Standard 1 through Standard 100>> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---