DEPARTMENT OF HEALTH AND HUMAN SERVICES
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CMCS Informational Bulletin

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FROM: Brian Neale, Director
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SUBJECT: **Medicaid Managed Care Regulations with July 1, 2017 Compliance Dates**

The Centers for Medicare & Medicaid Services' (CMS) Medicaid managed care final rule[1] includes several provisions that have a compliance date beginning with the rating period for managed care contracts that start on or after July 1, 2017. States and managed care plans are required to comply with these provisions; however, as states have noted, there can be administrative challenges associated with updating states' managed care contracts and operational procedures. These challenges can prevent timely compliance with the new July 1, 2017 requirements.

Health and Human Services Secretary Thomas E. Price, M.D. and CMS Administrator Seema Verma, MPH, issued a letter to the nation's Governors on March 14, 2017[2], affirming the continued HHS and CMS commitment to partnership with states in the administration of the Medicaid program and noting key areas where we will improve collaboration with states and move towards more effective program management. In that letter, CMS committed to a review of the managed care regulations in order to prioritize beneficiary outcomes and state priorities. Any modifications or changes to the Medicaid managed care final rule will generally necessitate rulemaking as required by the Administrative Procedure Act[3] (APA). However, while we conduct this thorough review, CMS intends to use our enforcement discretion to focus on working with states to achieve compliance with the managed care regulations when states are unable to implement new and potentially burdensome requirements of the final rule by the required compliance date, particularly provisions with a compliance deadline of contracts beginning on or after July 1, 2017. This use of enforcement discretion will be applied based on state-specific facts and circumstances and focused on states' specific needs.

To implement this targeted enforcement discretion, states will need to identify for CMS those regulations of the final rule that they are unable to implement by the required compliance date. States should work through their normal regional office processes to identify the specific regulations. CMS will work with states on assessing compliance with the specific regulation, including (1) the specific goals and intent for the regulation; (2) compliance with regulatory standards that were in effect prior to the Medicaid managed care rule publication in 2016; (3) alternatives the state could consider in moving toward compliance and strategies for how states

1 Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule, 81 Fed. Reg. 27498 (May 6, 2016)
2 Letter to the nation's Governors on March 14, 2017
3 Guide to the Rule Making Process

can best mitigate specific risks and concerns with non-compliance; and (4) developing a timeline for future compliance with the regulatory requirement.

Notwithstanding this guidance, CMS is unable to permit flexibility for all provisions of the final rule for which compliance is required for contracts beginning on or after July 1, 2017. Specifically, we cannot permit flexibility for:

1. The actuarial soundness and payment provisions found in §§ 438.4, 438.5, 438.6, and 438.7;

2. The pass-through payment provisions found in §438.6(d); and

3. The medical loss ratio (MLR) provisions found in §§ 438.8 and 438.74.

These provisions in the final rule have significant federal fiscal implications for the Medicaid program and CMS will require compliance by the specified date in the final rule. Additionally, the pass-through payment regulations in §438.6(d) and the MLR regulations in §438.8 have the July 1, 2017 compliance date incorporated into the regulatory text.

We note for clarity that the MLR provisions for managed care contracts that start with rating periods for contracts beginning on or after July 1, 2017 require that states include requirements for managed care plans to calculate and report an MLR and the underlying data as described in §438.8(k). This provision is different than the requirement that capitation rates be developed in such a way that the managed care plan would reasonably achieve an MLR of at least 85 percent as described in §438.4(b)(9). That specific provision is applicable for the managed care contract rating period that begins on or after July 1, 2019.

To assist states in meeting the pass-through payment provisions in §438.6(d), there are mechanisms to build in the amounts currently provided through pass-through payments in approvable ways, such as approaches consistent with §438.6(c) that tie managed care payments to services and utilization covered under the managed care contract that are in compliance with the final rule.

Technical Assistance

CMS remains committed to providing technical assistance to states and other stakeholders in understanding the Medicaid managed care regulatory provisions and developing implementation approaches that maximize the provision of Medicaid services in a manner compliant with program requirements. If you have questions or would like to request technical assistance related to the guidance in this informational bulletin, please send an email to ManagedCareRule@cms.hhs.gov. We look forward to continuing our partnership to deliver on our shared goals of providing high quality, sustainable healthcare to those who need it most.